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Health

https://www.health.state.mn.us/

AT A GLANCE

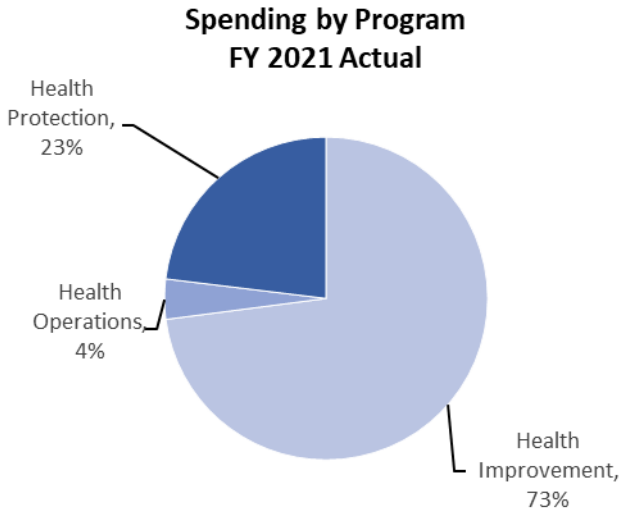
- Manage annual budgetary resources of $863 million.
- Secure annual federal funding of $406 million to support critical public health activities
- Provide guidance and oversight for over $264 million in annual outgoing grants to more than 500 unique grantees across the state.
- Maintain a highly skilled workforce of 1,655 staff that includes doctors, nurses, health educators, biologists, chemists, epidemiologists, and engineers.
- Meet rigorous standards set by the Public Health Accreditation Board.

PURPOSE

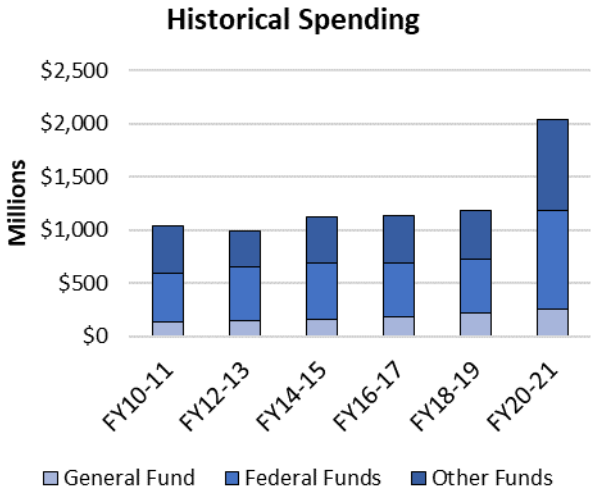
The Minnesota Department of Health (MDH) mission is to protect, maintain, and improve the health of all Minnesotans. MDH is the state's lead public health agency, responsible for operating programs that prevent infectious and chronic diseases, while promoting and ensuring clean water and air, safe food, quality health care, and healthy living. The department works to improve the health of all communities in the state by incorporating the best evidence and health equity considerations into our decisions or activities.

MDH carries out its mission in close partnership with local public health departments, tribal governments, the federal government, health care delivery organizations in acute and long term care, and many health-related organizations. In meeting its responsibilities, the department also recognizes the strong connection between overall population health and a wide range of government policies from economic development to education to transportation. The department uses the best scientific data and methods available to prevent illness and injury, propose strategies to improve the availability and quality of health care, and help ensure the conditions in which all people can be healthy.

BUDGET



Source: Budget Planning & Analysis System (BPAS)



Source: Consolidated Fund Statement

STRATEGIES

While Minnesota ranks as one of the healthiest states in the nation, significant disparities in health outcomes persist because the opportunity to be healthy is not equally available for everyone in the state. The MDH vision is one of health equity, meaning a state in which all communities are thriving and all people have what they need to be healthy. Improving the health of those experiencing the greatest inequities will result in improved health outcomes for all.

Our key strategies for protecting, maintaining, and improving Minnesotans' health include:

- Maintaining a nation-leading position in disease investigation and response, environmental health protection, and laboratory science.
- Reinforcing our partnerships with the state's local public health organizations to ensure a strong public health infrastructure in all corners of the state.
- Working with cross-sector partners in health care and beyond to change policies and practices at the community level to support greater opportunities for promoting health and reducing risks, both to improve the health of the population and to reduce future health care costs.

The Department of Health is primarily governed by the following statutes:
M.S. 144 (https://www.revisor.mn.gov/statutes/?id=144)
M.S. 145 (https://www.revisor.mn.gov/statutes/?id=145)
M.S. 145A (https://www.revisor.mn.gov/statutes/?id=145A)
M.S. 62J (https://www.revisor.mn.gov/statutes/?id=62j)
Each budget activity narrative lists additional relevant statutes.

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	122,667	130,380	144,775	304,594	160,626	155,769	356,638	346,843
1100 - Medical Education & Research	79,306	78,934	78,984	68,568	7,725	7,725	0	0
1200 - State Government Special Rev	57,266	57,770	66,735	77,737	72,644	72,644	79,949	82,478
1250 - Health Care Response	40,253	94,014						
1251 - COVID-19 Minnesota	145,739	66,248						
2000 - Restrict Misc Special Revenue	3,826	2,965	2,964	10,361	1,995	1,995	9,571	19,396
2001 - Other Misc Special Revenue	110,718	39,492	46,916	75,281	66,586	66,586	66,586	66,586
2050 - Environment & Natural Resources	342		180					
2302 - Clean Water	5,665	5,956	6,416	10,183			11,296	11,904
2360 - Health Care Access	35,180	34,864	34,645	43,561	38,385	40,644	52,207	56,921
2403 - Gift	6	1,001	0	154				
2800 - Environmental	636	1,255	647	1,217	932	932	1,332	1,332
2801 - Remediation	232	191	239	275	257	257	257	257
3000 - Federal	228,661	449,540	934,107	693,199	490,164	366,422	490,164	366,422
3001 - Federal TANF	10,503	11,530	11,579	11,713	11,713	11,713	11,713	11,713
3010 - Coronavirus Relief	24,112	202,902	40,066					
3015 - ARP-State Fiscal Recovery			81,121	22,091	3,466		3,466	
8201 - Drinking Water Revolving	622	672	666	762	756	756	756	756
Total	**865,735**	**1,177,715**	**1,450,040**	**1,319,696**	**855,249**	**725,443**	**1,083,935**	**964,608**
Biennial Change				726,286		(1,189,044)		(721,193)
Biennial % Change				36		(43)		(26)
Governor's Change from Base								467,851
Governor's % Change from Base								30
Expenditures by Program								
Health Improvement	651,476	899,950	810,151	607,785	479,189	442,987	639,898	610,878
Health Protection	169,970	232,643	591,132	652,697	320,839	227,351	382,873	292,653
Health Operations	44,289	45,122	48,757	59,214	55,221	55,105	61,164	61,077
Total	**865,735**	**1,177,715**	**1,450,040**	**1,319,696**	**855,249**	**725,443**	**1,083,935**	**964,608**
Expenditures by Category								
Compensation	157,405	179,670	176,822	216,061	211,017	198,474	253,029	246,996

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Operating Expenses	282,115	533,554	798,232	576,674	275,247	187,089	320,806	230,605
Grants, Aids and Subsidies	424,142	462,123	472,983	524,196	366,220	339,115	507,335	486,242
Capital Outlay-Real Property	2,021	2,119	1,663	2,734	2,734	734	2,734	734
Other Financial Transaction	52	249	340	31	31	31	31	31
Total	**865,735**	**1,177,715**	**1,450,040**	**1,319,696**	**855,249**	**725,443**	**1,083,935**	**964,608**
Total Agency Expenditures	865,735	1,177,715	1,450,040	1,319,696	855,249	725,443	1,083,935	964,608
Internal Billing Expenditures	34,745	49,897	67,085	57,118	45,045	38,207	58,283	51,926
Expenditures Less Internal Billing	**830,990**	**1,127,818**	**1,382,955**	**1,262,578**	**810,204**	**687,236**	**1,025,652**	**912,682**
Full-Time Equivalents	**1,532.18**	**1,698.87**	**1,644.49**	**1,702.95**	**1,695.39**	**1,595.43**	**2,018.27**	**1,933.76**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In	77	13,452	395	19,724				
Direct Appropriation	156,214	132,627	165,001	291,544	160,828	155,971	344,840	335,045
Transfers In	4,242	6,913	1,329	1,072			12,000	12,000
Transfers Out	25,238	10,630	1,548	1,274	202	202	202	202
Cancellations	51	11,587	678	6,472				
Balance Forward Out	12,576	395	19,724					
Expenditures	**122,667**	**130,380**	**144,775**	**304,594**	**160,626**	**155,769**	**356,638**	**346,843**
Biennial Change in Expenditures				196,323		(132,974)		254,112
Biennial % Change in Expenditures				78		(30)		57
Governor's Change from Base								387,086
Governor's % Change from Base								122
Full-Time Equivalents	164.41	153.16	166.75	164.60	153.38	149.61	377.21	376.34
1100 - Medical Education & Research								
Balance Forward In	529	215	427	433				
Receipts	78,991	78,991	78,991	68,135	7,725	7,725	0	0
Transfers In	150	150	150	150	150	150	0	0
Transfers Out	150	150	150	150	150	150	0	0
Balance Forward Out	213	271	433					
Expenditures	**79,306**	**78,934**	**78,984**	**68,568**	**7,725**	**7,725**	**0**	**0**
Biennial Change in Expenditures				(10,688)		(132,102)		(147,552)
Biennial % Change in Expenditures				(7)		(90)		(100)
Governor's Change from Base								(15,450)
Governor's % Change from Base								(100)
Full-Time Equivalents	2.03	1.22	1.06	1.06	1.06	1.06	0.00	0.00
1200 - State Government Special Rev								
Balance Forward In		3,049		4,542				
Direct Appropriation	60,330	60,261	71,278	73,195	72,644	72,644	79,949	82,478
Transfers In	1,449	1,449						
Transfers Out	2,303	2,140						
Cancellations		4,848						
Balance Forward Out	2,210		4,543					

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures	**57,266**	**57,770**	**66,735**	**77,737**	**72,644**	**72,644**	**79,949**	**82,478**
Biennial Change in Expenditures				29,435		816		17,955
Biennial % Change in Expenditures				26		1		12
Governor's Change from Base								17,139
Governor's % Change from Base								12
Full-Time Equivalents	310.84	302.15	347.84	347.99	347.99	347.99	387.88	387.88

1250 - Health Care Response

Balance Forward In		89,954						
Direct Appropriation	132,526	10,339						
Cancellations		6,279						
Balance Forward Out	92,273							
Expenditures	**40,253**	**94,014**						
Biennial Change in Expenditures				(134,267)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents		3.36						

1251 - COVID-19 Minnesota

Balance Forward In		44,792						
Direct Appropriation	157,189	87,830						
Cancellations		66,374						
Balance Forward Out	11,449							
Expenditures	**145,739**	**66,248**						
Biennial Change in Expenditures				(211,987)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents		116.35						

2000 - Restrict Misc Special Revenue

Balance Forward In	5,956	6,881	7,430	8,239				4,913

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Receipts	2,320	2,208	2,592	1,042	915	915	13,404	18,316
Transfers In	1,798	1,003	1,046	1,080	1,080	1,080	1,080	1,080
Net Loan Activity	271	242	136					
Balance Forward Out	6,519	7,370	8,240				4,913	4,913
Expenditures	**3,826**	**2,965**	**2,964**	**10,361**	**1,995**	**1,995**	**9,571**	**19,396**
Biennial Change in Expenditures				6,534		(9,335)		15,642
Biennial % Change in Expenditures				96		(70)		117
Governor's Change from Base								24,977
Governor's % Change from Base								626
Full-Time Equivalents	11.27	6.49	6.36	4.62	4.00	4.00	4.00	8.50

2001 - Other Misc Special Revenue

Balance Forward In	14,837	17,418	18,131	9,011				
Receipts	37,651	34,848	38,181	66,270	66,586	66,586	66,586	66,586
Internal Billing Receipts	30,058	29,404	32,316	41,145	41,145	41,145	41,145	41,145
Transfers In	97,240	41	300					
Transfers Out	26,379	1,762	684					
Balance Forward Out	12,631	11,054	9,012					
Expenditures	**110,718**	**39,492**	**46,916**	**75,281**	**66,586**	**66,586**	**66,586**	**66,586**
Biennial Change in Expenditures				(28,013)		10,975		10,975
Biennial % Change in Expenditures				(19)		9		9
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	339.78	327.65	324.50	323.09	323.09	323.09	323.09	323.09

2050 - Environment & Natural Resources

Balance Forward In	398	69	214					
Cancellations			33					
Balance Forward Out	56	69						
Expenditures	**342**		**180**					
Biennial Change in Expenditures				(162)		(180)		(180)
Biennial % Change in Expenditures								
Governor's Change from Base								0

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Governor's % Change from Base								
Full-Time Equivalents	0.71							

2302 - Clean Water

Balance Forward In	1,879	3,373	4,713	4,228				
Direct Appropriation	6,497	6,497	5,955	5,955	0	0	11,296	11,904
Cancellations		0	24					
Balance Forward Out	2,712	3,914	4,227					
Expenditures	**5,665**	**5,956**	**6,416**	**10,183**			**11,296**	**11,904**
Biennial Change in Expenditures				4,979		(16,599)		6,601
Biennial % Change in Expenditures				43		(100)		40
Governor's Change from Base								23,200
Governor's % Change from Base								
Full-Time Equivalents	26.34	19.15	19.74	19.25			43.05	51.15

2360 - Health Care Access

Balance Forward In	3,799	6,425	4,214	6,729				
Direct Appropriation	37,285	36,968	37,512	36,832	38,385	40,644	52,207	56,921
Transfers In	182							
Transfers Out	182	634						
Cancellations	39	4,051	351					
Balance Forward Out	5,865	3,844	6,730					
Expenditures	**35,180**	**34,864**	**34,645**	**43,561**	**38,385**	**40,644**	**52,207**	**56,921**
Biennial Change in Expenditures				8,161		823		30,922
Biennial % Change in Expenditures				12		1		40
Governor's Change from Base								30,099
Governor's % Change from Base								38
Full-Time Equivalents	65.26	47.52	58.89	58.89	55.34	53.86	70.01	68.48

2403 - Gift

Balance Forward In	98	1,105	116	154				
Receipts	1,013	9	38					
Transfers In	18							

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Transfers Out	18							
Balance Forward Out	1,105	113	154					
Expenditures	**6**	**1,001**	**0**	**154**				
Biennial Change in Expenditures				(853)		(154)		(154)
Biennial % Change in Expenditures				(85)		(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents		3.58						

2800 - Environmental

Balance Forward In		528		285				
Transfers In	1,067	932	932	932	932	932	1,332	1,332
Cancellations		205						
Balance Forward Out	431		285					
Expenditures	**636**	**1,255**	**647**	**1,217**	**932**	**932**	**1,332**	**1,332**
Biennial Change in Expenditures				(27)		0		800
Biennial % Change in Expenditures				(1)		0		43
Governor's Change from Base								800
Governor's % Change from Base								43
Full-Time Equivalents	3.85	2.50	3.64	3.64	3.64	3.64	6.14	6.14

2801 - Remediation

Balance Forward In		30		18				
Transfers In	257	257	257	257	257	257	257	257
Cancellations		96						
Balance Forward Out	25		18					
Expenditures	**232**	**191**	**239**	**275**	**257**	**257**	**257**	**257**
Biennial Change in Expenditures				91		0		0
Biennial % Change in Expenditures				22		(0)		(0)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	1.96	1.08	1.78	1.78				

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
3000 - Federal								
Balance Forward In	382	912	13,866	381				
Receipts	234,267	451,484	920,622	692,818	490,164	366,422	490,164	366,422
Balance Forward Out	5,989	2,856	381					
Expenditures	**228,661**	**449,540**	**934,107**	**693,199**	**490,164**	**366,422**	**490,164**	**366,422**
Biennial Change in Expenditures				949,105		(770,720)		(770,720)
Biennial % Change in Expenditures				140		(47)		(47)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	599.13	602.82	696.23	767.99	800.94	706.23	800.94	706.23
3001 - Federal TANF								
Balance Forward In	0							
Receipts	10,503	11,530	11,579	11,713	11,713	11,713	11,713	11,713
Expenditures	**10,503**	**11,530**	**11,579**	**11,713**	**11,713**	**11,713**	**11,713**	**11,713**
Biennial Change in Expenditures				1,258		134		134
Biennial % Change in Expenditures				6		1		1
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	2.32	0.99	2.06	2.06	2.06	2.06	2.06	2.06
3010 - Coronavirus Relief								
Balance Forward In		53,512	62,831					
Direct Appropriation	75,195	202,256	20,737					
Transfers Out		740						
Cancellations	944	48,212	43,503					
Balance Forward Out	50,138	3,913						
Expenditures	**24,112**	**202,902**	**40,066**					
Biennial Change in Expenditures				(186,949)		(40,066)		(40,066)
Biennial % Change in Expenditures				(82)				
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents	0.10	106.01	7.66					

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
3015 - ARP-State Fiscal Recovery								
Balance Forward In				21,458				
Direct Appropriation			127,170	633	3,466	0	3,466	0
Cancellations			24,591					
Balance Forward Out			21,458					
Expenditures			**81,121**	**22,091**	**3,466**		**3,466**	
Biennial Change in Expenditures				103,212		(99,746)		(99,746)
Biennial % Change in Expenditures						(97)		(97)
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents			4.09	4.09				
6000 - Miscellaneous Agency								
Balance Forward In	15	0	8	54				
Receipts	76	71	71	72	72	72	72	72
Transfers Out	91	64	25	126	72	72	72	72
Balance Forward Out		8	54					
8201 - Drinking Water Revolving								
Balance Forward In	10			6				
Transfers In	612	672	672	756	756	756	756	756
Balance Forward Out			6					
Expenditures	**622**	**672**	**666**	**762**	**756**	**756**	**756**	**756**
Biennial Change in Expenditures				133		84		84
Biennial % Change in Expenditures				10		6		6
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	4.18	4.84	3.89	3.89	3.89	3.89	3.89	3.89

(Dollars in Thousands)

	FY23	FY24	FY25	Biennium 2024-25
Direct				
Fund: 1000 - General				
FY2023 Appropriations	**292,744**	**292,744**	**292,744**	**585,488**
Base Adjustments				
All Other One-Time Appropriations		(1,000)	(1,000)	(2,000)
Current Law Base Change		(130,916)	(135,773)	(266,689)
Approved Transfer Between Appropriation		0	0	0
Forecast Base	**292,744**	**160,828**	**155,971**	**316,799**
Change Items				
988 Suicide & Crisis Lifeline		4,913	(1,321)	3,592
Address Growing Health Care Costs		2,110	3,150	5,260
Adolescent Mental Health Promotion		2,790	2,790	5,580
Advancing Equity through Capacity Building and Resource Allocation		1,486	1,486	2,972
Advancing Equity through Community Engagement and Systems Transformation		1,602	1,602	3,204
All Payer Claims Database Enhancements		496	352	848
Climate Resiliency		8,924	8,924	17,848
Community Health Workers – Enhancing Health and Well-being with Community-Led Care		971	971	1,942
Community Mental Well-being		2,350	2,350	4,700
Community Solutions		4,980	5,055	10,035
Comprehensive Drug Overdose and Morbidity Prevention Act		28,906	28,236	57,142
COVID Delayed Preventive Care		7,500	7,500	15,000
Cultural Communications		1,724	1,724	3,448
Diversity, Equity, and Inclusion		181	181	362
Emergency Response Sustainability, Strategic Health Care Stockpile and COVID-19 Transition		16,825	16,662	33,487
Extend Prescription Drug Price Transparency		837	643	1,480
Family Planning Special Projects		6,952	6,952	13,904
Federal Funds Oversight		530	530	1,060
Health Equity Advisory and Leadership (HEAL) Council		65	65	130
Healthy Beginnings, Healthy Families		12,052	11,853	23,905
Help Me Connect		463	921	1,384
Home Visiting		15,000	15,000	30,000
Homeless Mortality Study		134	149	283
Improving the Health and Well-Being of People with Disabilities		1,278	1,278	2,556
Lead Remediation in Schools and Childcare Centers		500	500	1,000
Lead Service Line Inventory		3,000	3,000	6,000
Legalizing Adult-Use Cannabis		8,115	8,115	16,230
Maintain Current Service Levels		7,859	9,576	17,435
Minnesota One Health Antibiotic Stewardship Collaborative		312	312	624
No Surprises Act Enforcement		1,210	1,090	2,300

(Dollars in Thousands)

	FY23	FY24	FY25	Biennium 2024-25
Office of African American Health		2,182	2,182	4,364
Office of American Indian Health		2,089	2,089	4,178
Public Health System Transformation		17,120	17,120	34,240
Repeal Women's Right to Know and Positive Alternatives Programs		(3,679)	(3,679)	(7,358)
School Health		1,432	1,932	3,364
Sentinel Event Reviews for Police-Involved Deadly Encounters		561	561	1,122
Strengthening Public Drinking Water Systems' Infrastructure		8,155	8,155	16,310
Supporting Long COVID Survivors and Monitoring Impact		3,146	3,146	6,292
Telehealth in Libraries Grant Pilot Program		911	911	1,822
Telehealth Study Budget Change	(1,200)	1,200		1,200
Trauma System Fee Adjustment		83	83	166
Equitable Health Care Task Force		779	749	1,528
Fetal Infant Mortality Reviews		749	960	1,709
HIV Prevention Health Equity Programming - Ryan White HIV Funding		2,267	2,267	4,534
MN Uninsured and Underinsured Adult Vaccine Program		1,470	1,470	2,940
Preserving Funding for Medical Education and Research Costs		1,482	1,482	2,964
Total Governor's Recommendations	**291,544**	**344,840**	**335,045**	**679,885**
Fund: 1200 - State Government Special Rev				
FY2023 Appropriations	**73,195**	**73,195**	**73,195**	**146,390**
Base Adjustments				
Current Law Base Change		(551)	(551)	(1,102)
Forecast Base	**73,195**	**72,644**	**72,644**	**145,288**
Change Items				
Assisted Living Licensure and Home Care		3,531	3,531	7,062
Background Studies Increase		2,880	2,880	5,760
Legalizing Adult-Use Cannabis		(3,424)	(3,424)	(6,848)
Maintain Current Service Levels		3,650	6,179	9,829
Trauma System Fee Adjustment		668	668	1,336
Total Governor's Recommendations	**73,195**	**79,949**	**82,478**	**162,427**
Fund: 2302 - Clean Water				
FY2023 Appropriations	**5,955**	**5,955**	**5,955**	**11,910**
Base Adjustments				
One-Time Legacy Fund Appropriations		(5,955)	(5,955)	(11,910)
Forecast Base	**5,955**	**0**	**0**	**0**
Change Items				
Clean Water Legacy - Drinking Water Contaminants of Emerging Concern		4,746	5,354	10,100
Clean Water Legacy - Future of Drinking Water		250	250	500
Clean Water Legacy - Groundwater Restoration and Protection Strategies		750	750	1,500
Clean Water Legacy - Private Well Initiative		1,500	1,500	3,000

(Dollars in Thousands)

	FY23	FY24	FY25	Biennium 2024-25
Clean Water Legacy - Recreational Water Quality Online Portal		300	300	600
Clean Water Legacy - Source Water Protection		3,750	3,750	7,500
Total Governor's Recommendations	**5,955**	**11,296**	**11,904**	**23,200**
Fund: 2360 - Health Care Access				
FY2023 Appropriations	**36,832**	**36,832**	**36,832**	**73,664**
Base Adjustments				
Current Law Base Change		953	3,812	4,765
Biennial Appropriations		600		600
Forecast Base	**36,832**	**38,385**	**40,644**	**79,029**
Change Items				
Chronic Conditions Spending Report		(185)	(185)	(370)
Maintain Current Service Levels		657	1,098	1,755
Revitalize Health Care Workforce		13,350	15,364	28,714
Total Governor's Recommendations	**36,832**	**52,207**	**56,921**	**109,128**
Fund: 3015 - ARP-State Fiscal Recovery				
FY2023 Appropriations	**633**	**633**	**633**	**1,266**
Base Adjustments				
All Other One-Time Appropriations		2,833	(633)	2,200
Forecast Base	**633**	**3,466**	**0**	**3,466**
Total Governor's Recommendations	**633**	**3,466**	**0**	**3,466**
Dedicated				
Fund: 1100 - Medical Education & Research				
Planned Spending	**68,568**	**7,725**	**7,725**	**15,450**
Forecast Base	**68,568**	**7,725**	**7,725**	**15,450**
Change Items				
Preserving Funding for Medical Education and Research Costs		(7,725)	(7,725)	(15,450)
Total Governor's Recommendations	**68,568**	**0**	**0**	**0**
Fund: 2000 - Restrict Misc Special Revenue				
Planned Spending	**10,361**	**1,995**	**1,995**	**3,990**
Forecast Base	**10,361**	**1,995**	**1,995**	**3,990**
Change Items				
Preserving Funding for Medical Education and Research Costs		7,576	7,576	15,152
Total Governor's Recommendations	**10,361**	**9,571**	**9,571**	**19,142**
Fund: 2001 - Other Misc Special Revenue				
Planned Spending	**75,281**	**66,586**	**66,586**	**133,172**

(Dollars in Thousands)

	FY23	FY24	FY25	Biennium 2024-25
Forecast Base	**75,281**	**66,586**	**66,586**	**133,172**
Total Governor's Recommendations	**75,281**	**66,586**	**66,586**	**133,172**
Fund: 2403 - Gift				
Planned Spending	**154**			
Forecast Base	**154**			
Total Governor's Recommendations	**154**			
Fund: 3000 - Federal				
Planned Spending	**693,199**	**490,164**	**366,422**	**856,586**
Forecast Base	**693,199**	**490,164**	**366,422**	**856,586**
Total Governor's Recommendations	**693,199**	**490,164**	**366,422**	**856,586**
Fund: 3001 - Federal TANF				
Planned Spending	**11,713**	**11,713**	**11,713**	**23,426**
Forecast Base	**11,713**	**11,713**	**11,713**	**23,426**
Total Governor's Recommendations	**11,713**	**11,713**	**11,713**	**23,426**
Fund: 8201 - Drinking Water Revolving				
Planned Spending	**762**	**756**	**756**	**1,512**
Forecast Base	**762**	**756**	**756**	**1,512**
Total Governor's Recommendations	**762**	**756**	**756**	**1,512**
Revenue Change Summary				
Dedicated				
Fund: 1100 - Medical Education & Research				
Forecast Revenues	**68,135**	**7,725**	**7,725**	**15,450**
Change Items				
Preserving Funding for Medical Education and Research Costs		(7,725)	(7,725)	(15,450)
Total Governor's Recommendations	**68,135**	**0**	**0**	**0**
Fund: 2000 - Restrict Misc Special Revenue				
Forecast Revenues	**1,042**	**915**	**915**	**1,830**
Change Items				
Preserving Funding for Medical Education and Research Costs		7,576	7,576	15,152
Total Governor's Recommendations	**1,042**	**8,491**	**8,491**	**16,982**
Fund: 2001 - Other Misc Special Revenue				
Forecast Revenues	**66,270**	**66,586**	**66,586**	**133,172**

(Dollars in Thousands)

	FY23	FY24	FY25	Biennium 2024-25
Total Governor's Recommendations	**66,270**	**66,586**	**66,586**	**133,172**
Fund: 3000 - Federal				
Forecast Revenues	**692,818**	**490,164**	**366,422**	**856,586**
Total Governor's Recommendations	**692,818**	**490,164**	**366,422**	**856,586**
Fund: 3001 - Federal TANF				
Forecast Revenues	**11,713**	**11,713**	**11,713**	**23,426**
Total Governor's Recommendations	**11,713**	**11,713**	**11,713**	**23,426**
Fund: 6000 - Miscellaneous Agency				
Forecast Revenues	**72**	**72**	**72**	**144**
Total Governor's Recommendations	**72**	**72**	**72**	**144**
Non-Dedicated				
Fund: 1000 - General				
Forecast Revenues	**1,352**	**1,359**	**1,359**	**2,718**
Change Items				
Trauma System Fee Adjustment		(354)	(354)	(708)
Total Governor's Recommendations	**1,352**	**1,005**	**1,005**	**2,010**
Fund: 1200 - State Government Special Rev				
Forecast Revenues	**77,137**	**77,307**	**80,775**	**158,082**
Change Items				
Legalizing Adult-Use Cannabis		(7,411)	(10,879)	(18,290)
Trauma System Fee Adjustment		668	668	1,336
Total Governor's Recommendations	**77,137**	**70,564**	**70,564**	**141,128**

Change Item Title: 988 Suicide & Crisis Lifeline

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	4,913	(1,321)	(1,321)	(1,321)
Revenues	0	0	0	0
Special Revenue Fund				
Expenditures	0	9,825	9,825	9,825
Revenues	4,913	9,825	9,825	9,825
Net Fiscal Impact = (Expenditures – Revenues)	0	(1,321)	(1,321)	(1,321)
FTEs	**4.5**	**4.5**	**4.5**	**4.5**

Recommendation:

The Governor recommends funding for the 988 Suicide & Crisis Lifeline (formerly known as the National Suicide Prevention Lifeline). The 988 Suicide & Crisis Lifeline (the Lifeline) provides free and confidential phone, text, and chat support for any person who may be experiencing a suicide, mental health, substance use crisis or other emotional distress. The Governor recommends funding the Lifeline through the imposition of a monthly 12 cent telecommunication surcharge on all wired, wireless, prepaid wireless, and Voice Over Internet Protocol (VOIP) lines in Minnesota. $4,000,000 in grants in fiscal year 2024 and $9,000,000 in grants in fiscal year 2025 and ongoing will be provided to Minnesota 988 Lifeline Centers to fund promotion, staffing and operations of the Lifeline. The surcharge revenue will deposit into a dedicated special revenue account for 988 related services.

Rationale/Background:

988 Lifeline Centers are local, independently operated, crisis centers that play an essential role in providing crisis counseling, de-escalation, and safety planning for anyone experiencing a suicide or mental health crisis 24 hours a day, seven days a week. Minnesota currently has four Lifeline Centers that answer 988 calls for anyone calling from a Minnesota area code. The core objective of the Lifeline Centers is to answer incoming contacts to 988 to reduce feelings of hopelessness, suicidal intent, and connect people to the most appropriate local resource and services.

On July 16, 2022, the United States transitioned to the use of a new three-digit dialing code, 9-8-8, to reach the 988 Suicide & Crisis Lifeline. This transition was in response to the National Suicide Hotline Designation Act of 2020 that was signed into federal law in October 2020. Although this was a nationwide transition, individual states are responsible to ensure and secure adequate funding to respond to 90 percent or more of all incoming 988 calls, texts, and chats that originate from their respective state. Further, Federal Communications Commissions (FCC) and federal legislation has permitted states to impose a surcharge on mobile and VOIP enabled services for the purpose of funding 988 Lifeline Centers and related services.

Between January 1 and August 31, 2022, Minnesota Lifeline Centers answered 80 percent of incoming 988 calls in-state. This is below the federal government target of 90 percent or higher. During this same period, zero percent of chat and zero percent of text were being answered by in-state centers; also, below the federal government target of 90 percent or higher.

Proposal:

This proposal will build upon and enhance the existing suicide lifeline program to accommodate additional responsibilities that Lifeline Centers will need to take on. Unlike before, there are now three new ways people can connect to the Lifeline – through calls, chats, or texts. Currently, four 988 Lifeline Centers are funded through an existing $1.3 million appropriation that allows centers to respond to calls for all 87 counties in Minnesota 24 hours a day, seven days a week. The addition of chat and text are new responsibilities and services that Lifeline Centers must prepare to take on as the 988 Suicide & Crisis Lifeline expands nationally.

Between January 1, 2022, and August 31, 2022, there was a 31 percent increase in call volume, 602 percent increase in chat, and 245 percent increase in text to the Lifeline from Minnesota area codes. The high increases in chat and text demonstrates that these are preferred modalities of communications by some users.

Lifeline Centers will need to increase staffing capacity to adequately meet the demand for 988 service. The department projects that call, chat, and text volumes will continue to increase over time. It is critical that the state maintains and sustains capacity to answer 988 contacts in-state to ensure Minnesotans are receiving local support during vital moments of crisis or distress. In addition to staffing capacity, additional training for Lifeline Center staff is needed. Chat and text service require specialized training on how to communicate clearly and effectively with someone in crisis through written communication over an electronic device. Further, investing in compatible technology across Lifeline Centers will ensure people who call 988 are connected to local resources efficiently.

To support and sustain the 988 Lifeline in Minnesota, a monthly statewide telecommunication surcharge is being proposed for each subscriber of a wired, wireless, prepaid wireless, and VOIP line. The Governor recommends a monthly 12 cents telecommunication surcharge in fiscal year 2024 and 2025 to adequately fund the expanded responsibilities of Lifeline Centers and potential increases in 988 calls, chats, and texts. The collection of the surcharge would begin January 1, 2024 to allow telecommunication service providers notice and time to prepare for the new change. In fiscal year 2024, the department expects to receive 6 months of revenue from the surcharge.

This proposal will also create a special revenue account for all 988 revenue and expenditures, including the surcharge. According to federal legislation, 988 telecommunication surcharges can only be used to support 988 and related services. Revenue generated from the surcharge must also be reported annually to the Federal Communications Commission (FCC). Creation of a special revenue account will allow for transparency in demonstrating the revenue and expenditures related to 988 Lifeline services. The proposal allows revenue to accrue the first year to maintain a positive budgetary balance in the dedicated account.

This proposal will provide $4,000,000 in fiscal year 2024, increasing to over $9,000,000 in fiscal year 2025 in competitive grants for Minnesota Lifeline Centers that are part of the 988 Suicide & Crisis Lifeline network. The previously appropriated general fund dollars in grants for the Lifeline Centers will be added to the proposed appropriations starting in fiscal year 2025 and each year thereafter which will result in a $1,321,000 savings to the general fund.

This proposal complements the work of our partners at the Department of Human Services who provide support to mobile crisis, warm lines, crisis stabilization, and crisis beds. This also complements the work and partnerships with the Department of Public Safety's Emergency Communications Network 911 System Program.

Impact on Children and Families:

Suicide remains the second leading cause of death among youth aged 10 to 19. Suicidal ideation and attempts have been slowly increasing among students in Minnesota. In 2019, the most recent version of the Minnesota Student Survey, approximately 13% of 125,375 students considered suicide within the previous year, and 4% reported attempting suicide within the previous year.

Approximately 19% of Lifeline Calls in Minnesota were young people between the ages of 10 and 24. The 988 Suicide & Crisis Lifeline provides families, parents, and young people a safe space to openly talk about suicide, mental health, and substance use. It is also a place to receive education on how to talk about suicide with others.

Equity and Inclusion:

The 988 Lifeline serves all Minnesotans and will reduce barriers for individuals seeking support during a suicidal or mental health crisis. The department will work in collaboration with Minnesota Lifeline Centers to build a robust training component for Lifeline Centers staff, so they are equipped to approach all 988 contacts with non-judgment, empathy, cultural humility, and person-centeredness. This includes sharing information and local referral resources that are most appropriate for the individual contacting 988.

Because the Lifeline is confidential, callers are not required to provide demographic information or any self-identifying information. Demographic detail is only captured when a caller discloses this information during an interaction with a Lifeline Crisis Counselor.

33,885 Minnesotans called the Lifeline in 2021. Below is listed the counties with the highest call volume to the Lifeline for 2021. County-level data for 2022 has not been made available by the Lifeline Administrator.

1. Hennepin County – 20,749 calls
2. Saint Louis County – 1,328 calls
3. Stearns County – 1,101 calls
4. Olmstead County – 934 calls
5. Isanti County – 712 calls

The Veterans Crisis Line has not changed because of the transition to 988. A veteran, service member, or their families can dial 988 and be prompted to connect with the Veterans Crisis Line where they will continue to receive the specialized service they have always received.

A positive impact of practicing cultural humility would encourage callers, chatters, and texters to reach out for support when they are experiencing a suicide or mental health crisis. Having 988 in place will move Minnesota forward in creating a transformative system that will link individuals to the appropriate crisis services they need. 988 will remain a standard nationwide calling number which can positively impact how future generations connect and access mental health support.

Tribal Consultation:

MDH did not participate in the Nation-to-Nation formal consultation.

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

All tribal governments are impacted due to the nationwide changes of the 988-dialing code. Any person dialing or texting to 988 from a Minnesota area code will be routed to a Minnesota Lifeline Center. Tribal nations would be impacted with the imposition of the 988 surcharge. Information related to the transition to 988 has been shared with the department's tribal liaison and has been shared with the tribal health directors.

The Substance Abuse and Mental Health Service Administration (SAMHSA) is the federal agency overseeing the transition of the 988 Suicide & Crisis Lifeline. SAMHSA is working in partnership with the Indian Health Service (IHS) to communicate and partner directly with all federally recognized tribes regarding the 988 transition.

IT Costs
None

Results:
Part A: Performance measures
Since the transition to 988, volumes across calls, chats, and texts have increased demonstrating a demand and need for the support that the Lifeline provides. Between January 1 and August 31, 2022, 23,011 calls were made to the 988 Suicide & Crisis Lifeline from Minnesota. 80% of those calls were answered in-state by a Minnesota Lifeline Center. Calls that cannot be answered in-state are routed to a national back-up center located out-of-state. During this same period, 4,950 chats and 1,857 texts were made to the Lifeline. These chats and texts were answered through a national backup center because Minnesota Lifeline Centers do not have the staffing capacity to answer chat and text.

The Substance Abuse and Mental Health Service Administration (SAMHSA), the federal agency overseeing the Lifeline, has set a target goal for all states to achieve a 90 percent or higher in-state answer rate for calls, chats, and texts. While there has been progress made to answer 988 calls, limited staffing capacity at Minnesota Lifeline Centers have been a barrier in answering 988 chats and texts.

One vital service offered by 988 Lifeline Centers is follow-up. If the person contacting the Lifeline consents to follow-up services, they will receive a brief call from the Lifeline Center 24 to 72 hours after their initial contact. During a follow-up call, the call is focused on assessment of risk – checking if the safety plan created needs to be updated or if additional information or referral to local resources is needed. Follow-up is cost effective and can reduce the perceived risk of future suicidal behavior. A 2018 study by the Lifeline showed that 79.6% of people participating in follow-up care indicated the intervention stopped them from killing themselves. Under 988, all Lifeline Centers will be expected to provide follow-up care for any person who consents to the service.

One goal of the Lifeline is to save lives and connect callers to local resources. This will be measured though the number of individuals who reach out to the Lifeline and receive a referral to local mental health or substance use information and resource.

Type of Measure	***Name of Measure***	***Current Value***	***Date***	***Projected Value (without)***	***Projected Value (with)***	***Date***
Quantity	Annual number of calls, chats, and texts received from 988/National Suicide Lifeline	33,887	FY 23	33,887	47,702	FY 24-FY27
Quality	Percent of received calls answered in-state	80%	FY 23	<80%	90% or higher	FY 24-FY27
Quality	Percent of received chats and text answered in-state	0%	FY 23	0%	90% or higher	FY 24-FY27
Quality	Percent of follow-up provided for people enrolled in this service	0%	FY 23	0%	90% or higher	FY 24-FY27

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of individuals reaching out to the Lifeline who received referral to mental health or substance use resources	No baseline available	FY 23	NA/	NA	FY 24-FY27

Part B: Evidence-based practices

Evidence-based Practice	**Source of Evidence**
Crisis lines provide free and confidential counseling via telephone-based conversation, web-based chat, or text message to individuals in crisis, particularly those with severe mental health concerns such as suicidal thoughts.	What Works for Health, https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/crisis-lines

Statutory Change(s):

Minnesota Statutes, sections 145.56, 403.11, 403.161, 403.162, 403.163, 406.164, 270B.12

Change Item Title: Address Growing Health Care Costs

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	2,110	3,150	3,150	3,150
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	2,110	3,150	3,150	3,150
FTEs	**9.1**	**11.6**	**11.6**	**11.6**

Recommendation:

The Governor recommends a general fund appropriation to implement a proposal aimed at constraining health care spending growth and improving affordability of health care services. This proposal includes establishing a health care spending target program developed by a newly formed public/private health care spending target commission, informed by a health care spending technical advisory council, established to create an evidence base for developing policy initiatives to limit growth in spending, and assessing readiness of rural communities to participate in value-based payment arrangements.

Rationale/Background:

Health care spending routinely rises faster than inflation and wages, resulting in health care taking an increasingly bigger bite out of the budgets of employers, governments, and individuals. For a variety of reasons, narrow, targeted initiatives aimed at reducing spending growth have failed to curb overall cost increases in Minnesota and nationally. One important factor appears to be that spending by some represents income for others – the health care industry is in business to provide care and thereby generate revenue.

Several states have implemented initiatives that produce new information on drivers of spending growth (e.g., prices, technology, drug spending, waste and inefficiency, and administrative spending) and established targets or actual caps on spending through which they work on changing existing dynamics in provider and payer health spending.

At the same time, rural community providers continue to struggle financially and, in some cases, close sites or service lines. Existing financial models and revenue cycles are not designed to incent providers to support health, but rather treat illness. Keeping people healthy and out of the hospital or clinic adversely impacts the already precarious financial situation many rural providers are experiencing. Therefore, curtailing spending growth and incenting providers to keep communities healthy need to be coordinated and complementary to maintaining critical infrastructure.

Proposal:

Growth in health care spending has affected the ability of Minnesotans to access health care services. The package of initiatives proposed here will establish targets of health spending in order to moderate the rate of spending growth; create an evidence base for developing policy initiatives to limit growth in wasteful spending; and assess readiness of, and plan for, rural communities to participate in value-based or global payment arrangements aimed at maintaining infrastructure.

Specifically, this proposal includes three initiatives:

1. *Establish spending growth targets*. Support a public/private health care spending target commission (informed by a health care spending technical advisory council), tasked with establishing a system of spending targets to create motivation for payers and providers to limit spending growth, including by collecting needed data through multiple modes.
2. *Analysis of low value services and administrative spending.* Perform analyses to better understand and address the drivers of administrative spending and the scope of low-value care, aligning with the goal of meeting spending targets.
3. *Assess community readiness for adopting value-based payment systems.* Assess readiness of rural communities to participate in value-based or global payment arrangements and develop a plan and model to help achieve stabilized financing for the rural health care system. The goal is to address spending growth policy strategically and thoughtfully, so as not to inadvertently disadvantage already struggling providers in rural areas, increase disparities, or discourage appropriate care, while innovating to develop payment methods that reward rural providers for keeping their communities healthy.

Impact on Children and Families:

Improving affordability of health care and reducing the incidence of foregone care will positively impact the health and well-being of children and families. Value-based purchasing will stabilize care in rural areas for families and children.

Equity and Inclusion:

Spending growth is affecting a broader cross-section of the population, but Minnesotans who are lower income, lack health insurance, underinsured, represent populations of color and American Indians, and people with higher health care needs are disproportionately affected. Improving affordability of health care and reducing the incidence of foregone care will positively impact health care equity by reducing barriers of cost. Value-based purchasing will stabilize care in rural areas for rural Minnesota residents.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)	14,400	3,600	3,600	3,600	3,600	3,600
Total						
MNIT FTEs	.07	.07	.07	.07	.07	.07
Agency FTEs						

Results:

The establishment of spending targets, the evidence from the analysis of drivers of spending, and the annual reports that review provider and plan performance against the spending targets, will move addressing spending growth (or health care inflation) into a more central position in the discussion of health care delivery system reform. This proposal will contribute to the development of thoughtful, relevant policies that require health care entities to meet spending targets and support adoption of new payment models.

Community consensus around spending growth, shared accountability between providers and payers, and recognition of the need to actively support stability of the health care system in rural Minnesota are additional outcomes. The proposal is transformative because it brings responsibility for “global” spending to the entire health care system, rather than implementing narrowly focused and/or isolated initiatives.

The establishment of a spending target commission, and their initial work to establish targets, would take place in fiscal year 2024, with results from new agreed upon measures emerging in fiscal year 2025. Measurement of spending performance against targets is anticipated to begin in fiscal year 2026.

MDH would implement the program and provide administrative and staff support for the Health Care Spending Growth Target Commission. MDH will establish the form and manner of data reporting, collect data identified for use by the program, provide analytical support, assist health care entities with reporting of the data, as well as staff the Health Care Spending Technical Advisory Council.

Value-based payment initiatives aimed at stabilizing funding for hospitals and health systems serving rural communities can ensure that critical infrastructure is in place to provide everything from preventive care to ambulance services and specialty care and treatment when needed. In fiscal year 2024, MDH will build on community and health care system input and develop a model of a payment option for a rural area to begin to demonstrate ways to move to value-based payment while accounting for lower volume and geographic access to care. In fiscal year 2025, Minnesota would develop a readiness assessment and proposed plan that builds on other initiatives in the state, including the Medical Assistance IHP program.

Performance measures

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quality	Stakeholder engagement to establish spending targets: number of participants	0	20+	2024
Result	Reduce rate of growth in health plan administrative spending as a percent of total spending to the median over the past 10 years	7.9%	7.4%	2026

Statutory Change(s):

Minnesota Statutes, chapter 62J (Health Care Cost Containment)

Change Item Title: Adolescent Mental Health Promotion

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	2,790	2,790	2,790	2,790
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	2,790	2,790	2,790	2,790
FTEs	**2.5**	**2.5**	**2.5**	**2.5**

Recommendation:

The Governor recommends a general fund investment to provide competitive grants to community-based organizations to equip community members with the knowledge, skills, and competencies to deliver evidence-based, culturally informed mental health support and programming to young people. Of the total appropriation, $2,250,000 annually will be given in grants beginning in fiscal year 2024.

Rationale/Background:

There has been a growing mental health crisis among young people since 2009. The COVID-19 pandemic exacerbated this crisis, with increased reports of depression, hopelessness, stress, anxiety, and suicide. Nearly 16% of Minnesota youth (ages 12-17) experienced at least one major depressive episode in 2022, double the rate from 2015. Specific competencies, including experiencing a sense of belonging or positive peer relationships, are protective factors for mental wellbeing among youth, but racial disparities persist across each of these competencies. For example, the 2019 Minnesota Student Survey data shows only 48% of black students reported a sense of belonging, compared to 62% of white students; similarly, only 74% of black students, as compared to 86% of white students, reported positive peer relationships. American Indian or Alaska Native youth were the least likely to report a high number of protective factors at only 33.1% compared to other races/ethnicities.

Young people need opportunities to develop skills to thrive and experience positive mental health, including the ability to engage with supportive adults and peers, and skills to manage daily stress and make responsible decisions. Non-clinical, community driven, and peer support mental health programs are evidence-informed, cost-effective and engage adults and young people who are embedded in the community, extending the benefits beyond a single set of relationships. Such programs are complementary to the clinical mental health system and not a replacement for clinical care.

There are an increasing number of evidence-based and culturally informed models for community-led and peer support. For example, community health workers from immigrant communities are implementing the evidence-based program Living Life to the Full, a cognitive behavioral skills course. Other examples include: Own Your Roar, a peer-to-peer program where athletes teach self-help skills to other athletes and The Confess Project, a national effort largely in the Black community to equip barbers with mental health knowledge so they can offer general support and, in some cases, connections to care.

Proposal:

The department will implement new community or peer led mental health promotion programming for young people in community settings to improve their mental health and resilience and reduce racial disparities in mental health. MDH will provide $2,250,000 annually in competitive grants ranging from $50,000 to $100,000 annually to community-based organizations, including non-profits, local public health, and Tribal public health, to implement community selected models. Funding decisions will consider geographic distribution, as well as focus on Black, American Indian, LGBTQ, new immigrant, and rural communities.

Grantees will equip community members, including adults or young people (peers), with the ability to facilitate classes or discussion, mentor, and model mental health skills and tools with young people. They may utilize an established culturally responsive and evidence-based curriculum, or a training tailored to the specific needs of a population. Training could include a range of skills and knowledge building such as managing stress and anxiety, recognizing emotions, understanding trauma, building a social support system, identifying common mental health concerns, disrupting negative thought patterns, active listening, mindfulness, connection with cultural identity, and empowering young people.

Community members will facilitate, discuss, and model mental well-being skills and tools to help young people learn, practice, and experience key ingredients for their mental health, including positive relationships, self-regulation, and positive identity. Community members may include trusted adults and young people or non-specialized healthcare workers, such as community health workers who are representative of the community.

Grantees may focus on a particular population to train such as trusted messengers, people with existing relationships and frequent contact (e.g., coaches, faith leaders, youth workers), or those with lived experience (children with an incarcerated parent, LBGTQ+). Delivery models may include group activities, classes, support in natural settings (e.g., coach to athlete), or structured peer programs.

The proposal includes staff to oversee the grantees, provide technical assistance and training, implement a robust evaluation to support investment in effective models, and ensure compliance with grant terms.

Impact on Children and Families:

This proposal will build a network of community-driven mental health supports using culturally responsive and evidence-based strategies to help young people improve all aspects of their mental health, especially their relationships and social connections, awareness and understanding of mental health, and help-seeking behavior. By leveraging trusted leaders embedded in the community, these non-clinical mental health supports will be more accessible to young people and families, especially those from marginalized or isolated populations, or populations that experience greater mental health stigma.

Equity and Inclusion:

This proposal uses an equity-focused framework to mental health. The supports are provided by community members who reflect the community, in community settings that are readily accessible, and for community members without barriers based on diagnosis, insurance, or availability. Organizations identify solutions or models that reflect unique needs of the local community, culture, or specific populations. These efforts contribute to increased availability and accessibility of culturally responsive mental health supports, improved access to services, and reduced health inequities. This proposal strengthens community trust and deepens knowledge of different cultural challenges to address mental health and the stigma or social implications of addressing mental health in diverse communities.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

MDH will consult with Tribal public health leaders through site visits in 2022 and through the regularly convened Tribal and Urban Indian Health Directors meeting.

Results:

Part A: Performance measures

This proposal includes a dedicated program evaluator who will develop a common satisfaction survey for all grantees that focuses on the relevance, cultural responsiveness, and delivery method of program content. Additional quantity, quality, and outcome measures will also be gathered to identify the frequency and interaction of impacts of each model and the specific mental health components addressed.

Pre- and post-questionnaires will be collected from participants with questions about mental health perspectives, awareness and utilization of mental health tools, and subjective mental well-being. The questionnaire will also assess mental health with questions from the Minnesota Student Survey that capture key components, including: sense of belonging (social integration), social competency, relationships (peer, family, teacher, community), empowerment, personal growth, educational engagement, and positive identity.

The performance data collected will be from the Minnesota Student Survey and include 10 components that are shown to have a targeted effect on overall mental health and well-being. This data is gathered every three years and will assess overall impact in targeted communities, districts, and schools. MDH will work with future grantees to ensure the collection of these performance measures and monitor progress and overall outcomes during the implementation of the mental health promotion and intervention funded projects.

Type of Measure	***Name of Measure***	***Current Value***	***Projected Value (without)***	***Projected Value (with)***	***Date***
Quantity	Number of young people reached	0	0	30,000 annually	FY 2024
Quantity	Number of adult and young people trained in various models	0	0	1,000	FY 2026
Quality	Number of trainees and participants report that the content is satisfactory and is relevant to their mental health work.	0	0	90% (27,900)	FY 2026
Results	Percentage of young people who participate in a funded program who report improved mental health	0	0	75% on average across programs.	FY 2026
Results	Percent reduction in disparities within the populations served	0	0	An average of 3-5% reduction in disparities.	FY 2026

Statutory Change(s):

New statute

Change Item Title: Advancing Equity through Capacity Building and Resource Allocation

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,486	1,486	1,510	1,510
Revenues	0	0		
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,486	1,486	1,510	1,510
FTEs	**4**	**5**	**5**	**5**

Recommendation:

The Governor recommends a general fund investment to establish a program that will advance equity in procurement and grantmaking at the department to improve the infrastructure of Community Based Organizations (CBOs) led-by and serving Minnesotans most impacted by health inequities. Of the annual appropriation, $500,000 is for grants. Specifically, MDH will provide technical assistance and capacity building grant opportunities to CBOs, including faith-based organizations, to "set them up for success." The investment will ensure that (1) more community-based organizations (CBOs) receive training and skills to more effectively compete for MDH's grant opportunities and (2) MDH and its grantees form strong, mutually beneficial partnerships with co-learning and cross-training opportunities.

Rationale/Background:

Grantmaking and contracting within MDH is a critical tool in ensuring the equitable delivery of public health services. MDH and the Governor's Office continue to hear from community leaders, including a 2019 letter from leaders in Minnesota's urban American Indian community, that the state's grantmaking and procurement processes require significant improvements in order to truly serve all Minnesotans equitably. In response, MDH must improve and routinize a process to both review its current grants and improve process and policies for future grantmaking to ensure that the distribution of grant dollars is equitable.

A 2013 study of 1,000 of the largest U.S. foundations found that less than 7 percent of grant money went toward funding racial or ethnic minorities, even though those same populations make up over 40 percent of the U.S. population. Funding pertaining to American Indian causes was consistently the lowest, amounting to less than 1 percent of all total giving. The same study found that only 6 percent of grant dollars went to people with disabilities and less than half a percent of grant dollars went towards LGBTQ communities.[1]

In order to ensure that communities disproportionately impacted by health inequities are able to access state resources and funding, MDH must invest in reviewing and improving its grantmaking and contracting processes. In addition, many community based organizations lack experience in grants and procurement processes and policies and would strongly benefit from training specific to state grants and procurement in order to build their capacity to access and maximize funding opportunities.

[1] Chan and Fischer, Eliminating Implicit Bias in Grantmaking Practice, Standford Social Innovation Review, Dec 2016, http://www.d5coalition.org/wp-content/uploads/2016/04/D5-SOTW-2016-Final-web-pages.pdf

Proposal:

This proposal advances equity in grants and procurement at the department to improve the infrastructure of Community Based Organizations (CBOs) led-by and serving Minnesotans most impacted by health inequities by (1) developing a training program for community based organizations to improve their capacity to partner and providing capacity building opportunities to applicants, and (2) by improving MDH processes and policies to ensure equitable access to funding, as follows.

Provide capacity building opportunities to help community-based organizations (CBOs), including faith-based organizations, be better equipped and prepared for success in procuring grants and contracts at MDH and beyond. A particular focus will be on building skills and competencies of CBOs led by communities of focus and serving populations of color, American Indian, LGBTQ, and those with disabilities in metro and rural communities in Minnesota who have been disproportionately impacted by health and other inequities. Capacity building grants totaling $500,000 annually will be awarded to up to 20 eligible CBOs and tribal communities.

Create a framework for MDH to attain equitable practices in grantmaking to ensure that internal grantmaking and procurement policies and practices prioritize equity, transparency, and accessibility. This will include creating a simple tracking system for MDH to better monitor and evaluate equitable procurement processes and their impact in terms of the organizations MDH funds. It will also include providing technical assistance to MDH leadership and programs in grantmaking and procurement processes and providing tools and guidance to ensure equitable and transparent competitive grantmaking processes and award distribution across communities most impacted by inequities and develop measures to track progress over time. Creation of a tracking system for MDH will support improved monitoring processes and assist in evaluating equity in procurement to determine the percentage of grants/contracts and funds going to focus communities and to measure how those numbers change over time as equity initiatives are implemented.

MDH requires staff to achieve both priorities by doing the following:

- Oversee the improvement process and lead MDH's initiative of advancing equitable grantmaking and procurement across MDH by collaborating with stakeholders and developing strategies that embed equity internally and track progress over time.
- Provide capacity building training sessions to community-based organizations in communities most impacted by inequities on topics including, but not limited to: fiscal management, budgeting, grant writing, evaluation and reporting, and monitoring program spending, and support the agency wide rollout of the equity in procurement and grant making initiative. The department also requires staff to implement the capacity building curriculum and related initiatives, liaise with leadership and supervisors across MDH and provide guidance on achieving strategic priorities related to equitable procurement and grantmaking.
- Conduct financial reporting and provide fiscal support.

MDH has already begun this work, led by a group of grant management and community engagement staff. For example, MDH staff have created multiple guides for programs to ensure equitable promotion of grant opportunities - including targeting communities and parts of the state that have not historically participated in the grant application process, as well as reduce overall bias in the grantmaking process and scoring. These resources have been well received by grants staff across the agency, who have asked for additional resources and support in improving their processes. This proposal would build upon this work by funding a highly trained team of grant managers, contract specialists, and community capacity building planning staff to provide more intensive capacity building and support for grant programs across the department.

Evaluation plays a key role in incorporating the voices of community during and after their funding cycle. Incorporating evaluation into the grant requirements will improve MDH's ability to obtain feedback on areas of improvement, success, challenges, and allows for data to be regularly collected. Through regular process evaluation, MDH can incorporate lessons learned and build in needed technical assistance and support for CBOs.

Impact on Children and Families:

Embedding equitable grantmaking into state processes will ensure the state funds efforts that advance equitable, inclusive, and effective programs and organizations who are led and trusted by the communities they serve – communities that have historically been marginalized and disenfranchised and that experience the worst health disparities. By ensuring equitable distribution of state resources, this proposal will contribute to strengthening community capacity to create their own healthy futures.

Capacity building CBO grants will lead to a more equitable and inclusive community engagement approach to public health decisions would ensure that the people most affected and most marginalized, especially those who have been historically left out of these conversations, have a say in the health program decisions that affect their lives. Holistic programming of these organizations allows for people to receive support in housing, employment, mental health, and more. Investing in organization which already have an established trust in their community builds capacity for response, as well as encourages staff retention, training, and long-term operation. When these trusted hubs thrive so too will the communities that depend on them for many program services.

More than ever, children and families need funding opportunities to build resilience to get back on track after the significant and often toxic stress and trauma experienced throughout the COVID-19 pandemic and recent civil unrest. Providing more equitable resource distribution to populations of color, American Indians, LGBTQ and disability communities will directly improve the lives and health outcomes of children and families most impacted by inequities. This proposal will afford the historic opportunity to not just mitigate the impact of the structural inequities but create stronger communities that will foster resilience, connection and cultural healing.

Equity and Inclusion:

For the internal training and skill building, all leaders and programs will be encouraged to participate in technical assistance and tracking efforts to ensure there is an equity lens embedded into procurement and grantmaking efforts at MDH that increases opportunities for those most historically marginalized and underrepresented. For the community capacity building efforts with external CBO partners, the primary audience(s) for community capacity building are CBOs that include one or more of the following populations: African American, African immigrant, American Indian, Asian American, Latinx, LGBTQ Minnesotans, and Minnesotans with disabilities. We understand the need to take an intersectional approach (such as people of color and American Indians with disabilities and people of color and American Indians who are LGBTQ). MDH will make final selections of grantees for seed funding based on a competitive review of proposals, while also ensuring that the final cohort of selected contractors covers a range of geographic areas and reaches the communities in Minnesota listed above. We will prioritize entities that are led by people of color, American Indians, people with disabilities, and/or LGBTQ individuals in metro and rural communities in Minnesota.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

None

Results:

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quantity	Number of equity in grants/contract guides or tools created for internal process improvement	4 guides/tools	At least 4 guides/tools	FY 2023 FY 2024-26
Quantity	Percent of grant programs who use/implement guides/tools	40%	75%	FY 2023 FY 2024-26
Quality	Percentage of grant makers who report guides/tools improved equity in their processes	50%	90%	FY 2023 FY 2024-26
Quantity	Number of grant/contract processes or policies that go through an equity review and update	No current baseline	10	FY 2023 FY 2024-26
Results	Percentage of funding, going to organizations led by focus communities	No current baseline	10%	FY 2023 FY 2024-26
Quantity	Number of community-based organizations and tribes provided one-on-one technical assistance or capacity building support	No current baseline	100	FY 2023 FY 2024-26
Quantity	Number of trainings provided to community-based organizations and tribes	No current baseline	8	FY 2023 FY 2024-26
Quality	Percent of CBOs that participate report that they are better equipped to obtain needed funding /resources to advance health equity in their communities	No current baseline	75%	FY 2023 FY 2024-26

Statutory Change(s):

New statute

Change Item Title: Advancing Equity through Community Engagement and Systems Transformation

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,602	1,602	1,930	1,930
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,602	1,602	1,930	1,930
FTEs	**5**	**5**	**5**	**5**

Recommendation:

The Governor recommends a general fund investment to establish a program that will advance equitable and inclusive community engagement by cultivating a community of practice and building internal capacity for engagement within the state and local public health systems. This program will prioritize giving voice to communities, in both formal and informal power structures, and empowering those who have been historically marginalized to shape the way the public health systems engage their communities and contribute to a shared understanding of engagement between the state, local public health, and communities. In FY24 and 25, a total of $672,387 annually in grant funding will be awarded to 20 grantees and in FY26 and 27, a total of $1,000,000 annually in grant funding will be awarded to 20 grantees to support community engagement related system change efforts within MDH and local public health.

Rationale/Background:

Equitable, inclusive, and meaningful community engagement is core to MDH and local public health efforts to advance health equity and improve the health of all Minnesotans. Meaningful engagement of those that are most impacted by inequities serves as a powerful vehicle for bringing about change to improve the health of the community and its members. When community engagement takes place with core principles guiding its processes and activities, it propels strengthened partnerships and alliances, expanded knowledge, improved health and health care programs and policies, and healthier communities. Improvements in these domains and their associated indicators create motion and catalytic action that moves community members toward health equity and well-being through transformed systems.[1] Evidence has shown that community engagement has been regarded as a critical element of successful health programs to achieve “the health for all” goal, including reducing inequalities, improving social justice, enhancing benefits, and sharing responsibility towards public health.[2] The increased focus on community engagement in the public health and healthcare system over the years represents an opportunity for change to ensure meaningful and sustainable impact.

Over the last several years, both MDH and other social services and public health practitioners are recognizing the need to engage the communities they serve. Yet, available evidence shows that many entities still only conduct superficial engagement— in other words, transactions whereby the community is not meaningfully provided access to the public health program decision-making process, and interactions tend toward tokenism and marginalization, or whereby the community is simply informed of plans or consulted to provide limited

1 Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health
2 Community engagement in public health: a bibliometric mapping of global research. Ming Yuan1, Han Lin2* , Hengqin Wu3, Mingchuan Yu4, Juan Tu5 and Yong Lü6

perspectives on select activities.[3] Sustained and widespread change toward improved health and well-being cannot occur until systems that impede meaningful community engagement change, and that cannot happen without the engagement of those closest to the challenges proposing realistic solutions. Moreover, local public health departments are charged with promoting overall community health and well-being and addressing the causes of disease and disability. To achieve these goals in the 21st century, local health departments need to engage diverse communities in developing a broad spectrum of solutions to today's most pressing public health crisis, including structural and systemic inequities that perpetuate health disparities, and other complex community health issues.

While MDH is proud of its successes in keeping Minnesotans healthy, it also recognizes that the opportunity to be healthy is not equally available everywhere and for everyone in Minnesota. If a significant and tangible effort is not made by MDH, other state enterprises, local public health, and community organizations to work collaboratively with and through those who are most impacted by inequities, continued progress towards making Minnesota a healthier state will not be possible. Therefore, it is important for MDH to invest in advancing equitable, inclusive, and meaningful community engagement to ensure health equity for all Minnesotans.

Proposal:

This proposal will establish a program that advances health equity through equitable, inclusive, and meaningful community engagement by providing capacity building opportunities to MDH staff and local public health and by providing community engagement grant funding to local public health and community organizations. The proposal includes the following elements:

1. **Capacity building opportunities to help increase knowledge, skills, and abilities of MDH staff, local public health (LPH), and other communities of practice that engage all communities through an equitable and inclusive lens and eliminate systemic barriers to inclusive and equitable community engagement.** This capacity building effort will help advance joint development of public health processes, products, and policies with community members most impacted by health inequities. MDH will provide training, coaching, and technical assistance for staff, LPH, and communities of practice to engage effectively with communities most impacted by inequities. Training will include information to increase the ability to work with a range of organizations (small or large) and communities; understand individual, institutional and systemic racism; build and sustain relationships; use trauma-informed engagement strategies and talk about race. MDH also will develop engagement tools, resources, and training material to use with internal staff and external partners. In order to ensure consistent accountability, MDH will develop a policy that will establish minimum requirements for community engagement in MDH-funded public health programs.
2. **Community engagement capacity building funding to local public health and other communities of practice**. MDH will award grants to ensure that capacity building efforts are translated into practice and that community relationships and partnerships are strengthened and include avenues for meaningful participation of Minnesota's diverse communities (e.g., populations of color, American Indian, LGBTQIA+, and those with disabilities). A particular focus will be funding projects that 1) intend to meaningfully engage and strengthen the capacity of communities of focus to create their own healthy futures and that 2) intend to revise current policies, goals and strategies, identify new strategies, and actions to support efforts to listen authentically to, and partner with, Minnesotans most impacted by inequities.
3. **Collaboration and Partnership**: MDH will advance equitable community engagement by proactively collaborating with and cultivating a community of practice within State and local government that engages the community most impacted by inequities through an equitable and inclusive lens. MDH will evaluate its current community engagement efforts and community advisory groups to assess gaps and areas of improvement to authentically engage the communities we serve. Collaborating with other

3 Facilitating Power. 2020. The Spectrum of Community Engagement to Ownership. Available at: https:// d3n8a8pro7vhmx.cloudfront.net/facilitatingpower/ pages/53/attachments/original/1596746165/ CE2O_SPECTRUM_2020.pdf?1596746165 (accessed October 15, 2021).

communities of practices will help increase shared understanding of community engagement and enhances policies and programs that reflect community voices and perspectives. Statewide collaboration is necessary for us to co-creating solutions in partnership with community members, who, through their own experiences, know the barriers to opportunity best.

These efforts will be supported by a 1.0 FTE supervisor, 3.0 FTE health equity planners, a 1.0 FTE senior data analyst will provide evaluation support and track individual and collective impacts of the programs implemented.

This program builds upon MDH's long-term community engagement strategic plan partially developed in 2020 to 2022. This effort was halted due to the COVID-19 pandemic, whereby most of the MDH's community engagement work with community partners was shifted to align multiple systems, partners, and institutions in addressing barriers to COVID-19 prevention (vaccine, testing, etc.) related messaging, communications, and lifesaving resources. This included providing direction, guidance and strategic coordination amongst MDH's community engagement staff, local public health, tribal public health, health care organizations, the Governor's Office, MDH Communications Office, and state government agencies to provide equitable, and culturally and linguistically appropriate emergency response to the most vulnerable Minnesotans. As a result, MDH created a regional health equity network unit to bring together partners including local public health, tribal public health, regional community partners, MDH efforts, and others to support an equitable response to COVID-19 and build the capacity of the public health system to more broadly advance health equity into the future.

The proposed program also builds upon the Governer's equitable community engagement goals and the One Minnesota Initiative[4] by funding a highly trained team of community engagement capacity building staff who provide more intensive community engagement capacity building for community members, MDH staff, and local public health. This team of staff would also provide regular technical assistance and coaching on inclusive, equitable and meaningful community engagement and system change for program staff across MDH, local public health and community organizations as needed.

Impact on Children and Families:

Equitable and inclusive community engagement initiatives will impact the health of children and families by building the capacity of the public health workforce on health equity with an emphasis on the oppression of communities that government programs, including public health, have historically left out; the extent and consequences of oppression; intersectionality, power, and development of cultural competency and health literacy; and the unique characteristics (i.e., culture, values, major concerns, strengths) of the communities in which staff and key partners work. Equitable and inclusive community engagement initiatives will support better health for children and families by shifting power through partnerships in which people who experience the conditions that cause inequities have leadership roles and avenues to share their perspectives and shape their healthy future. It will also create a bridge between families and their communities and the public health and health systems that can support institutional changes in those systems to be more culturally, linguistically, and ethnically responsive and diverse, leading to positive health outcomes for children and families. Equitable and inclusive community engagement initiatives will also support better health for children and families by supporting protective factors such as healthy parents in mind and body; connection to resources such as quality childcare and pre-school, food access programs, health insurance, and parenting classes and supports; and healthy community-level programs and resources such as vaccination and testing clinics, farmers markets and other healthy food access programs, and health and wellness-focused programming.

Equity and Inclusion:

An equitable and inclusive community engagement initiative represents movement toward better health outcomes for communities and also help ensures representation, inclusion, and lived experiences of those engaged in the efforts. It will build the capacity of the public health workforce and community organizations to

[4] https://mn.gov/governor/administration/inclusionequity/

ensure representation of community engagement efforts are intentionally diverse, comprising multicultural, multiethnic, and multigenerational perspectives, particularly those that are traditionally not invited or involved in improving health and health care policies and programs. Furthermore, it will focus on the role of diversity, inclusion, and health equity as core components of partnership characteristics and functioning and health equity as a key outcome or goal of partnerships.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs:
None

Results:

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quantity	Number of community engagement training curriculum developed	0	1	09/30/2025
Quantity	Develop and test authentic community engagement indicators	0	1	09/30/2025
Quantity	Number of community engagement landscape assessment conducted	0	1	09/30/2025
Quantity	% MDH Divisions staff who completed community engagement and system transformation training series	No baseline	45%	09/30/2027
Quantity	Increased percentage of MDH grants that require some level of community engagement	No Baseline	25%	09/30/2027
Quantity	% Participating local public health staff who completed community engagement training series	No Baseline	50%	09/30/2026
Quantity	% of Local public health employee who completed community engagement and system transformation training series	No Baseline	20%	09/30/2027
Quantity	Number of statewide community engagement forum/meeting conducted	No Baseline	8	09/30/2027
Result	% of local public health who reported engaging community in equitable and inclusive way measure by authentic community engagement indicators	No Baseline	10%	09/30/2027
Quantity	Create MDH-wide Community Engagement Communities of Practice	0	1	09/30/2027

Statutory Change(s):
None

Change Item Title: All Payer Claims Database Enhancements

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	496	352	308	274
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	496	352	308	274
FTEs	**2**	**2**	**1.5**	**1.5**

Recommendation:

The Governor recommends strengthening a Minnesota data asset to become a more effective tool for policy analysis to improve health and inform strategies to increase equity in care and outcomes. It consists of two components:

Capturing Race and Ethnicity Data Through MN All Payer Claims Database: The Governor recommends a one-time general fund appropriation in fiscal year 2024 for modifications of the Minnesota All Payer Claims Database (MN APCD), governed under Minnesota Statutes 62U.04, to enable analysis of health care use, spending, disease burden and quality of care along race and ethnicity. Collecting race and ethnicity data in the MN APCD would help advance Minnesota's goal to promote the understanding of, and ability to address, health inequities. Researchers and stakeholders would be able to generate evidence for communities most impacted by health inequities to inform policy solutions.

Modifying Data Collection Authority on Dental Claims: The Governor recommends a general fund appropriation to revise Minnesota Statutes 62U.04 to require the collection of dental claims from by certain payers. This proposal will shed light on trends in dental health services and connect dental health to other health outcomes. These data can inform policies to improve preventive oral health care, which in turn supports overall health, and address potentially affordability concerns for effective dental care. Adding dental care claims to the MN APCD requires an investment to expand the data collected and submitted by Minnesota's APCD data aggregator and to expand the capacity of the MN APCD to store the additional data. Funds recommended within this proposal will be used for the purpose of purchasing the dental claims from the data aggregator, IT development and implementation of MN APCD expansion to accommodate the new data, and analytic and rulemaking capacity.

Rationale/Background:

Capturing Race and Ethnicity Data Through MN All Payer Claims Database: The MN APCD systematically collects and integrates medical claims, pharmacy claims, and eligibility files from private and public payers. These data cover the spectrum of care delivery, including inpatient hospitalizations, outpatient office visits, telehealth, and prescription drugs. These health care transaction data allow for analyses of patterns by geography, sex, and age, but do not enable the state to understand and illustrate disparities in health care services access and outcomes. Collecting race and ethnicity would help advance Minnesota's goal to promote the understanding of, and ability to address, health inequities.

This proposal would greatly improve MDH's ability to look at variation in health care utilization, prices, and spending patterns across race and ethnicity among Minnesota residents and represent a beginning to more fully

understand the impact of social determinants of health. Policymakers and stakeholders will be able to learn from the evidence on communities most impacted by health inequities in order to design solutions to these longstanding challenges.

Including race and ethnicity data, in the MN APCD aligns with the Governor's One Minnesota Initiative to focus on the health and well-being of all Minnesotans and aligns with national efforts, including by APCD partner states to enhance data collection by health plans. These data will further contribute to the enhancement of existing studies on chronic conditions, long COVID-19, hypertension and medication therapy management, cardiac rehabilitation surveillance, antibiotic stewardship, and maternal and child health; they will be additive to data on demographics that have emerged so far.

Modifying Data Collection Authority on Dental Claims: Oral health is an essential part of overall health and there is currently a lack of consistent information on dental care coverage, use of services, cost, the incidence of dental disease and the interaction with overall health. Significant disparities exist for low-income children and adults and people of color who disproportionately suffer from dental disease and oral conditions due to limited access or high costs. There is also national evidence that many individuals with dental coverage do not use these benefits. The MN APCD systematically collects and integrates medical claims, pharmacy claims, and eligibility files from private and public payers. Collecting dental claims data in addition to existing data on medical services and prescription drugs will provide a more complete understanding of dental care utilization and services in Minnesota and barriers to accessing services, including costs. Together, this will inform future health care planning and policy decisions.

Proposal:

Capturing Race and Ethnicity Data Through MN All Payer Claims Database: This proposal requires costs in fiscal years 2024 and 2025 for one half-time additional staff to align the Minnesota requirements with emerging national standards and assess and support improving the quality of the data. In addition, the proposal requires one-time costs in fiscal year 2024 for activities by a contracted vendor to implement the modifications to MS 62U.04, requiring the submission of race and ethnicity data as part of enrollee information. Expanding the MN ACPD to include race and ethnicity data will enable data users to explore access, utilization, disparities and trends in healthcare use by race and ethnicity in Minnesota.

Modifying Data Collection Authority on Dental Claims: This proposal requires costs in fiscal year 2024 and beyond for one full-time and one half-time additional staff to conduct rule making, shape technical requirements, assess and improve the data, and conduct research using the data. In addition, the proposal requires costs for a contracted vendor in fiscal year 2024 to extend the collection of data for the MN APCD to include dental care claims paid by dental care payers. Expanding the MN ACPD to include dental claims will enable data users to explore access, utilization, and cost of dental care in Minnesota.

This change requires technical modifications and documentation, engagement of stakeholders, modification of data submission processes, and updates to MN APCD data dashboards and public use files as well as additional analysis on an ongoing basis. To implement this proposal, and to collect and integrate dental claims payment data into the MN APCD, MDH assumes it will initiate and complete expedited rulemaking in fiscal year 2024 and fiscal year 2025 to amend established rules (Minnesota Rules, chapter 4653).

Impact on Children and Families:

Capturing Race and Ethnicity Data Through MN All Payer Claims Database: Collecting race and ethnicity data would enable MDH researchers to get a better understanding of health inequities in our health care system and will inform policy solutions to improve health outcomes of all children and families in Minnesota.

Modifying Data Collection Authority on Dental Claims: Collecting dental claims data would enable policymakers and payers to make informed decisions about oral health care coverage on the basis of robust empirical evidence.

This proposal has the potential to affect access to dental care and thereby oral and ultimately physical health of Minnesotans, by illustrating patters of dental care early in children's life.

Equity and Inclusion:

Capturing Race and Ethnicity Data Through MN All Payer Claims Database: Collecting race and ethnicity data will strengthen MDH's research capacity to measure health care utilization, prices, and spending patterns. These data will be valuable to all Minnesotans, including researchers and policy makers, to develop impactful policy solutions that improve the health of all Minnesotans, especially those most impacted by health disparities.

Modifying Data Collection Authority on Dental Claims: Given the documented disparities in dental access in national data, this proposal combined with the proposal aimed at collecting race and ethnicity data has the potential to inform strategies to identify and reduce inequities.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

Capturing Race and Ethnicity Data Through MN All Payer Claims Database: There are no IT costs associated with adding race and ethnicity data to the MN APCD.

Modifying Data Collection Authority on Dental Claims: IT costs associated with collecting dental claims is included in the table below.

Category	***FY 2024***	***FY 2025***	***FY 2026***	***FY 2027***	***FY 2028***	***FY 2029***
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)	20,000	8,000	8,000	8,000	8,000	8,000
Total						
MNIT FTEs	.1	.1	.1	.1	.1	.1
Agency FTEs						

Results:

Capturing Race and Ethnicity Data Through MN All Payer Claims Database: MDH will work closely with data submitters on their generating and submitting race and ethnicity data. We will monitor the data submissions with the goal of collecting data from 50% of payers required to submit claims to the MN APCD. MDH will monitor the

error rate of data submitted with the goal of 95% of the data being received as accurate. As a result of race and ethnicity data being submitted to the MN APCD, researchers, program managers, and policymakers will have data available to understand the cost and utilization of health care for all communities in Minnesota so that they can improve upon programs and policy supporting equitable access to health care.

Performance data will be collected from the data aggregation vendor and from the administrative records of the MN APCD.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Percentage of claims with REL data	0	Sep-2022	0	30%	Jun-2025
Quality	Percentage of claims with REL submitted without error	0	Sep-2022	0	95%	Jun-2025
Results	Number of data users accessing REL data for health equity research	0	Sep-2022	0	20	Jun-2025

Modifying Data Collection Authority on Dental Claims: MDH will monitor the volume of dental claims that payers submit with the goal of collecting reliable, high-quality data from 100% of payers with sufficient levels of dental claims; what dental payers will be subject to reporting will be determined through rule making. MDH will monitor the error rate of claims data submitted with the goal of 95% of the claims being received as accurate.

As a result of dental care claims data being submitted to the MN APCD, stakeholders, including researchers, program managers, and policymakers, will actively use evidence on the cost and utilization of dental care in Minnesota to improve programs and design evidence-based policy supporting equitable access to dental care.

Performance data will be collected from the data aggregation vendor and from the administrative records of the MN APCD.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Percent of dental care payers submitting data (required to submit per statute)	0	Sep-2022	0	100%	Jun-2025
Quality	Percent of claims submitted without error	0	Sep-2022	0	95%	Jun-2025
Results	Number of data users related to delivery of oral health care	0	Sep-2022	0	10	Jun-2025

Statutory Change(s):

M.S. 62U.04, subdivision 4

Change Item Title: Assisted Living Licensure and Home Care

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
State Government Special Revenue Fund				
Expenditures	3,531	3,531	3,531	3,531
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	3,531	3,531	3,531	3,531
FTEs	**20.5**	**20.5**	**20.5**	**20.5**

Recommendation:

The Governor recommends a state government special revenue fund increase to the appropriations for both assisted living and home care licensures to ensure adequate staffing for oversight of health and safety requirements in assisted living facilities and home care agencies, to align with revenue, and to meet program demand. Beginning in fiscal year 2024, the recommended increase in the assisted living licensure base is $2,040,000 and the increase in the home care base is $1,491,000.

Rationale/Background:

The legislature established assisted living licensure in 2019, and established an appropriation based on estimates of the likely number of future licensees. Now that the first year of the program is complete, MDH has more accurate estimates of revenue based on the number of participating providers than prior to the passage of the assisted living licensure law. By the beginning of 2022, there were 2,000 assisted living providers who needed to be surveyed in the next two years, which is 25% higher than the original estimates. The higher-than-expected number of assisted living licenses means that revenue is also higher than originally estimated, since the program is supported by fees that providers pay as part of their license process. That additional revenue will cover the costs of this proposal; no fee increase is needed.

For home care agencies and home care providers, an increased appropriation is needed to provide adequate staffing for surveys of providers as required by state statutes. Historically, funding limitations have not allowed MDH to carry out all required surveys in a timely manner. This is particularly important for three-year surveys, which are a type of inspection that helps protect the health and safety of Minnesotans receiving home care services. Current fee levels would support this additional spending without the need for a license fee increase.

The establishment of assisted living licensure provided the commissioner with various fine and penalty enforcement mechanisms. However, the statutory language in some cases lists specific fine or penalty amounts while in others it does not. The establishment language also directed the usage of fine and penalty funds to be used for recommendations made from the Home Care and Assisted Living Program Advisory Council under Minnesota Statutes, section 144A.4799 to the commissioner. To help clarify those fine amounts, the department is listing those amounts directly. Additionally, associated with this change is the need to make the new fine and penalties available for the advisory council recommendations.

Proposal:

The recommendation to increase funding for adequate agency staffing is to ensure department survey staff can carry out regulatory aspects of this work as required by statute given more accurate assessments of demand. This work, which involves onsite assessment of a facility's compliance with the quality and safety requirements of the statute, helps protect the health and safety of Minnesotans in assisted living facilities. Revenue generated by licenses for assisted living providers will be used to cover costs associated with survey work. The existing fee structure does not need to change; current fee revenue is higher than originally estimated due to the larger number of assisted living providers who sought licenses. The recommendation also includes an increase to the home care appropriation to align with revenue and ensure appropriate level of staff to monitor and enforce compliance with health and safety requirements for home care providers. Funding will be used to increase staff levels to complete required oversight and inspections consistent with statutory timelines, to make technology and workflow changes, and to pay for associated costs of those staff.

There are three sections of statute where the department clarifies the fine or penalty amount under Minnesota Statutes, sections 144.16, 144G.19, and 144G.57. Each of these sections also contain the necessary statutory language to permit the advisory council to make recommendations to the commissioner on the use of the fines and penalty funds.

Impact on Children and Families:

Ensuring that all Minnesotans have access to the care they need in a way that allows them to stay safe is beneficial for those receiving care as well as the people who care about them.

Equity and Inclusion:

Providing additional resources to ensure safety for people in assisted living and home care will help more Minnesotans stay healthy and avoid additional health concerns. Surveys help ensure a basic safety standard across the state and make sure that someone's zip code doesn't determine the quality of care they receive.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

None.

Results:

Type of Measure	***Name of Measure***	***Current***	***Future***	***Dates***
Quantity	Number of assisted living survey inspections	New	500	7/31/23
Quality	Percent of on-time assisted living inspections	New	100%	7/31/23
Quality	Percent of on-time home care surveys per year	93.5%	100%	6/30/23
Quantity	Meet statutory guidelines for number of home care inspection surveys per year	No	Yes	6/30/23

Statutory Change(s):

Minnesota Statutes, sections 144G.16, 144G.19, and 144G.57.

Change Item Title: Background Studies Increase

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
State Government Special Revenue Fund				
Expenditures	2,880	2,880	2,880	2,880
Revenues	0	0	0	0
Net Fiscal Impact = -(Expenditures – Revenues)	2,880	2,880	2,880	2,880
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends a state government special revenue appropriation to cover the costs of increased background study processing fees for MDH licensed providers payable to the Department of Human Services (DHS) as identified in Minnesota Statutes, section 245C.10. In 2021, the legislature established a new fee structure, raising the cost of background studies from $20 to $42 for each background study processed by DHS. This funding recommendation will cover the MDH costs of the new agreement with DHS, in addition to DHS's proposed $2 increase in the 2023 session, which will reflect the cost increase for the processing of background studies.

Rationale/Background:

In 2021, the legislature established a new fee structure to increase the cost of background studies by $22. These background studies include many of the MDH licensed providers. Currently, MDH has an interagency agreement with DHS that requires MDH to pay for the processing of each background study submitted by providers licensed by MDH. The current interagency agreement ended on December 31, 2022 and is being modified to reflect the $44 for each study processed, which includes the $42 increase from the 2021 session and DHS's proposed $2 increase in the 2023 session.

The request for additional funds ensures background studies can continue to be conducted in accordance with both federal and state requirements. Since DHS began conducting background studies, significant changes were made to laws and standards. These licensed providers serve increasing numbers of the state's most vulnerable child and adult populations. As a result of the changes, more provider types are required to submit background studies on new hires, and in some cases, studies must be submitted for their existing employees as well. Additionally, turnover in employees at provider organizations increases the number of background studies to be processed. While the legislature passed changes in 2022 to eliminate the requirement for duplicate background studies for certain providers, this change does not offset the higher costs coming from the fee increase.

Proposal:

This proposal provides an increase for background study costs from the state government special revenue fund (SGSR). Adjusting the amount will cover the current expenses from the new fee structure enacted in 2021. The increased funding will ensure continued processing of background studies for MDH licensed providers to safeguard vulnerable children and adult populations served by these providers and employees.

Impact on Children and Families:
Funding will ensure all statutorily required background studies are processed to help protect vulnerable children and individuals who are provided care and services by these providers and employees.

Equity and Inclusion:
Equitable processing of background studies will help create safer environments for all regulated providers.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Results:

Type of Measure	***Name of Measure***	***Current Value***	***Future***	***Date***
Quantity	Average number of background studies ran per year	100,000	100,000	6/30/2024

Statutory Change(s):
Not applicable

Change Item Title: Chronic Conditions Spending Report

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Health Care Access Fund				
Expenditures	(185)	(185)	(185)	(185)
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(185)	(185)	(185)	(185)
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends repealing the existing language in Minnesota Statutes Section 62U. 10 Subd. 6 to subd. 8, which require the preparation of an annual report on health care spending directly attributable to a specific set of chronic conditions and risk factors. This recommendation is driven by MDH inability, with existing data and methodological challenges, to produce reliable and meaningful annual estimates of actual disease-attributable spending and compare them to projected spending for the set of conditions specified in the statute. Repealing this language would result in a $185,000 decrease to the department's base in the Health Care Access Fund in fiscal year 2024 and each year thereafter.

Rationale/Background:

In 2015, the Minnesota Legislature, in Minnesota Statutes, section 62U.10, subd. 6 to subd. 8, directed the Minnesota Department of Health (MDH) to use the Minnesota All Payer Claims Database (MN APCD), along with other data sources, to report on actual and projected health care spending directly attributable to a specific set of chronic conditions and risk factors. The statute requires MDH to produce these estimates annually and include in the report a calculation of the difference in actual to projected spending for enrollees in state-administered health care programs. MDH has released three reports to date, based on data from 2014, 2015, and 2016, respectively. The fourth report was delayed due to COVID-19 and will now include data from 2017 and 2018. The 2017-2018 report is scheduled to be released in the late part 2022.

MDH has conducted this work for several years with the assistant of a data analysis vendor but has struggled with three aspects of this work: (1) the structural deficit in financing the work; (2) methodological challenges associated with estimating disease attributable spending with limited available data; and (3) the applied value of this information, given that most people with chronic disease are treated for multiple conditions, the limited interest in the stakeholder community in the estimates, and the annual cadence of the work that is not supported by the long-term patterns driving chronic diseases or the long-term benefits of preventing their onset.

The production of this report requires using and connecting data from multiple systems, including state and national surveys, the MN APCD, and other sources. Some of these data sources are updated annually, some less frequently, making production of meaningful annual estimates challenging and year-over-year changes difficult to interpret. Further, due to limitations and availability of data, estimates for obesity and smoking exposure are restricted to Minnesota adults ages 18 – 64. This is problematic because many of the adverse (and costly) outcomes associated with these conditions take years to develop and occur at older ages. In addition, the identification of conditions and unrelated conditions changes over time with clinical evidence, changes in coding practices, and coding schema, making it necessary to revisit methodology and the calculation of the baseline.

Finally, beginning with data from calendar year 2016, MDH has experienced some drop-off in submission of claims data from self-insured employers into the MN APCD, which introduces additional challenges in producing estimated spending for all Minnesotans who received health care services for one or more of the conditions identified in statute. The vendor has developed methods to take this into account, but this has added an additional step to the analysis process and corresponding additional expenses. Together, these realities and challenges have resulted in MDH expenses routinely exceeding the legislative appropriation for this work ($180,000/year) and rising over time.

Proposal:

This proposal is to repeal Minnesota Statutes Section 62U.10 Subd. 6, 7, and 8 and end the $180,000 annual Health Care Access Fund appropriation beginning in fiscal year 2024. This resolves the issues MDH faces in providing a reliable analysis to meet the current statutory obligation due to the ongoing data challenges and the additional cost incurred to attempt to remedy the issues.

MDH recognizes the importance of understanding the burden of chronic conditions and associated spending in Minnesota, as well as the imperative to prevent these conditions to the extent possible, provide timely care and treatment, assure that spending on these conditions is appropriate and affordable for all, and to monitor changes and progress in these patterns. Unfortunately, the methodology used does not produce reliable or actionable estimates which justify continuing this work. MDH is committed to working with stakeholders and the Legislature on exploring what alternative analytic endeavors could contribute meaningful evidence in place of this repealed study.

Impact on Children and Families:

While this proposal does not directly impact children and families in Minnesota, repealing the report could allow for the Legislature to devote resources to more meaningful application.

Equity and Inclusion:

Although the prevalence of many chronic conditions varies by race, ethnicity and country of origin, the MN APCD does not collect the data to permit subgroup analyses by race, ethnicity, country of origin, or language.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

None

Results:

This proposal will not negatively impact staff or operational costs.

Statutory Change(s):

Minnesota Statutes 2015, Section 62U.10 Subdivisions 6,7,8

Change Item Title: Climate Resiliency

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	8,924	8,924	2,292	2,292
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	8,924	8,924	2,292	2,292
FTEs	**8**	**8**	**8**	**8**

Recommendation:

The Governor recommends a general fund investment to fortify public health resilience against the human health impacts of climate change and participate in interagency efforts that support local communities. Activities include a combination of financial and technical assistance and data analysis and reporting to implement, strengthen, evaluate, and track public health resiliency efforts in the face of climate change across the state. Of the total appropriation in fiscal years 2024 and 2025, $7,500,000 will be provided each year in grants for local organizations and local public health to plan for the health impacts of extreme weather events; waterborne, vector borne and zoonotic diseases; public health disaster response; emotional and mental health supports; and develop adaptation actions. Beginning in fiscal year 2026, $1,000,000 will be provided each year in grants. The proposal replaces federal funding from the Centers for Disease Control and Prevention's (CDC) climate and health program that ended in August 2021.

Rationale/Background:

Climate change is the biggest health threat facing humanity. Climate change threatens our very existence by impacting the basic elements we depend upon for life: safe and available drinking water, clean air, our food supply, and our health. The threats of climate change have touched Minnesotans through the spread of disease; droughts ruining crops; flooding destroying homes and businesses; wildfires making outdoor air unhealthy to breathe for everyone; and heat waves causing heat-related illnesses. From the safety and health of our housing, to changes in our outdoor environment that spread diseases carried by animals and insects, to our mental health, there is nothing that climate change does not affect. Yet, with the loss of CDC funding, MDH has limited ability to support public health climate resiliency and participate in climate-related planning and events.

Some of the known direct health impacts of climate change include more heat-related illnesses due to heat waves; injuries, deaths, and contaminated drinking and recreational waters from extreme precipitation and flooding; increases in disease transmission from animals and vectors; increased and exacerbated respiratory and cardiovascular diseases, such as asthma attacks from wildfire smoke and pollen; food insecurity from crop failures and rising food prices; mental health impacts from experiencing extreme weather events, climate-related instability, and other changes to the places we call home; and increasing societal and healthcare costs from more emergency department visits, hospitalizations, and premature deaths.

Proposal:

This new interagency initiative, coordinated with the Minnesota Pollution Control Agency, Department of Natural Resources, and other state and local agencies, will increase the resilience of Minnesota and its communities from

health impacts from increasingly heavy precipitation, flooding, drought, extreme heat, wildfire smoke, and emerging zoonotic, waterborne and vector-borne diseases.

The intended result of this proposal is that communities throughout Minnesota are prepared for the health impacts of climate change and are resilient. The proposal strengthens community health and resiliency through proactive funding and technical assistance to local organizations and local public health agencies to help them prepare for climate changes, by understanding their assets and risks and planning for and implementing appropriate community-based and -led actions that protect their health.

This recommendation supports the Governor's Executive Order 19-37 on climate change action and is recommended by specific priority actions in Goal 5 of the Climate Action Framework that was developed through feedback from the public, the Healthy Lives and Climate Equity Workgroup, and the Governor's Advisory Council on Climate Change.

The proposal consists of two main elements: 1) grants to local organizations and agencies, and 2) administrative and programmatic capacity to bolster MDH's ability for administering the grants, tracking and reporting the state of climate change and health in Minnesota, and providing technical assistance.

Grants to Local Organizations and Agencies

MDH will provide grants to local public health, tribal health, community organizations, soil and water conservation districts, and other local government and organizations for planning for the health impacts of extreme weather events and developing adaptation actions. Up to 30 grants in fiscal years 2024 and 2025, with a range of awards between $50,000 and $250,000, will be awarded for developing climate and health action plans and implementing health-protection strategies. Beginning in fiscal year 2026 and beyond, funding will be available for up to four grants each year.

Bolstering MDH's MN Climate & Health Program

Currently, MDH supports a percentage of one supervisor to engage in climate and health activities. Previously, MDH had a grant from CDC that funded a small climate and health program that performed some of the proposed functions, but MDH lacked funding for grants for communities so that they could actively participate in building resiliency. This proposal will fund eight positions to reinvigorate and create a robust MN Climate and Health Program that can tackle the current and looming health impacts from climate change. The funding will support MDH's capacity to provide technical assistance and training to communities, including GIS mapping of risks and assets; grant administration; outreach, communication, and education on the health impacts of climate change; tracking, data analysis, and reporting on the state of health impacts from climate change in Minnesota; relevant research projects; program oversight; and evaluation of program activities and grant projects.

Impact on Children and Families:

Climate change impacts everyone, but some people are more susceptible to climate change, particularly children. Studies have shown that children are more impacted by extreme weather events and are more sensitive to heat stress and air pollution. Research also shows that our youth are already being impacted by mental health issues associated with climate change. Additionally, low-income families will struggle with keeping their families safe and recovering from increases in extreme weather, such as keeping their homes cool in extreme heat, abating mold growth from flooding and extreme precipitation, and ensuring that their indoor air is safe when wildfire smoke makes outdoor air unhealthy to breathe.

Equity and Inclusion:

Everyone is affected by climate change, but some communities are hit harder than others. Social, economic, historical, and political factors shape the ability of some communities to prepare for, cope with, and recover from climate change impacts. Existing inequities based on race, age, gender, geography, economic status, existing health conditions, and more place some communities at greater risk. Black, Indigenous and people of color have demonstrably poorer health due to unequal access to health care, biased housing practices that placed them closer to sources of pollution, and other factors. Climate change amplifies these existing health disparities. For example, American Indian and African American middle and high school-aged kids are more likely than other students to have been diagnosed with asthma. Asthma is exacerbated by poor air quality and wildfire smoke. Historically racist housing policies (such as redlining) are associated with urban heat islands and lack of tree canopy in low-income neighborhoods of color, which suffer more from extreme heat as a result. Communities that already lack resources are burdened by the costs of preparing for and recovering from climate-related events.

Applications for the proposed grants from BIPOC and other communities that are at a greater risk for health impacts will be prioritized for funding so that technical assistance and funding goes to the people who need it most.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Minnesota tribal governments and organizations will be eligible for grant funding. The funding would support planning for climate change impacts and help their communities become more resilient to climate change. No formal consultations occurred related to this proposal; however, MPCA's tribal liaison and liaisons from other agencies have been involved in both site visits and formal consultations related to the Climate Action Framework, and this proposal supports several Framework priority actions.

MDH would announce the funding opportunity and technical assistance at existing regular meetings MDH has with tribal health agencies, the MN Tribal Environmental Council (MNTEC), and other tribal meetings. MDH also will work with the Office of American Indian Health and their grant administrators to ensure that the proposal is disseminated in appropriate ways to all the tribes, that the grant process is suitable, that MDH addresses tribal concerns, and that assistance in the grant process is available for those that request it.

IT Costs

N/A

Results:

MDH will collect the performance measures below to help evaluate the success of the program. Besides recording the number of grants awarded and total funding, MDH will track the number of technical assistance calls, trainings, and educational presentations it provides. Additionally, the number of people served by those services will be recorded. MDH will provide up to 30 grants each fiscal year to local public health, tribal health, community organizations, soil and water conservation districts, and local governments for planning for the health impacts of extreme weather events and developing adaptation action plans. The results of the grants will also be shared, including the number of Climate and Health Action Plans that were written, the number of people who participated in the development of the plans, the number of actions that were implemented within the Action Plans, and changes in knowledge, attitudes, and behaviors from participating in planning for and implementing climate and health strategies.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of grants administered	0	9/15/2022	0	20-30/fiscal year	FY24
Quantity	Number of technical assistance calls/ trainings/educational presentations	0	9/15/2022	1-3/fiscal year	20-30/fiscal year	FY24
Quantity	Number of People Served	0	9/15/2022	10-50 people reached/ fiscal year	50-300 people reached/ fiscal year	FY24
Quality	Number of Climate and Health Action Plans developed	unknown	9/15/2022	0 additional	20-30/fiscal year	FY24
Results	Changes in people's knowledge, attitudes, and behaviors	unknown	9/15/2022	No change	Increase in knowledge of climate and health impacts; increase in community/ individual level health protective actions	FY25 and beyond

Statutory Change(s):
After M.S., 144.1461

Change Item Title: Community Health Workers – Enhancing Health and Well-being with Community-Led Care

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	971	971	971	971
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	971	971	971	971
FTEs	**1.5**	**1.5**	**1.5**	**1.5**

Recommendation:

The Governor recommends a general fund investment of $971,000 each year to expand, strengthen, equip, and evaluate the community health worker workforce in Minnesota to support the health and well-being of Minnesotans by partnering with the MN Community Health Worker Alliance to create a statewide infrastructure of community health workers.

Rationale/Background:

Community health workers (CHWs) are trusted resources in their communities, sharing life, cultural and linguistic experience with their clients. CHWs are uniquely positioned to make a significant contribution to improving health outcomes by addressing the social conditions that impact health status, called social determinants of health (SDOH). Their work can expand far beyond healthcare, bringing health and racial equity into public safety, social services, youth and family services, schools, neighborhood associations, and more. CHWs were at the frontlines of their communities during the pandemic and continue to address COVID-19 through primary prevention (e.g., organizing vaccination clinics and testing sites), secondary prevention (e.g., assisting with quarantine hardships) and tertiary prevention (e.g., side effects of long-COVID). CHW models have proven cost effective with a return on investment ranging from 3:1 to more than 15:1. This return on investment was likely even greater during the height of COVID-19.

Minnesota is a frontrunner in the development of the CHW profession as the first state to create and offer a statewide CHW curriculum based in post–secondary education and one of the few states that offers reimbursement for CHW services through Medical Assistance, although reimbursable services are limited. Minnesota is fortunate to have the CHW Alliance, a statewide, health equity nonprofit that acts as a convener, catalyst, and expert in CHW strategies. MDH was awarded funds in 2022 from the Health Resources and Services Administration (HRSA) to support enrollment in the CHW certificate program and increase employment opportunities in partnership with the MN CHW Alliance through creation of a tuition-assistance program and registered apprenticeship opportunity.

However, while the framework exists to have a strong and vibrant CHW workforce, many barriers exist to CHWs serving to their full potential such as restrictive reimbursement policy, limited organization of the workforce to have efficient and effective impact on health, and limited understanding of the existing CHW models.

Proposal:

Funding for the MN CHW Alliance to develop capacity for CHWs to address health disparities: Initiatives include expanding the MN CHW Alliance's role as a clearinghouse and center of excellence for CHW resources; strengthening partnerships with CHW certificate school; strengthening connections with decision-makers at DHS and health plans; and providing technical assistance to employers in a broad range of employment sites (i.e., health clinics, social services, public safety, schools, family home visiting programs, factories, childcare and elder programs).

Funding for MDH program evaluation and technical assistance:

- **Conduct an environmental scan at the state and national levels to assess and understand CHW models.** Initiatives include conducting literature reviews and national networking to explore the structure, cost, challenges, and impact of existing CHW models;
- **Rigorously evaluate the existing CHW models in Minnesota.** Initiatives include tracking and analyzing indicators of success and/or health improvement in areas served by CHWs including exploration of costs, benefits, and challenges of the existing models in different geographic and demographic areas; and exploring the community and clinical relationships of CHWs;
- **Create a sustainable plan for CHW infrastructure.** Initiatives include proposing a statewide, sustainable infrastructure plan that supports the varied needs of diverse communities with the best fitting CHW model.

MDH staffing needs include contract and partner management and collaboration; evaluation and assessment of CHW models in MN and nationwide; conduct an impact evaluation (e.g., return-on-investment study); create a sustainability plan; assist with grant management, fiscal oversight, and accountability.

Successful implementation of these proposed plans will include increased number of CHWs in the field with CHW certificates; increased employers offering positions to CHWs; increased awareness of the profession; and improved network of effective CHW services that reach all of Minnesota.

Impact on Children and Families:

The CHW initiative will support better health for children and families by supporting protective factors such as healthy parents in mind and body; connection to resources such as quality childcare and pre-school, food access programs, health insurance, and parenting classes and supports; and healthy community-level programs and resources such as vaccination and testing clinics, farmers markets and other healthy food access programs, and health and wellness-focused programming.

Equity and Inclusion:

The CHW initiative will help to address health disparities through culturally appropriate strategies because CHWs are of the community in which they serve. CHWs become trusted sources of information, advisors on health maintenance actions, promoters of preventive measures, and facilitators of community-level changes that address the social determinants of health (e.g., housing, food access, transportation). CHWs work with communities that may be hesitant to access traditional care in traditional settings; as a trusted member of their community, CHWs can share information and facilitate care that might be misunderstood, not heard, or not available through the existing methods of care and communication. The MN CHW Alliance is a partner in the design of this proposed initiative. Collaborative work sessions have been held with the Alliance, the CHW curriculum committee, current CHW employers, and CHWs to map out the necessary initiatives to achieve a more productive and efficient infrastructure for CHWs in MN; this proposal will provide a solid foundation for the work.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs:
None

Results:
The impact of improving and supporting the CHW infrastructure in MN will be evaluated in several ways. The CHW Registry, managed by the MN CHW Alliance, provides counts of CHWs and access to CHWs for surveys and other evaluation strategies. Distribution of data through newsletters, reports, webpages, and presentations will take place in CHW networking and advisory groups, community partners, collaboration with DEED and other state agencies, and other distribution pathways in content areas benefiting from CHWs (i.e., asthma, diabetes).

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	# CHW systems	10	FY 2020	10	25	FY 2026
Quantity	# Vulnerable communities reached (using social vulnerability index)	No baseline	FY 2023	No change	40	FY 2026
Quality	CHW models nationwide and models in MN	N/A	FY 2023	N/A	Description of national and existing MN models	FY 2025
Results	Cost analysis per model	N/A	FY 2023	N/A	Data analysis report (e.g., ROI)	FY 2026
Results	Geographic reach of CHWs	No baseline	FY 2023	No change	Map of state coverage	FY 2026
Results	# Individuals & communities reached by CHWs	No baseline	FY 2023	No change	Displayed in map of state coverage	FY 2026

Statutory Change(s):
New statute

Change Item Title: Community Mental Well-being

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	2,350	2,350	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	2,350	2,350	0	0
FTEs	**4**	**4**	**0**	**0**

Recommendation:

The Governor recommends funding from the general fund to establish a grant program that will fund community-based organizations and local health departments to develop and implement community solutions for mental health resources and post-COVID-19 recovery and healing for communities of focus who have been disproportionately impacted by COVID-19. Of the total amount, $1,680,000 will be provided annually in grants to communities.

Rationale/Background:

COVID-19 highlighted long-standing health inequities for populations of color, American Indians, LGBTQ+, disability in metro and/or rural communities in Minnesota. It also has put increased burden and stress on individuals and families who needed to navigate and contend with multiple health and socioeconomic impacts, including physical and mental health, housing, education, childcare, and unemployment. Throughout the response, MDH and local health departments have engaged and funded communities to develop and implement communication, testing and vaccination strategies that work for them. It is now time to fund communities to develop and implement strategies for community healing.

Mental well-being and psycho-social-spiritual resilience education and skills-building can 1) prevent or minimize many types of mental health and psycho-social-spiritual disorders beyond the current collective traumas and help people heal more easily when another collective crisis occurs and 2) motivate people to engage in pro-social activities that can increase their own sense of well-being by assisting others or engaging in positive civic activities. Effective coping skills can improve economic, education, and health outcomes including mitigating risk for poor cognitive development and externalizing behaviors for children, and help families effectively deal with problems including increased employment.[1]

Proposal:

This proposal will establish a grant program for funding community-based organizations, faith based organizations, tribal governments, and/or local health departments to develop and implement community healing grants for mental health resources, post-COVID-19 recovery, and healing in collaboration with communities of focus serving populations of color, American Indian, LGBTQ+, and those with disabilities in metro and rural communities in Minnesota who have been disproportionately impacted by COVID-19.

[1] Benzie, K., & Mychasiuk, R. (2009). Fostering family resiliency: a review of the key protective factors. Child and Family Social Work, 14, p 103-114.

MDH will issue a request to community-based organizations and tribes, in collaboration with local public health, to aid in engaging communities around community healing, using culturally relevant, linguistically appropriate, and timely community engagement activities to meet the needs related to community healing; working with the state and its partners to address those community needs; and connecting communities to trusted information and resources related to mental health and wellbeing support.

Grant supported activities focus on providing communication and outreach to communities about well-being, hosting community dialogues about well-being, and supporting skill development and creating opportunities for community members to practice skills for mental well-being. Understanding well-being from a holistic perspective and recognizing the range of needs that may be present among community participants will be important activities. Also, grantees will connect participants to other community-based resources. Additional ongoing needs may include the opportunity to develop deeper social connections, access clinical mental health support, connect meaningfully with cultural identity, engage in healing justice opportunities, or access concrete supports such as food and housing. Grantees will deepen partnerships with organizations that offer key resources and develop or enhance formal strategies to connect community members to available supports and opportunities. Grantees will also participate in training opportunities on model well-being practices and support training for additional community healers to continue to build sustainability. Finally, grantees will help host or participate in community meetings to develop or contribute to a network of organizations that are committed to promoting healing and thriving, to collectively assess and help the community make meaning out of current and evolving social factors. Community meetings will feed directly into outreach, communication, and dialogues.

Two FTEs in this request will oversee the grantees and provide technical assistance and training where needed to meet the needs of the grant as outlined in grantee workplans and provide fiscal support to grantees to ensure proper spending. A 1 FTE research analyst would provide evaluation support to grantees to track individual and collective impact(s) of the programs implemented. 1 FTE management analyst to provide fiscal support to grantees and monitor program funds.

Impact on Children and Families:

Children and families need opportunities to build resilience to get back on track after the significant and often toxic stress and trauma experienced throughout COVID-19 and the civil unrest. Providing opportunities for children and families to learn skills for self-regulation, social connection, cultural identity, as well the opportunity to grieve as a community are critical for everyone's healing. Experiencing healthy outlets for grief and recovery will help children build a positive identity, self-determination, and self-efficacy. This recommendation will afford the historic opportunity to not just mitigate the impact of the trauma endured by children, but create stronger communities that will foster resilience, connection, and cultural healing.

Equity and Inclusion:

The primary audience(s) for community healing must include one or more of the following populations: Black, African immigrant, American Indian, Asian American, Latino/a, LGBTQ Minnesotans, and Minnesotans with disabilities. Organizations are encouraged to reach diverse communities with an intersectional approach and intentionality (such as people of color and American Indians with disabilities and people of color and American Indians who are LGBTQ).

In collaboration with local public health and tribes, we will make final selections of grantees based on a competitive review of proposals, while also ensuring that the final cohort of selected contractors covers a range of geographic areas and reaches the communities in Minnesota listed above. We will prioritize entities that are led by people of color, American Indians, people with disabilities, and/or LGBTQ individuals in metro and rural communities in Minnesota.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs
None

Results:

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quantity	Number of implemented 'community healing' strategies per each focus community	0	At least 5 strategies	FY 2020 FY 2023-25
Quantity	Number of participants per each grantee per activity (by focus community)	0	12-15 participants	FY 2020 FY 2023-25
Quality	Percentage change in perception of improved wellbeing.	No current baseline	10% Year 1; 25% Year 2; 40% Year 3	FY 2020 FY 2023-25
Results	% of participants that were connected to (and/or connected with someone) culturally relevant mental health supports, as needed (by focus community)	No current baseline	at least 10% will be connected to mental health supports	FY 2020 FY 2023-25

Statutory Change(s):
None

Change Item Title: Community Solutions

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	4,980	5,055	5,055	5,055
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	4,980	5,055	5,055	5,055
FTEs	**4**	**4**	**4**	**4**

Recommendation:

The Governor recommends a general fund appropriation for the continued support of the Community Solutions for Healthy Child Development Grants. This request expands and extends the community solutions funds which are essential to improve child development outcomes related to the well-being of children of disadvantaged communities and American Indian children from prenatal to third grade and their families, reduce racial disparities in children's health and development, and promote racial and geographic equity. The previous general fund dollars appropriated for these activities will end on June 30, 2023. Of the total funding annually, $4,000,000 will be given in grants to community-based organizations and tribal governments.

Rationale/Background:

The Community Solutions program was created by the Minnesota Legislature in 2018. It was designed to address the large and persistent disparities—among the worst in the nation—for Black, Afro-Latino, and other non-white children and American Indian children and their families. The program was among the first recommendations made by Voices and Choices for Children, a statewide advocacy organization for black, indigenous, and other non-white individuals. Governed by a steering committee reflecting the geographic and ethnic diversity of populations in the state, Voices and Choices was founded by Lieutenant Governor Peggy Flannigan, who was at that time, executive director of the Children's Defense Fund of Minnesota, and Mayor Melvin Carter, at that time, the director of the Governor's Children's Cabinet.

In 2015 Voices and Choices released a report, Recommendations for the Wellbeing of Families of Color and American Indian Families in Minnesota. The report reviewed recommendations from effective programs over a 20-year period with positive outcomes for families in African American, Asian Pacific, Latino, and American Indian Communities. Despite the effectiveness of the programs, few if any of the recommendations had been institutionalized by the state public sector. This left a gap in effective, community-based strategies and the capacity of public agencies to recognize and build upon them. The program supports solutions developed by the affected communities for improving the wellbeing of young children and their families, with a particular emphasis on children prenatal to age three. The program focuses on the social determinants of health, including housing, income, transportation, racism and discrimination, education, neighborhood conditions, employment, and social connectedness. These determinants are also at the epicenter of the COVID-19 virus and intensify the focus on local solutions to meet local needs.

For the first phase of the program in fiscal years 2020 to 2023, a competitive grant process was conducted in order to fund community-based organizations focused on early childhood that are both led by and serving Black, Indigenous, and people of color (African American, Asian Pacific, Latino, American Indian communities). Out of forty-six applications, twenty-three organizations were funded.

Proposal:

Expand and strengthen the Community Solutions grant program that was previously established in 2020. Community Solutions grant funding of $4,000,000 Grant will be competitively awarded to up to 50 community-based organizations to provide outreach, technical assistance, and program development to increase the capacity of new and existing service provides with a goal to meet the statewide needs especially in areas of the state where there are no services. Eligible grantees will include:

- Entities led by African American, Asian Pacific, and Latino communities and serving those communities, or led by American Indians and serving American Indians
- Entities located in or proposing to serve communities located in counties that are moderate to high risk according to the Wilder Research Risk and Reach Report
- Entities in counties that have a higher proportion of African American, Asian Pacific, and Latino communities and/or American Indians than the state average (MN population is ~21% people of color and 1-2% American Indians)
- Community-based organizations that are serving African American, Asian Pacific, and Latino communities and American Indians and have not had access to state grant funding

Grants will be available to tribal and community partnerships to identify and implement strategies that promote optimal health and wellbeing for pregnant and parenting families with young children. This grant program will build on the capacity of communities to promote child and family well-being and address social determinants of healthy child development. The grant program will focus on increasing health and racial equity and healthy child development and reducing health disparities experienced by African American, Asian Pacific, and Latino and/or American Indian children from prenatal to 3rd grade.

Expansion of the Community Solutions Equity Grants portion of the recommendation will require 2 FTE planner positions to provide community engagement and grant management support for grantees and oversee the grantees and provide technical assistance and training where needed to meet the needs of the grant as outlined in the grantee workplans, 1 FTE management analyst to provide fiscal support to grantees and monitor program funds, and 1 FTE senior research analyst to provide evaluation support to grantees to track individual and collective impacts of the programs implemented.

Impact on Children and Families:

Minnesota is home to roughly 423,100 children under the age of six, of which about 30 percent are children from disadvantaged communities or American Indian children. Of the 30%, 69% live in the moderate to high and high composite risk counties. This further describes economic, health, and family stability risk factors that are at play throughout Minnesota.[1] Cumulative risk can cause toxic stress and have a compounding effect throughout life – negatively affecting children's brain development, learning ability, and lifelong health and well-being. While no single risk factor determines a child's developmental trajectory, cumulative risk is the most predictive of adverse outcomes in childhood and across the lifespan. African American, Asian Pacific, and Latino communities of color and tribal communities report strength in culture and community and the support of these strengths may mitigate the effects of cumulative risk. Supporting economic stability and safe stable nurturing relationships and environments (as defined by communities) at home, at school, and in community systems are top priorities to promote healthy development and well-being for pregnant and parenting families with young children. Supporting cultural and community strengths build capacity for action and requires the commitment to

[1] Wilder (2018) Risk, Reach, and Resilience Report. Retrieved from https://www.wilder.org/wilder-research/research-library/minnesota-early-childhood-risk-and-reach#page=95

developing authentic partnerships that lift up community voice and co-creates solutions. Developing authentic partnerships drives sustainable change to equitably support healthy development and well-being for pregnant and parenting families with young children. An intentional focus on families and communities experiencing racial, geographic, and economic inequity assures that their strengths will be part of solutions.

Equity and Inclusion:

Efforts to provide resources to communities most impacted who have invaluable knowledge and cultural wisdom to solve these issues is at the core of improving these disparities. This recommendation seeks to expand the Community Solutions program past its first phase of funding community-based solutions and learning with state agencies how best to support that process. Its continued aim is to institutionalize: 1) a better alignment across public agencies, 2) the flexibility to acknowledge and accommodate cultural differences, and 3) a process for building upon and investing in the expertise of people closest to the issues at hand. Accomplishing these aims will strengthening the fabric of community so essential to the wellbeing of children of color and American Indian children and their families. It will also help secure Minnesota's future.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Results:

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quantity	Geographic regions reached by grantees	4	8	2024-25
Quality	Culturally and linguistically appropriate strategies identified to promote health and well-being for at-risk pregnant and parenting families with young children	23+ strategies being implemented by 23 grantees	46	2024 -25
Quantity	Number of implemented strategies	23+	46	2024-25

Statutory Change(s):

2019 Minn. Laws 1st Sp. Sess. Chap. 9 Art. 11 Sec. 107. Subd 3

Change Item Title: Comprehensive Drug Overdose and Morbidity Prevention Act

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	28,906	28,236	33,807	33,807
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	28,906	26,236	33,807	33,807
FTEs	**25.5**	**25.5**	**25.5**	**25.5**

Recommendation:

The Governor recommends an investment from the general fund for comprehensive funding to address the drug overdose epidemic by implementing seven strategies:

1. **Advance** state-wide access to evidence based non-narcotic pain management (NNPM) services through the maintenance and promotion of the Non-Opioid Pain Alleviation Information Network – Minnesota (NO PAIN MN) website NOPAINMN.org.
2. **Provide** culturally specific outreach to increase awareness about overdose, reduce stigma, and provide training for community members on overdose education and naloxone distribution. This strategy includes expansive work with Minnesota's Tribal Nations, urban American Indians, African Americans, and Minnesota's East African communities, and other communities per emerging trends.
3. **Enhance** overdose prevention and supportive services for people experiencing homelessness, a population that is at significant elevated risk for fatal overdose. This strategy includes funding for emergency and short-term housing subsidies through the Homeless Overdose Prevention Hub and expanding support for syringe services programs serving people experiencing homelessness statewide.
4. **Strengthen and equip** employers to promote health and well-being of employees in recovery or with a history of substance use through the Recovery Friendly Workplace initiative.
5. **Improve** surveillance and identification of substances involved in overdoses (Minnesota Drug Overdose and Substance Use Surveillance Activity or MNDOSA), in partnership with MDH Public Health Laboratory**,** and strengthen existing epidemiologic capacity and data sharing to support community-level prevention efforts.
6. **Provide grants, implementation technical assistance, and evaluation expertise** to multidisciplinary public health/clinic/community coalitions to implement the Minnesota-developed Tackling Overdose With Networks (TOWN), that includes regional multidisciplinary overdose prevention teams (RMOPT), recovery community organizations (RCO), media messaging, Tribal Nations, local public health, and community engagement. This strategy will also support implementation of opioid settlement funded prevention practices at the community level.
7. **Address substance use disorder (SUD) in pregnant and postpartum women and infants.**

In summary, of the total amount over all the prevention strategies, $44,930,000 will be awarded annually in the first biennium as grants, and in each subsequent biennium $55,363,000 will be awarded as grants.

Rationale/Background:

Drug overdose deaths increased 25% from 2020 to 2021 (1,050 to 1,356 deaths) in Minnesota. The number of drug overdose deaths in 2021 was the highest annual number ever recorded for the state. Increases in drug overdose deaths were seen in both the Seven-county Metro area and Greater Minnesota. African American

Minnesotans are four times more likely to die of a drug overdose than white Minnesotans and American Indian Minnesotans are ten times more likely to die of a drug overdose than white Minnesotans. Since 2019, the highest number of drug overdoses has occurred in the 25-34 age group. Currently, for every drug overdose death, there are almost thirteen nonfatal drug overdoses. From 2017-2018, 31.3% of deaths during pregnancy and up to one-year postpartum identified substance use as a contributing factor to the death.

The overdose epidemic disproportionately affects people experiencing homelessness. An analysis by the Minnesota Drug Overdose and Substance Use Surveillance Activity (MNDOSA) of health systems in Northeast Minnesota found that 29% of patients with emergency department visits for drug overdoses were experiencing homelessness. The Hennepin Healthcare Research Institutes' homeless mortality study found that substance use, particularly fentanyl overdoses, were the leading cause of death for people experiencing homelessness in Minnesota from 2017-2021. One in three of all deaths in this period among people experiencing homelessness were caused by substance use. People experiencing homelessness accounted for one in ten of all substance use-related deaths during this time.

The drug overdose epidemic continues to evolve. Department of Human Services estimated a 380% increase in injection drug use among people admitted to treatment for substance use disorder in Minnesota between 2007-2019. The harms associated with injection drug use go beyond overdose to include increased adverse outcomes for pregnant women and their infants as well as transmission and outbreaks of infectious diseases. Homelessness can increase needle-sharing, re-use, and transactional sex, making people more vulnerable to acquiring drug-related infections, such as HIV, Hepatitis C, methicillin-resistant Staphylococcus aureus (MRSA) and endocarditis. Not only does homelessness increase the risk of acquiring HIV, but it also makes treatment more difficult, meaning people living with HIV are more likely to have a higher viral load and are more likely to transmit the virus to others.

Neonatal Abstinence Syndrome (NAS) is a postnatal drug withdrawal syndrome caused by a sudden discontinuation of fetal exposure to substances used or misused by the mother during pregnancy. Babies born with NAS experience withdrawal symptoms, such as breathing problems, poor feeding, diarrhea, seizures, and fever. Most babies will experience symptoms of NAS soon after birth and these symptoms can last for up to six months. Babies with NAS are also at a higher risk of being born prematurely or at a low birthweight. In Minnesota, the prematurity rate among newborns with NAS was 26 percent, compared to 11 percent of newborns without NAS. Babies born with NAS also experience prolonged hospitalization or admission. From 2016 to 2021, there were 2,409 NAS related hospital-visits in Minnesota. This corresponds to a statewide rate of 6.3 per 1,000 live births. As these babies grow, they are at a greater risk of experiencing developmental delays or speech impairment than children who were not born with NAS.

In 2020, MDH declared an HIV outbreak among people who inject drugs (PWID) in metro Hennepin and Ramsey counties after seeing a rise in new diagnoses alongside increased growth and subsequent dispersal of large homeless encampments. Currently, about half of the outbreak cases in the metro area are linked to an encampment setting. Similarly, in 2021, MDH declared a separate HIV outbreak in the Duluth area, with about a quarter of the outbreak cases reporting experiencing homelessness or unstable housing. Both outbreaks are disproportionately affecting American Indian/Alaska Native communities, which represent 26% and 42% of cases in the Hennepin/Ramsey and Duluth area HIV outbreaks, respectively, yet comprise only 1% of the population in MN.

The COVID-19 pandemic was another factor that exacted a brutal toll on people experiencing homelessness and persons living with opioid use disorder (OUD). Over the course of 2019 and 2020, while the overdose epidemic raged, serious illness and death from COVID-19 affected black and American Indian communities disparately, and outbreaks in infectious diseases (HIV, HVC, Hepatitis A, etc.,) clustered overwhelmingly in homeless communities throughout the state.

People with lived experience of sexual assault, domestic abuse, and human trafficking (sex and labor) need access to wraparound assistance from first contact with an agency through short-term and long-term support. These services include case management, emotional support, access to benefits, referrals to housing, access to inpatient and outpatient treatment, etc. Many SUD treatment service providers report that victims of interpersonal violence encounter substances in a variety of ways including through force or coercion by an abusive or exploitive party, as a means of coping with extreme trauma, or through trade for sex or something else of value to maintain access to drugs. Providers are not always equipped to meet the intensive needs of victims and survivors experiencing withdrawal or trying to maintain sobriety and are lacking referral resources in their communities. In addition, providers need additional support to implement and manage harm reduction practices within their programs.

We need comprehensive funding to address the overdose epidemic from all angles of prevention. Evidence-based, culturally specific, and collaborative prevention efforts will help Minnesota turn the tide in the overdose epidemic and prevent future deaths. The seven strategies proposed are innovative, are integrative, not currently funded by other sources, and will be synergistic in outcomes.

Proposal:

Strategy 1: Advance state-wide access to evidence based non-narcotic pain management (NNPM) services through the maintenance and promotion of the Non-Opioid Pain Alleviation Information Network – Minnesota (NO PAIN MN) website NOPAINMN.org. This work builds on the CDC's Promoting Safer and More Effective Pain Management ideas by providing information, education, resources, demonstrations and locations about safer and more effective pain management options. The website (https://nopainmn.org/) was developed by Hennepin Health Care and the Minnesota Department of Health; it provides evidence-based information and resources on eight main NNPM modalities with twelve sub-categories, and a Resource Map identifying more than 17,000 complementary and integrative health providers, over 50 health and hospital systems, and more than 600 health facilities and clinics in the state of Minnesota. Helping people find safe, effective pain management services will help individuals experiencing chronic pain improve their functioning and heal while improving their quality of life.

Strategy 2: Provide culturally specific outreach in Minnesota. This strategy recognizes the unique strengths within cultural groups along with specific risks and underlying factors that may contribute to higher death rates and greater numbers of overdoses. The grants funded in this strategy will increase awareness about overdose, reduce stigma, and provide training for community members on overdose education and naloxone distribution. Strategy 2 will provide funding to each of Minnesota's Sovereign Nations and up to three organizations serving urban American Indians in Minnesota. This strategy will also include funding for up to ten organizations serving Black Minnesotans. Finally, this project builds on current MDH work to engage Muslim faith leaders in the opioid epidemic response in the Twin Cities and will expand this reach beyond the Twin Cities to Minnesota's East African population statewide (St. Cloud, Rochester, Willmar, Marshall, Moorhead, and more).

Strategy 3: Overdose Prevention Hub for People Experiencing Homelessness, the **first component** of Strategy 3, will enhance housing and supportive services for people experiencing homelessness who are at-risk of overdose. The Community HUB Model was developed by the Agency for Healthcare Research and Quality (AHRQ) and has been used to connect at-risk individuals to health and social services and improve their health outcomes. Recently, a community resource hub for people to access fragmented service systems has been used by Minnesota Department of Education.

Interviews with people living with HIV who use drugs and are experiencing homelessness have shown the necessity of tailored strategies to help people find and maintain housing while managing withdrawal symptoms. The goal of the Hubs is to provide people who are homeless (and at high risk of becoming homeless) and who are at serious risk of overdose and infectious disease with a community space in which multiple service providers can offer low barrier access to services in a central "hub" that is open for "drop-in" services after typical service agencies have closed – hours in which the people are often most at risk. Hubs will use a whole health model,

providing (1) housing and other social services; (2) linkage to medical, mental health and dental services through onsite nursing and telehealth connection to medical providers; (3) cultural/traditional healing services; (4) overdose prevention services (naloxone, education, etc.,); (5) food assistance resources and community meals; (6) laundry and hygiene resources; and (7) peer support with groups and opportunities for community connections and relationship building. Hubs will provide emergency and short-term housing subsidies with access to mental health and substance use counseling and treatment, accompanied by job skills, mentoring, and other support services identified as we seek to turn the curve of the overdose epidemic. Each Hub will include services focused on the needs of pregnant and post-partum people.

Community partners and organizations with robust street outreach teams and harm reduction services will collaborate on providing enhanced services to people experiencing homelessness and linkage to these hubs. A primary objective is to provide access to temporary housing. Hubs will provide services to people who experience homelessness and who have complex problems, including opioid use and other substance use disorders as well as mental health conditions which often make them at increased risk of serious health outcomes (e.g., overdose, transmission of infectious diseases, use of ED service, involvement with law enforcement, etc.). Building on referrals from community outreach workers, the faith community, harm reduction and syringe services programs, EMS and law enforcement, this approach will be the first step to helping high risk homeless individuals to get help with substance use, move off the street, learn job skills, and stabilize their lives. **Community Health Workers** (CHWs) will be employed in each of the Hubs. CHWs are trusted resources in their communities, sharing life, cultural and linguistic experience with their clients. MDH will develop training to increase CHWs' knowledge of substance use disorder (SUD), management strategies, harm reduction practices, and treatment options to which they can guide clients. One grant to a CHW lead organization will equip CHWs to focus on the prevention of shared risk factors between drug overdose and gun violence.

Eight Hubs will be established and grant funding will be provided in the eight regions of Minnesota (one region being the metropolitan area, seven in Greater Minnesota).

A ninth Hub will specifically serve urban American Indians in the Twin Cities Metropolitan Area. This Hub will provide connection and resources to services described above but will ensure leadership from the community and connection to culturally appropriate resources and services. Each hub grant for nine organizations will be awarded $300,000, for a total of $2,700,000 annually.

The **second component** of Strategy 3 will expand access to harm-reduction services among particularly vulnerable populations: people experiencing homelessness and/or pregnant-postpartum women; this provides practical strategies aimed at reducing negative consequences associated with drug use and is a mission-critical step that can show immediate results in preventing infectious disease and drug overdose death. A critical part of harm reduction includes access to Syringe Services Programs (SSPs), community-based programs that provide a range of services including: (1) linkage to substance use disorder treatment, including medications for opioid use disorder (MOUD); (2) access to and disposal of sterile syringes and other equipment; (3) vaccination, testing, and linkage to care and treatment for infectious diseases; and (4) education about overdose prevention and access to medication that can reverse an overdose, such as Narcan or naloxone. SSPs are experts at bringing services to where people are and their staff, many of whom have lived experience, are often the only people with consistent, trusting relationships with people who inject drugs, providing lifesaving services and a critical gateway into treatment and housing. Many homeless service providers are unfamiliar with SSPs and the services they provide; this funding will help better integrate these services. The impact of SSPs in this work is borne out in the evidence, as people who inject drugs (PWID) who have access to an SSP are five times more likely to enter treatment for a substance use disorder, and nearly three times more likely to reduce or stop injecting drugs. SSPs have also been linked to a 42-66% reduction in the transmission of HIV and HCV. In 2021, the six SSPs that are currently funded by MDH distributed nearly 52,000 doses of life-saving naloxone; in the same year, clients at these six SSPs reporting reversing nearly 1,200 overdoses with naloxone accessed at these SSPs.

In summary, Strategy 3 includes 1) Funds to cover startup costs, coordination with homeless outreach and housing providers, coordination with existing infectious disease prevention and care providers, and traditional syringe services programs. This strategy will: provide Homeless Overdose Prevention Hubs in Minnesota; develop an American Indian-specific Hub in the Twin Cities Metropolitan Area; 2) Funds to identify and prevent the shared risk factors between drug overdose and gun violence; and 3) Funds to maintain existing and to establish new syringe services programs that can work with people experiencing homelessness to provide linkage to care, overdose prevention, and safer use supplies. These strategies are also being advanced as part of the Interagency Housing Stability Work Group.

Strategy 4: Establish the Recovery Friendly Workplace Initiative (RFWI). The RFWI will (1) identify model work environments (and then replicate them) that are conducive to enabling persons in addiction and mental health recovery to sustain and re-enter the workforce as productive members of society; (2) raise public awareness and provide information that reduces stigma for getting help, reduces discrimination towards people in recovery, promotes equity, and supports health and safety for employees; and (3) promote active community engagement that will assist in reducing the negative impact (stigma and discrimination, work productivity, etc.) of unaddressed substance misuse and untreated mental health. MDH will work with Minnesota's current network of 13 Recovery Community Organizations throughout the state to develop the RFWI to give business owners the resources and support they need to foster a supportive environment that encourages the success of their employees in recovery. MDH will build on the MDH Minnesota Business Partnership Employer Toolkit which promotes individual wellness by creating work environments that further mental and physical well-being of employees. The RFWI gives business owners the resources and support they need to foster a supportive environment that encourages the success of their employees in recovery. This will proactively prevent substance misuse and support recovery from substance use disorders in the workplace and community.

Similar programs have been successfully launched in several states (Ohio, Pennsylvania, New Hampshire, Rhode Island, Connecticut). In addition to expanding the training content and building Minnesota's workforce capacity by increasing the number of certified peer recovery specialists, the RFWI program will reduce stigma for getting help, increase access to help, promote safe use, storage, and disposal of medications, and will help employers understand how substance misuse impacts their bottom lines – and how they can save lives and money by addressing it.

Strategy 5: The department will improve surveillance and identification of substances involved in overdoses (Minnesota Drug Overdose and Substance Use Surveillance Activity or MNDOSA). Timely and accurate data on fatal and nonfatal drug overdose in Minnesota are necessary to guide prevention efforts. Existing statewide surveillance systems are subject to data lags by several months and do not reflect the overdose crisis or drug environment in real time. The MNDOSA program provides timely data on substances involved in emergency department visits in Northeast MN and the Metro area and has found important differences by region. Expansion of the program is needed to characterize the drug landscape throughout the state. The MNDOSA program also provides detailed data on populations at risk and expansion would allow data collection across the state to inform prevention priorities.

This proposal intends to expand the program's capacity to include a minimum of eight grants to hospitals distributed across the Northwest, West Central, Southwest, South Central, Southeast, and North Central regions of Minnesota. This proposal will fund staff time to collect, analyze and disseminate data to local partners who will use the data to secure grants and allocate prevention resources. Expansion of the program will result in data on drug overdose and substance misuse cases treated in emergency departments, including advanced toxicology results from clinical specimens from each region in the state. The findings from these data will provide communities and their decision makers with granular and up-to-date data on drug overdose and substance misuse in their region. Collecting representative statewide data will yield insight into regional and local trends, hotspots, and populations at greatest risk of drug overdose.

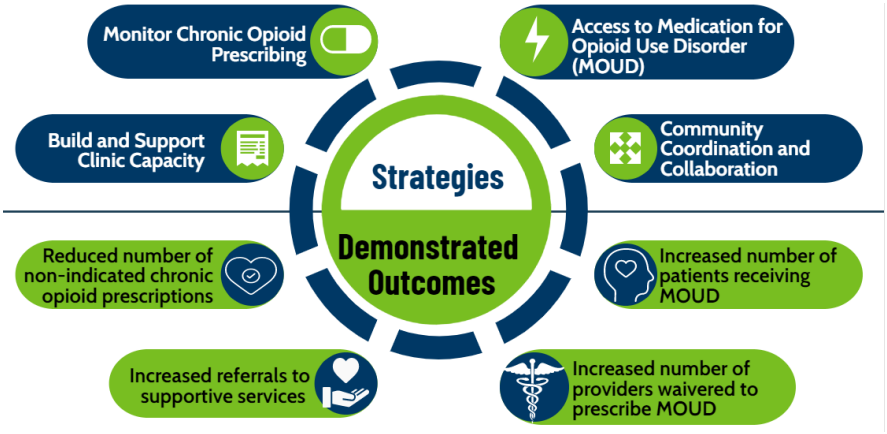
Differences in drug use and the impact of these drugs on the local healthcare system are evident by comparing the current MNDOSA data between the Northeast region and the metro area. These differences are likely throughout the state, suggesting each region has unique defining characteristics of the drug epidemic. Future success will be determined by effective onboarding of new hospital(s) or systems in varied geographical regions of the state and providing them with useful and timely toxicology data for their area along with aggregated data from across the state. This information will allow them to tailor prevention efforts to newly emerging drug trends in their specific areas. Toxicology testing of clinical samples from overdose events provides missing information about the causative agent(s) that lead to increased burdens on hospital ERs. Individuals who choose to consume illicit substances are at an elevated risk of unknown exposures and the substances they are exposed to are not pure and the concentrations are not controlled. Understanding the scope of what those individuals are exposed to will help guide prevention efforts. MNDOSA aims to provide data to understand the burden of specific drug use on the health care system which will come from more expansive surveillance of the non-fatal overdose population.

MNDOSA aims to collect timely and accurate information on the specific drug use trends within the state of Minnesota and their impact on the healthcare system. The MNDOSA program collects detailed demographic information as well as biological specimens from individuals that have been admitted to hospitals, are part of a drug overdose cluster, or are experiencing symptoms not consistent with the drug that they thought that they took. Using advanced toxicological testing developed at the MDH Public Health Laboratory, these specimens will be analyzed for a regularly expanding list of over 1,000 compounds. The results from these tests will be used to inform prevention efforts, understand the impact of specific drug compounds on the health care system and allow the rapid identification of newly emerging novel psychoactive substances in our community. The increase in funding from the governor's budget for MNDOSA will allow the program to expand to all eight public health regions of the state and accommodate the increased volume of specimens that will need to be analyzed. Of note, more children are dying due to fentanyl exposure than has ever happened before.

With MNDOSA and other data we will **strengthen existing epidemiologic capacity and data sharing to support community-focused data and local prevention efforts** through two activities. **1)** MDH will create systems and tools to share data with local communities (e.g., counties, cities, health boards, etc.) that result in data-informed decision making to address substance use and drug overdose. MDH staff will provide technical expertise and support to local communities and local public health agencies that are addressing substance use and drug overdose by sharing data and resources that are accessible, timely, and comprehensive that provide actionable data. The data resources will depend on the locale, but include public use data sets, interactive data through data visualization tools, online data query tools, or reports and briefs, along with epidemiologic expertise to craft important questions and provide context to the data. **2)** To provide a more comprehensive understanding of the determinants of drug overdose, MDH will invest in epidemiologic activities and reinvigorate data sources that fill gaps in our understanding of drug overdose and substance use. This work will rely upon existing data sources and their linkage, and the development of new data sources and indicators, such as surveys of people who use drugs and identify cross sectional topics of importance at the individual, family, community, and societal levels (e.g., gun violence, trafficking, suicide). Apart from solely identifying factors that increase risk, this work will also center on understanding strengths and resiliencies among communities. Our current data sources focus on fatal and hospital-treated drug overdoses. These data sources, however, only provide a minimal window into understanding the drug overdose epidemic.

In summary, Strategy 5 will expand MNDOSA from the current two hospitals to at least six more hospitals. Funds will be used for grants with the hospitals to fund staff time dedicated to project management, data collection, sample collection and shipping of specimens. With the addition of six more hospitals, the department will need to expand its capacity for specimen testing; as such, the lab will need to purchase a new High Resolution Mass Spectrometer and will incur additional supply expenses. This strategy will fund MDH staff time to create data tools and be a resource for local communities to develop data-informed decision making, as well as seek to understand the determinants of drug overdose and substance use at the individual, family, community, and societal levels.

Strategy 6: Expand Community Connected Care - Tackling Overdose with Networks (TOWN), regional multidisciplinary overdose prevention teams, community-led primary prevention, faith community focus, crime victim services, youth mental health. In Greater Minnesota, drug overdose deaths increased 23% from 2020 to 2021. To address the rise of overdose deaths in rural and tribal communities, MDH piloted a clinical care team-based model utilizing a multi-strategy approach in alignment with Centers for Disease Control and Prevention (CDC) recommendations for preventing overdose in rural contexts (CDC, 2018) with twelve clinics across Minnesota. This model, called Tackling Overdose with Networks (TOWN), utilizes 4 key strategies to increase access to services, increase the number of providers able to prescribe, and reduce dangerous prescribing practices. Five clinic sites will be selected for expansion of the TOWN model based on need, focusing on geographic areas with the highest rates of overdose for American Indian and African American populations. Using the Social Vulnerability Index, we will identify priority areas and assess community clinics for readiness to implement this evidence-based strategy to prevent overdose.



Regional multidisciplinary overdose prevention teams will consist of public health, public safety, health care, behavioral health, and education professionals working together to address the overdose crisis at the community level. Their work will complement the work of local clinics and provide synergistic impact by strengthening community prevention efforts, empowering individuals to make healthy choices, reducing stigma, and addressing the overdose crisis at the community level. Prevention teams would have an option to add interventions that have an emphasis on the perinatal population within their community/region. Eight geographic regions in Minnesota (modeled after the EMS [emergency medical services] and local public health regions) will plan and implement drug overdose prevention projects. These teams will help local communities identify priorities based on community identified needs and race rate disparity data to ensure efforts reach Minnesotans most vulnerable for drug overdose. This will help communities align efforts with other local, state, and federal funds, including opioid settlement funds and achieve collective impact. MDH will provide community grants ($200,000 per region annually) to these priority communities to work as a coalition to implement overdose prevention strategies (e.g., school based – Kognito, Friend2Friend, substance use module of social emotional learning in school; community based improving health equity – job training and housing; and harm reduction or diversion). Applicants can select to apply for additional funds if they seek to implement strategies to promote family-centered care with a focus on the mother-baby dyad and linking families to community resources and other supports.

Community-led primary prevention. Minnesota's Tribal Nations and Community Health Boards need dedicated resources for primary prevention. Many evidence-based and evidence-informed prevention practices, policies and strategies are available from which to select that can be tailored and adapted to the specific community conditions. These funds will provide base support per Tribal Nation (11) and Community Health Boards (51). A total of $8,200,000 annually will be available for primary prevention efforts to be allocated based upon tribal and county overdose morbidity and mortality rates. Communities and Tribes will also have access to funds to support communications efforts through media outlets to be allocated based on needs identified by communities.

Faith community engagement and messaging. Faith-leaders have been a proven inroad to community groups. Faith leaders have, in the past, been invited to partner with traditional public health messengers as resources to speak into multi-generational health risk and protective factors. These groups will be tasked with exploring and addressing two linked epidemics that share many of the same root causes: the drug misuse and overdose epidemic and the gun violence epidemic. Inviting these leaders (Rabbis, Imams, priests, pastors, traditional healers) to explore what we can do together to change the trajectory of overdose and violence in Minnesota is an innovative approach that has not yet been utilized. MDH will provide data, manage funding distribution, and provide time and space for advisory action coalitions to gather and plan. We will prepare and provide requested research briefs, investigate national strategies that show promise, and provide connections to other groups. We will participate as a listener in round-table discussions to hear the needs and ideas of community members and learn about their strengths and assets. We have the experience to organize and/or participate in these types of discussions across the state to ensure strategies meet the needs of the varied geographic regions of Minnesota. Short cycle grant opportunities (up to 25 grantees funded at varying levels) will be available to these groups to fund promising evidence-based or culturally informed solutions during which MDH will support with evaluation assistance and reporting capacity. One example is supporting Prison Fellowship as a means to break the cycle of recidivism for both substance and gun-related incidents.

Crime victim services. Crime victim services providers serving people with lived experience of sexual assault, domestic abuse, and human trafficking (sex and labor) report an inability to provide ongoing care and support to victims of interpersonal violence who are exposed to opioids and other substances as part of their victimization and it often results in loss to follow-up contact. Many service providers report that victims of interpersonal violence encounter substances in a variety of ways including through force or coercion by an abusive or exploitive party, as a means of coping with extreme trauma, or through trade for sex or something else of value to maintain access to drugs. They may return to dangerous situations in which substances and violence are present when they are not offered viable alternatives for support and safety. In consultation with Department of Public Safety, MDH will award up to 5 competitive grants to crime victim services programs to meet this gap in services. The intended result is that programs serving victims of interpersonal violence will be able to dedicate additional staff and resources to wraparound support for access to substance use care, particularly in the gap period when victims reach out to help but may not be able to immediately receive treatment beyond detox.

Youth mental health. Youth are affected by SUD and overdose in a multitude of ways. They may be living with someone who has an SUD, they may witness the effects including overdose of SUD in their community, and they may be living with SUD themselves. Enhancing education about emotional regulation and relationships and positive relationships with adults are protective factors for multiple health outcomes including drug misuse, gun violence, interpersonal violence, among others, and can reduce the impact of other adverse childhood experiences (ACEs) a youth may acquire. These important protective factors can be addressed through staffing policies in schools to require a social worker and/or school counselor to provide guidance, emotional regulation education, counseling, resource connections, and a positive relationship in every level of school (primary and secondary). Telehealth and virtual options are also available. 1) MDH will work with MDE to offer grants to 21 schools to fund a school counselor. Schools will be selected based on capacity to add this position to staffing, commitment to appropriate trainings (focused on trauma-informed practices and train-the-trainer programs to educate other school staff (such as Sources for Strength); responding to SUD in youth and parents), as well as data-informed demonstration of impact on the school community of drug overdose. Applicants can propose virtual options as well as sharing this position among multiple schools with appropriate plans for resource-sharing. 2) MDH will offer grants to community mentoring programs through an RFP process to expand their reach and improve their ability and capacity to reach youth, create positive relationships, and improve community connectedness. 3) Kognito is a practice-based digital learning tool to improve mental health and well-being in schools, campuses, and communities. Kognito role-play simulations enable organizations to rapidly build the capacity of educators and students to lead real-life conversations that change lives. This tool has already been implemented successfully as a suicide prevention tool and a number of schools now have access to drug and

alcohol deterrence modules for both teachers and students. Expansion of access to this program is one way to strengthen social emotional learning and prevention initiatives in schools.

The Recovery Friendly Workplace Initiative (RFWI) described and funded in Strategy 4 addresses another vital community sector that must be involved in a wholistic community-wide effort to prevent drug overdose.

Strategy 7: Addressing SUD in pregnant/postpartum women and infants
Addressing pregnant and postpartum women who may be using substances during or after pregnancy is a need in Minnesota if we are to decrease overdoses, decrease maternal deaths, and improve outcomes for infants exposed to opioids. This strategy applies a multifaceted model to improve identification, surveillance, and implementation of prevention resources/programs for the pregnant/postpartum woman, family unit (multigenerational units to include partners), and infant. Substance use and adverse behavioral health have increased deaths during pregnancy and in the postpartum period, disproportionately impacting BIPOC pregnant women.

Development and implementation of a Neonatal Abstinence Syndrome (NAS) Monitoring System will identify best practices for a robust public health response for infants in this dyad. There remains an urgent need to monitor trends, build the evidence base, and define the full spectrum of adverse infant and childhood outcomes associated with prenatal opioid and other substance abuse exposure and expand the linkage to needed care and services. Surveillance of NAS and opioid exposure will help identify the physical and developmental health outcomes linked to prenatal opioid exposure and help target effective programs and services to mitigate adverse effects. Specifically, an NAS monitoring system will:

1. Assess the incidence of NAS in Minnesota and monitor trends over time.
2. Assess health, developmental, and educational outcomes.
3. Identify and refer families for timely intervention, family support and education. This includes addressing the needs of the family unit in the postpartum period, connecting with social services for infant diagnosed with NAS, and adapting care plans to address needs. Grant funding for community-based organizations, local public health, and Tribal governments to provide follow-up services (i.e., linkage to needed services and supports) for infants identified through the NAS Monitoring System.
4. Better characterize risk factors for NAS in Minnesota.
5. Assess capacity to address maternal substance use and provide multidisciplinary care for the child and family affected by substance abuse.

To address the specific needs of pregnant and postpartum women with substance use disorder, MDH will provide statewide resources and clinical expertise to local public health, tribal public health, clinical partners, and community organizations focused on this specific population. Strategies for pregnant and postpartum women may include increasing medication assisted treatment options, supporting projects to identify evidence-based care models for both mental health and substance use disorder, collaborating with the Minnesota Perinatal Quality Collaborative and the Minnesota Hospital Association on substance use quality improvement initiatives, and implementing substance-use related recommendations from the Maternal Mortality Review Committee. In addition, MDH will provide funding for the Minnesota Perinatal Quality Collaborative to extend the substance use disorder quality improvement initiative, which allows for participating hospitals to measure progress and receive additional support to improve outcomes for pregnant/postpartum women affected by substance use ($100,000 per year in grants in fiscal years 2024 and 2025). MDH will also provide grants to support community-driven trauma informed approaches, apply harm reduction techniques, support in-hospital patient advocates during the birthing process and in the postpartum period, enhance perinatal support pathways, and increase the availability of peer recovery specialists for pregnant/postpartum women).

Impact on Children and Families:

According to the 2019 Minnesota Student Survey of 8th, 9th, and 11th graders, 11% reported *Living with someone who drinks too much alcohol* and 5% reported *Living with someone who uses illegal drugs or abuses prescription drugs*. Homelessness impacts families and youth disproportionately. Half of all people experiencing homelessness statewide were in families (3,214) or unaccompanied youth under 25 (746). Aggregated data will be shared with

all partners and site-specific data will be shared with those site partners. Data will be used to inform prevention efforts and clinicians at participating hospitals through networks like the Minnesota Perinatal Quality Collaborative. This will provide them with more robust and complete information regarding the substances people are exposed to and the associated symptomology. Improvement on quality data metrics in this population will result in better patient treatment and better prevention messaging. This system will measure overdose related impact on emergency departments and hospitals. It will also help identify new substances being used and the related symptoms individuals are experiencing. These seven prevention strategies will reduce risk of overdose death, reduce HIV risk behaviors, improve public order, improve the quality of overdose and NAS related data, increase family stability and economic opportunities, improve interventions for infants/children exposed in utero and will help participants (including parents) seek treatment for their substance abuse.

Equity and Inclusion:

American Indian and Black Minnesotans have disproportionately high rates of fatal and nonfatal overdoses; they are also over-represented among those experiencing homelessness. Disparities also exist by geography, income, and education level. Moreover, most people (62%) counted in the statewide homeless Point-in-Time count in 2020 identified as Black, Indigenous, or People of Color. Both HIV outbreaks in Minnesota disproportionately affected American Indian and Black communities:

- Hennepin/Ramsey outbreak – 44% white, non-Hispanic, 26% American Indian/Alaska Native, 18% Black
- Duluth area outbreak- 42% American Indian, 54% white
- American Indian/Alaska Natives make up 26% and 42% of cases in the Hennepin/Ramsey and Duluth area HIV outbreaks, respectively, yet make up only 1% of the population in MN. Black/African Americans make up 12% of the HIV outbreak cases in Hennepin/Ramsey counties yet make up only 7% of the population in MN.
- The mortality rate for American Indian People Experiencing Homelessness is five times higher than the general MN population. The leading cause of death for people experiencing homelessness is opioid overdoses.

The seven prevention strategies address shared risk factors while also strengthening resilience and protective factors at individual, family, and community levels. The Recovery Friendly Workplace Initiative promotes a quality work environment by establishing and maintaining protective working conditions, such as fair and equitable treatment, respectful supervision, and promotion of supportive social connections and friendships among co-workers. Individuals with substance use disorder experience stigma (negative attitudes and stereotypes) that results in prejudice, discrimination, social exclusion, and limited opportunities to participate fully in employment and other life roles. The training, educational materials, presence of recovery coaches, doulas, and broad visible support will help reduce stigma and encourage treatment and recovery. Substance use disorder is not a moral failing; successful recovery is possible.

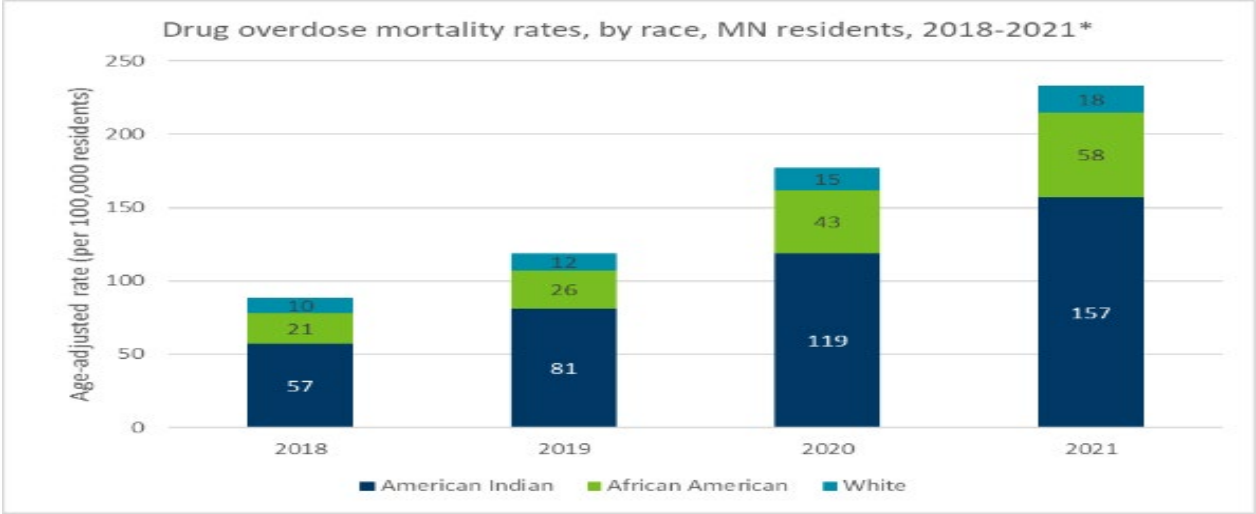
Tribal Impact:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

American Indian Minnesotans are nine times more likely to die of a drug overdose than white Minnesotans. MDH continues to work closely with Tribal Health Directors to share data and best practices. MDH did not engage in formal, government to government consultation on this topic; however, we have shared information and aligned our work with our MDH Tribal Liaison.

In 2021 the drug overdose mortality rates increased dramatically for American Indian and African American Minnesotans, widening the disparity in drug overdose mortality rates by race



DEPARTMENT OF HEALTH

SOURCE: Minnesota death certificates, Injury and Violence Prevention Section, Minnesota Department of Health, 2018 -2021
*NOTE: 2021 data are preliminary and likely to change when finalized.

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Tribal Consultation:
Does this proposal involve Tribal Consultation with one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs
None (or fractional)

Results:
Resources are scarce. We want to be certain, as stewards of the public's trust and funding, that we are doing the right things in the right way and at the right time (and with the right dosage). The performance and outcome measures, below, will keep the agency and its funded partners accountable for program success, while protecting, maintaining, and improving the health of Minnesotans.

Type of Measure	***Name of Measure***	***Current Value (Date Assessed)***	***Future Value with changes adopted:***	***Date Assessed by:***
Quality	Implementation of evidence-based local overdose prevention policies and programs	No baseline established	10 policies adopted and programs implemented	12/31/2024
Results	Overdose deaths and rate per 100,000 population	1,012 deaths and 17.7 per 100,000 population (December 2020)	800 deaths and 14 per 100,000 population	12/31/2024

Type of Measure	*Name of Measure*	*Current Value (Date Assessed)*	*Future Value with changes adopted:*	*Date Assessed by:*
Results	Nonfatal overdoses and rate per 100,000	14,475 nonfatal overdoses; 254/100,000 population (December 2020)	11,000 and 192.8 per 100,000 population	12/31/2024
Quantity	Syringes Distributed by the MDH-funded SSPs	1,796,622 (All of 2021)	Increase by 30%	12/31/2024
Quantity	Number of naloxone doses distributed to participants by MDH-funded SSPs	51,682 (All of 2021)	Increase by 20%	12/31/2024
Quantity	Overdose reversals reported by SSP participants to SSPs	1,195 (All of 2021)	Increase by 20%	12/31/2024
Quantity	Rapid HIV tests conducted by MDH-funded SSPs	820	Increase by 20%	12/31/2024
Results	90% of MDH-funded SSP participants who have a confirmed positive test for HIV are linked to care within 30 days	87%	90%	12/31/2024
Quantity	Number of laboratory test results per year	1,000 (9/15/2022)	3,000 – 4,000	1/1/2024
Quantity	Number of hospitals participating in the MNDOSA program	2 (9/15/2022)	8	4/1/2024
Quality	Analytes Tested	1,000 (9/16/2022)	>1,000	4/1/2024
Results	Sample Analysis Time	30 days (9/16/2022)	15 days	4/1/2024
Results	Maternal deaths (pregnancy-associated deaths) with substance use as a contributing factor	31.3% of pregnancy-associated death (maternal deaths from 2017-2018)	Decrease by 10%	12/31/2024
Results	Number of NAS cases per 1,000 live births	381 cases per year 2020	Decrease by 10%	12/31/2024

Statutory Change(s): Existing Statute for SSP Grants: Minn. Stat. 145.924
New statutory language will be submitted.

Change Item Title: COVID Delayed Preventive Care

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	7,500	7,500	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	7,500	7,500	0	0
FTEs	**7**	**7**	**0**	**0**

Recommendation:

The Governor recommends an investment from the general fund to address significant gaps in health care screening and management in urban and rural communities disproportionally impacted by COVID-19 to improve health outcomes for all Minnesotans and contain future health care costs. These funds will support nonprofit organizations, health care systems, and local public health agencies to link rural Minnesotans, Black, Indigenous, and people of color (BIPOC), and individuals with disabilities who delayed or did not seek critically needed health screening and care with services that are culturally appropriate, tailored for rural and urban communities, address underlying issues including housing, food and financial insecurity, and maximize use of evidence-based approaches including telehealth and use of paraprofessionals. Of the proposal total, $6,100,000 will be given out annually in community and clinical grants for fiscal years 2024-2025.

Rationale/Background:

The COVID-19 pandemic disrupted the health and well-being of Minnesotans and significantly reduced health care use making existing health disparities even worse for communities that face the greatest barriers to health. Faced with economic strife, increasing housing costs, food insecurity, and the risk of contracting and spreading COVID-19, there was close to a 30% reduction in health care visits from 2019 to 2021, impacting over 1.6 million Minnesotans. Delayed care was much higher for Minnesotans who reported their health as 'Fair' or 'Poor' or reported having a chronic condition. Between 2018 and 2020, there was a significant decline in screening, immunization, and management of acute and chronic health conditions such as control of high blood pressure, asthma, diabetes, and cardiovascular disease. COVID-related restrictions for visiting clinics and hospitals, health care workforce burnout, staff shortages, and limited resources challenged rural and community-based clinics to remain open, leading to both voluntary and involuntary delays in preventive care. While health care visits have increased since the height of the pandemic, data indicates that visits remain at lower rates than in the years preceding the pandemic.

Delays in seeking prevention services will ultimately lead to late-stage diagnosis of health conditions and poorer health outcomes. More than half Minnesota adults (more than 2.4 million people) have a chronic disease including asthma, diabetes, heart disease, and cancer. Rural, financially distressed, and BIPOC communities have higher rates of chronic disease than white Minnesotans. They are also more likely to be diagnosed later when the disease has advanced, which can lead to reduced quality of life, disability, or death. Rates of stroke hospitalizations, deaths, and risk factors are higher in African Americans, Asians, and American Indians compared to whites; rural populations compared to the large urban centers; and in low-income groups. Black Minnesotans between the ages of 35-44 are twice as likely to die from heart disease than the population average. Asian and Black patients with diabetes have the lowest rate of optimal care with 6.3% and 5.4% below state average,

respectively. This disparity existed before the pandemic but worsened in 2020. Cancer screening rates have also significantly decreased during the pandemic. For instance, patients who speak Hmong, Spanish, and Somali have colorectal screening rates at 25-42% below state average. Black and Hispanic communities are disproportionately undiagnosed and untreated for depression. Adult patients born in Mexico, Somali, and Laos have the largest gaps in follow-up care for depression.

Improving prevention and management would result in significant health care improvements, increase life expectancy, and reduce health care costs. For example, the National Cancer Institute projects that the impact of delayed preventive screening, diagnosis, and treatment for breast and colorectal cancer will result in 10,000 preventable deaths in the next decade. Ninety percent of the nation's $3.8 trillion per year health care costs can be attributed to people with chronic diseases and mental conditions and treatment of chronic disease constitutes a significant proportion of public insurance costs. In Minnesota, it is projected that from 2016 to 2027, health care spending will increase by nearly 50% or more for conditions such as hypertension, diabetes, dementia, and all chronic conditions (combined) for Minnesotans ages 60 and older.

Proposal:

Addressing the impact of delayed and forgone health care in Minnesota will require intentional, strategic outreach and collaboration with community organizations, local public health agencies, and health care systems. Effective pandemic responses demonstrate that community-centered and led strategies, providing health services via telehealth, addressing living conditions that impact health including food, housing and financial insecurity, and use of trusted paraprofessionals are cost effective and powerful new approaches. This initiative includes a request for new and existing areas of work.

Strategy 1. Community-centered partnerships. Eight 2-year grants will be awarded to community organizations in four regions of the state (two per region) to establish sustainable partnerships, build capacity, and adopt changes in system practices to improve quality and rates of chronic disease screening and disease management outcomes, and address underlying causes of poor health including food, housing, and economic insecurity. Initiatives will:

- Require community-led organizations to partner with health systems and local public health agencies to implement comprehensive approaches and a sustainability plan.
- Support family-based outreach and use of health care extenders (community health workers, community paramedics, community pharmacists, home care professionals), use of screening and disease management locations outside of clinics (mobile sites, home visits, telehealth), and use of patient centered technology (self-measured blood pressure monitoring, continuous glucose monitoring devices).
- Include technical assistance and training from Minnesota Department of Health to build capacity and equip community and clinic staff to use evidence-based and proven effective programs, ensure organizations fully utilize existing reimbursement options for services, and monitor and evaluate outcomes.

Strategy 2. Health care, community services, and local public health. Grants will be awarded to health care systems and clinics and local public health agencies to maximize use of culturally specific, proven, and emerging disease screening and management approaches including use of telehealth, use of mobile clinical services and other technologies to reach rural, BIPOC, and people with disability-related barriers. Twelve 2-year grants will be awarded to equip health care clinics and systems in four regions of the state. Three 2-year grants will be awarded to Local Public Health agencies to pilot use of Community Health Workers as local strategy. Initiatives will:

- Increase the delivery and use of effective community-delivered interventions to improve patient outcomes.
- Support care coordination using health care extenders such as community health workers who will link family with services and opportunities to address food, housing, and economic insecurity that impact health.
- Bolster and adapt use of telehealth for chronic disease management for patients.

- Include technical assistance from Minnesota Department of staff and contractors to build capacity for delivery of evidence based and promising programs, certification of chronic disease management coaches, and adaptation and translation of culturally specific chronic disease materials.
- Increase outreach to populations less likely to use clinics or social service organizations through use of health care extenders.

Strategy 3. Telehealth Pilot approaches to expand the use of telehealth for chronic disease management. Three pilot grants will be awarded to develop and test innovative adaptation of chronic disease management for telehealth and remote formats that address culturally and linguistically specific health literacy, numeracy, and digital literacy. Pilots will include funds to support participants technology needs, support evaluation, and dissemination of pilot outcomes.

Strategy 4. Payer-related policy recommendations. MDH will convene partners to identify policy recommendations that address barriers to access to care, payment, waivers, and reimbursement issues in public and private payer systems and for non-traditional providers such as community health workers and community pharmacists. Funds will support a report on barriers for reimbursement of chronic disease related health and social services. Partners will make recommendations on changes in policies, systems, and practices that directly impact patient outcomes and satisfaction, quality, and long-term health care costs.

Strategy 5. Measurement. MDH will strengthen measurement of chronic disease screening and management utilization for rural and BIPOC communities and people facing disability-related barriers to assess progress and inform policy decisions. Funds will support existing and expanded data collection and analysis of the Minnesota Health Access Survey, the Minnesota Study of Telehealth Expansion and Payment Parity, the Minnesota All Payer Claims Database (MN APCD), and support analysis of chronic disease related health care utilization planned by the Minnesota Electronic Health Record Consortium.

Impact on Children and Families:

Early detection and screening of chronic disease and chronic disease management can improve the health of children, families, and communities. Reports indicate that delayed care due to fear of contracting COVID-19 has negatively impacted children's lives, particularly around type-2 diabetes, cancer screening and treatment, and mental health. These reports highlight the importance of understanding and working with rural and BIPOC children and families to improve screening rates and chronic care management. This proposal centers community informed strategies and approaches to collaborating with health care systems, local public health, and community organizations to improve the health of children and families.

Equity and Inclusion:

COVID-19 has disproportionately impacted BIPOC, rural, low-income, and older adults across Minnesota. These are also the same communities experiencing the greatest inequities in health outcomes. By using a community engaged approach to co-identify priorities and strategies, this proposal aims to include these community members and organizations as decision-makers on how to best communicate and disseminate information to their communities in ways that promote and encourage action. The strategies outlined in this proposal reflect equitable and inclusive engagement – building partnerships across institutions, sharing best practices and community resources, implementing, and advancing telehealth use and access, expanding culturally specific modes of communication, and understanding the impact of these strategies. It funds health systems to build capacity and sustain health system changes that improve quality of care and services for populations disproportionally impacted by COVID-19.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Results:
Part A: Performance measures
This program will be evaluated from several perspectives.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of rural Minnesotans, Black, Indigenous, and people of color (BIPOC), and individuals with disabilities and families screened, enrolled, and who maintain engagement with chronic disease management programs and number who receive services to meet underlying social needs related to housing, food, and financial security.	TBD	Start of grants	TBD based on grants awarded Grants will be in 4 regions of the state addressing rural and urban areas	TBD based on grants awarded	End of grants
	Number of health care systems and clinics who have adopted or expanded culturally specific outreach and care programs for rural Minnesotans, Black, Indigenous, and people of color (BIPOC), and individuals with disabilities	TBD	Start of grants	TBD based on grants awarded Grants will be in 4 regions of the state addressing rural and urban areas	TBD based on grants awarded	End of grants
	Number of health care extenders such as community health workers across the state providing care coordination and linkage to services to address housing, food, and financial insecurity	TBD	Start of grants	TBD based on grants awarded Grants will be in 4 regions of the state addressing rural and urban areas	TBD based on grants awarded	End of grants

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
	Number of new policies, practices and environmental changes implemented to improve delivery of services for rural Minnesotans, Black, Indigenous, and people of color (BIPOC), and individuals with disabilities.	TBD	Start of grants	TBD based on grants awarded Grants will be in 4 regions of the state addressing rural and urban areas	TBD based on grants awarded	End of grants
	Adaptation and testing of three or more chronic disease management programs that use telehealth or other remote strategies to reach rural Minnesotans, Black, Indigenous, and people of color (BIPOC), and individuals with disabilities	TBD	Start of grants	TBD based on grants awarded Grants will be in 4 regions of the state addressing rural and urban areas	TBD based on grants awarded	End of grants
	Number of health care systems, clinics and community-based organizations that initiate or expand ability to be reimbursed for services	TBD	Start of grants	TBD based on grants awarded Grants will be in 4 regions of the state addressing rural and urban areas	TBD based on grants awarded	End of grants
Quality	Number of rural Minnesotans, Black, Indigenous, and people of color (BIPOC), and individuals with disabilities who report satisfaction with culturally appropriate care and linkages with community services.	TBD	Start of grants	TBD based on grants awarded Grants will be in 4 regions of the state addressing rural and urban areas	TBD based on grants awarded	End of grants

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Results	Percent of rural Minnesotans, Black, Indigenous, and people of color (BIPOC), and individuals with disabilities patients served that meet optimal quality measures for chronic disease management and treatment, report high satisfaction with care, and are linked to community resources to meet housing, food, and financial needs.	TBD	Start of grants	TBD based on grants awarded Grants will be in 4 regions of the state addressing rural and urban areas	TBD based on grants awarded	End of grants
	Number of clinics and organizations that reports successfully submitting and receiving payment for reimbursable services.	TBD	Start of grants	TBD based on grants awarded Grants will be in 4 regions of the state addressing rural and urban areas	TBD based on grants awarded	End of grants
	Number of policymakers, state agencies, community organizations that have a better understanding of policy issues impacting reimbursement for chronic disease screening and management services and specific recommendations for action steps to address barriers, improve services, patient, and state health outcomes.	TBD	Start of grants	TBD based on grants awarded Grants will be in 4 regions of the state addressing rural and urban areas	TBD based on grants awarded	End of grants

Part B: Evidence-based practices

Evidence-based Practice	**Source of Evidence**
Telemedicine, sometimes called telehealth, uses telecommunications technology to deliver consultative, diagnostic, and health care treatment services.	What Works for Health, https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/telemedicine

Statutory Change(s):

New statute language proposed.

Change Item Title: Cultural Communications

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,724	1,724	1,724	1,724
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,724	1,724	1,724	1,724
FTEs	**8**	**8**	**8**	**8**

Recommendation:

The Governor recommends a general fund appropriation to establish a cultural communications program that focuses on tailoring and co-creating messaging for audiences most impacted by health disparities. These audiences include non-English and Limited English Proficient (LEP) populations, populations of color, LGBTQ+, and people with disabilities. This program would standardize processes at Minnesota Department of Health (MDH) to maintain the National Standards for Culturally and Linguistically Appropriate Services (NCLAS) in addition to coordinating translation and American Sign Language (ASL)/ Computer Assisted Real-time Translation (CART) services for the agency to ensure messaging resonates with cultural communities to advance health equity. Of the total annual appropriation, $349,000 will be used to fund language translations and ASL interpretation services for the agency.

Rationale/Background:

Health inequities are directly related to the existence of historical and current discrimination and social injustice. In 2000, based on Title VI of the Civil Rights Act, and Presidential Executive Order 131661, the Office of Minority Health (OMH) published the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. Data collected in 2021 shows that Hmong, Somali, and Spanish speaking patients have significantly lower rates of optimal care compared to the statewide average. It also showed that Mexico, Somalia, and Laos were among the most common birth countries outside of the U.S. for Minnesota residents and the quality measures for these patients were often lower than those born in the U.S.[1]

Many people from various cultural backgrounds are unable to reach their highest level of health for several reasons – including lack of culturally and linguistically appropriate services. While existing resources allow limited opportunities to provide translation services, far more is required to fully ensure all our audiences have full access to relevant, timely, and useful information. Given the MDH mission and organizational focus on equity, the department recognizes the importance of striving to meet the National CLAS Standards' set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities. The department intends to build upon and meet those standards to ensure MDH can effectively implement culturally and linguistically appropriate services for all Minnesotans.

[1] "In Minnesota, Large Disparities in Health Care Persist by Race, Language, and Country of Birth." MN Community Measurement, 31 May 2022, https://mncm.org/in-minnesota-large-disparities-in-health-care-persist-by-race-language-and-country-of-birth/.

Proposal:

This proposal includes several important goals including 1) Align MDH services, policies, procedures, and governance with the National CLAS Standards and establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations; 2) Ensure MDH services respond to the cultural and linguistic diversity of Minnesotans and that MDH partners with the community to design, implement, and evaluate policies, practices, and services are aligned with the national cultural and linguistic appropriateness standard; and, 3) Ensure MDH leadership, workforce, and partners embed culturally and linguistically appropriate policies and practices into leadership and public health program planning, intervention, evaluation and dissemination. This program promotes culturally and linguistically appropriate services and health equity through policy, practices, and allocated resources to advance public health communication efforts along with the recruitment and retention of diverse staff. Success will include intentional external engagement process with cultural communities.

This program will also provide resources and coordination to ensure the legal right to translated materials and ASL services are offered proactively to internal staff and external stakeholders.

The proposal will fund 8.0 FTE (1.0 FTE CLAS coordinator, 1.0 FTE supervisor, 2.0 FTE translations and ASL coordinators, and 4.0 FTE communication specialists). The CLAS coordinator will work with leadership and divisions to ensure that MDH follows National CLAS Standards. The cultural communications supervisor will lead MDH's initiative of advancing culturally and linguistically appropriate communications services for communities most impacted by health disparities. The translations and ASL coordinators will process requests for the agency and standardize the translations process across divisions. The cultural communications specialists will ensure messaging resonates with LEP, non-English speaking, populations of color and diverse communities. This program will be coordinated across 3 divisions. The coordinator will work on policy and guidelines in collaboration with the Center for Health Equity, while the organizational change will be in collaboration with Human Resources. The culturally and linguistically appropriate services will be housed within the Communications office.

Impact on Children and Families:

Gaps in delivery of timely information for non-English and Limited English Proficient (LEP) populations, populations of color, LGBTQ+, and children and families with disabilities have been ongoing, and the challenge was worsened by the COVID-19 pandemic.

Health literacy is defined as the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others (personal health literacy); and the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others (organizational health literacy).[2]

The American Medical Association (2007) estimates that 90 million families and children lack sufficient health literacy skills necessary to prevent and manage disease and chronic conditions and effectively seek and obtain health care.[3] According to the Health Literacy Data Map, up to 48% of Minnesotans have basic to below basic health literacy skills within a county. Addressing overwhelming health literacy needs can reduce health care costs[4,5] and improve the accessibility, quality, safety, and patient satisfaction of health care, and improve the

[2] Health Literacy in Healthy People 2030. U.S. Department of Health and Human Services. December 3, 2020. https://health.gov/our-work/healthy-people/healthy-people-2030/health-literacy-healthy-people-2030

[3] Weiss MD, B., et al. Health Literacy and Patient Safety: Helping Patients Understand. American Medical Association, 2007

[4]National Health Literacy Mapping to Inform Health Care Policy. Health Literacy Data Map. University of North Carolina at Chapel Hill, 2014. Retrieved, http://healthliteracymap.unc.edu/

[5]Vernon, J.A. Trujillo, A., Rosenbaum, S., and DeBuono B. (2007). Low Health Literacy: Implications for National Health Policy. Retrieved Microsoft Word - FINAL Biz Case Report 10 4 07.doc (gwu.edu)

health and quality of life for millions of Minnesotans.[6] The burden of not systematically addressing health literacy costs the U.S. healthcare system upwards $238 billion a year.[5]

Inadequate health literacy affects all segments of the population – even people with higher education and strong literacy skills. Age, racial/ethnic, economic, and cultural and linguistic disparities exist in levels of ability to access, understand, and use of health information.[3]

According to The21Collective, which conducted a survey on the perception and impact of Covid-19 and vaccination in the Hmong Minnesota community, the Minnesota Department of Health was one of the trusted resources during the pandemic. This is significant since the Minneapolis-St. Paul metropolitan area has the largest concentration of Hmong communities outside of Asia, which also means they are largest Asian American population in Minnesota, making up 27% of the Asian American and Pacific Islander (API) communities. Minnesota is also home to the largest Somali community in the U.S., who live not only in the Minneapolis-St. Paul metropolitan area but also in greater Minnesota in rural cities and counties. During harvesting season, many migrant farm workers come to Minnesota for work. This community is often made up of LEP families who speak only Spanish and are located outside of the Minneapolis-St. Paul metropolitan. African American communities have experienced the greatest impacts when it comes to health disparities as shown with COVID hospitalizations and mortality rates per Minnesota's COVID-19 Situation Update and the needs for ASL interpreters and CART services have increased significantly as we have moved to a virtual and hybrid environment.

Equity and Inclusion:
The primary audience(s) for this program will include Limited English Proficient (LEP) populations, African American, LGBTQ+, and people with disabilities. We will focus on the top three most spoken languages at home other than English in Minnesota which are Hmong, Somali, and Spanish. The program will use an intersectional approach and also address the communication needs of these communities through the coordination of translation and ASL interpreter services.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs:
None

Results:

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quantity	Protocols for MDH to follow when engaging with cultural communities is created.	0	At least 1 for Hmong, Somali, Spanish, and disability community	2025
Quantity	% of MDH staff trained on cultural communications.	0	50%	2025
Quantity	# of culturally relevant materials created	1000/year	2000/year	2025

Statutory Change(s): None

[6]Koh, H.K., Brach, C., Harris, L.M., and Parchman, M.L. (2013). A Proposed 'Health Literate Care Model' Would Constitute A Systems Approach to Improving Patients' Engagement in Care. Health Affairs, 32(2): 357-367. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2012.1205

Change Item Title: Diversity, Equity, and Inclusion

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	181	181	337	337
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	181	181	337	337
FTEs	**1**	**1**	**2**	**2**

Recommendation:

The Governor recommends a general fund investment to establish a program to support efforts to advance policies and practices at MDH that proactively and consistently promote a diverse, equitable, inclusive, and accessible workplace that values and uplifts employees and creates a sense of belonging. This program will identify values, strategic themes, strategic priorities, and goals and outcomes necessary to help support the MDH's aspiration to create meaningful culture change informed by the Diversity, Equity, and Inclusion (DEI) Framework. It will inform all strategic and operational planning aspects of MDH's leadership, policies, procedures, practices, and resource development in the service of meeting its mission-critical commitment to improving the health of all Minnesotans.

Rationale/Background:

A diverse, equitable and inclusive environment is critical to MDH's mission of protecting, maintaining, and improving the health of all Minnesotans. Building a culture of inclusion that leverages diversity and focuses on equity has the potential to strengthen the organization's ability to attract and retain talent and foster a sense of belonging. Research shows that organizations with higher gender, ethnic, and leadership diversity perform better than their less-diverse peers. For example, those with higher gender diversity perform 48% more than the least gender-diverse peers, those in the top quartile of ethnic and cultural diversity outperform those in the bottom quartile by 36%, and those in the top quartile of leadership diversity outperform their peers by 28%.[1] Nonetheless, many agencies are struggling to have diverse groups of employees and an inclusive culture; one study showed that while 68% of leaders feel they create empowering environments, only 36% of employees agree, and the proportion of employees who do not feel included in their organization is ten times higher than what leaders believe.[2]

While MDH is working hard to ensure a diverse workforce and an inclusive work environment, only 15% of its workforce and 14% of its leadership identify as a person of color (POC), and on average, only 37% of POC staff or leaders have worked for the agency for more than five years, indicating the low retention rate for POC. MDH must take a proactive and intentional approach to embed DEI into its culture and engage in an ongoing journey of inclusion and engage in DEI work as a strategic mechanism through which systemic issues and the ingrained way things are done can be challenged and changed. Creating a scaled and purposeful DEI strategy for MDH leadership and staff will strengthen the organization and serve as a model to other state agencies, the greater community, and those who have experienced long-standing marginalization. Diversity, equity, and inclusion must go hand in

[1] Hunt, Vivian, et al. "Delivering growth through diversity." McKinsey & Company, January 2018. Web. January 2020.
[2] Shook and Sweet. "Getting to Equal 2020: The Hidden Value of Culture Makers." Accenture, March 2020. Web. June 2020.

hand; having a diverse employee base will not achieve benefits for all if the culture is not inclusive. With this proposal, MDH commits to being both diverse and inclusive.

Proposal:

This proposal will establish a program at MDH to strenghten its efforts to advance policies and practices that proactively and consistently promote a diverse, equitable, inclusive, and accessible workplace that values and uplifts employees and creates a sense of belonging. This program will take a holistic approach to DEI to bring an intentional organizational-led approach to MDH's DEI and help create a strong culture of accountability through the following mechanisms:

1. **Develop the Diversity, Equity, and Inclusion (DEI) Strategy**
   A DEI strategy will set the tone and direction for DEI at MDH. A four-step development process will include: 1) assessing the current state of MDH's DEI efforts to uncover DEI gaps and challenges around employee engagement, new hire and exit data, current DEI training and needs, workforce diversity, and draw out employee experiences on empowerment, belonging openness, and leadership; 2) collaborating with state and local partners to proactively gather external data to understand the broader DEI landscape and the macro-level impacts of political, technological, economic, social, and legal climates on employees from marginalized Minnesotans; 3) developing a scaled and purposeful DEI strategy to include clear roles and accountability mechanisms along with specific goals and initiatives that will be customized to MDH's DEI needs and challenges; and 4) developing an action plan and launching the strategy.
2. **Embed Inclusion into MDH Culture**
   This proposal will not only define the DEI strategy, but it also ensure that inclusion and equity are embedded into the MDH culture. For DEI initiatives to succeed, MDH needs to ensure that all employees feel a sense of belonging, valued for who they are, and empowered to participate and contribute freely. This proposal will ensure that everyone in MDH understands that they have a role in creating an organization that is diverse and inclusive for all people. Thus, the department will engage MDH's workforce in an ongoing journey of unlearning and learning the deeply rooted workplace culture that guides how the organization operates. This proposal will support efforts to ensure DEI is integrated/aligned with employee lifecycle and other organizational processes, systems, programs, and policies. It will help increase leaders that are committed to addressing systemic barriers within the organization and are accountable for and committed to modeling inclusive behaviors.
3. **Proactive collaboration and partnership**
   A scaled and purposeful DEI strategy will be successful only if it aligns with all other MDH priorities and initiatives, such as MDH's health protection, health improvement, and health operation initiatives. The DEI office will closely work with Human Resources/Affirmative Action Officer, the Center for Health Equity, the Office of American Indian Health, and other state agencies to create a common language to make it easier to communicate the vision and purpose of DEI in a straightforward and accessible manner to internal and external audiences/stakeholders. This proposal will also support a strategic policy review process that enables MDH, partners, and communities to collaboratively incorporate related equity assessments to ensure that diversity, equity, and inclusion values are embedded throughout policies and practices.

The proposal will support total of 1.0 FTE DEI planner/trainers for fiscal years 2024-2025 and 2.0 FTE DIE planner/trainers in fiscal years 2026-2027 to coordinate development of the DEI strategy, champion the DEI work and facilitate DEI trainings. The trainers are responsible for implementing DEI strategy and related initiatives, liaise with leadership and supervisors across MDH and provide guidance on achieving strategic priorities related to DEI.

Impact on Children and Families:

MDH is committed to diversity, equity, and inclusion across the agency and in the communities served. This is an essential cornerstone to achieve the mission of protecting, maintaining, and improving the health of children and families across Minnesota. The DEI initiative will impact employee families' and children's mental health by

reducing stigma, increasing psychological safety for minority identities (POC, persons with disability, LGBTQ+, etc.), and creating a culture that promotes better mental health.[3] In summary, commitment to consistent DEI initiatives is vital for better health outcomes for employees, families, and children.

Equity and Inclusion:
The Diversity, Equity, and Inclusion (DEI) Office is committed to promoting the values of inclusion throughout the agency. The focus is equity, which is just and fair inclusion into an organization in which all can participate, prosper, benefit, and reach their full potential. The DEI office develops activities and training to cultivate a climate in which all members are treated fairly and able to thrive in a welcoming atmosphere. This work is compliant with nondiscrimination laws, ADA laws, the MDH mission statement, and our governing documents, especially our policies on harassment, bullying, and hate speech. The office also will engage in proactive DEI efforts across the State enterprise by expanding MDH's DEI collaborative works.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs:
None

Results:

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quantity	Number of DEI strategies in place	0	1	FY 2024
Quality	Increase percent of supervisors/managers at MDH who participate in the MDH anti-racism/or Historical Trauma training	45%	75%	FY 2025
Quality	Increase percent of supervisors/managers at MDH who participate in the MDH anti-racism/or Historical Trauma training	No baseline	50%	FY 2025
Quality	Increase percent of BIPOC representation in MDH workforce	15%	17%	FY 2025
Quality	Increase representation of MDH employees living with disability	10%	12%	FY 2025
Quality	Increased percent of BIPOC representation in MDH leadership	14%	16%	FY 2025
Results	Reduced racial, gender, other wage gap/employee satisfaction with pay fairness	No baseline	NA	FY 2025
Results	% of BIPOC employees who worked for MDH for more than five years	37%	40%	FY 2025

Statutory Change(s):
None

[3] Three Reasons Why Mental Health is a DEI Issue. https://kgdiversity.com/three-reasons-why-mental-health-is-a-dei-issue/

Change Item Title: Drinking Water and Wastewater Advisory Council

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
State Government Special Revenue Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends reinstating the Drinking Water and Wastewater Advisory Council that expired on June 30, 2019. The council provided external review from the perspective of key stakeholders to the water supply and wastewater treatment programs at the Minnesota Department of Health and the Minnesota Pollution Control Agency (MPCA). Appropriations in the state government special revenue fund to implement the council, which did not expire after fiscal year 2019, are part of the forecast base for the two agencies. There is no new cost to reinstate the council.

Rationale/Background:

A formal stakeholder body has existed in some form since 1971, but the most recent iteration of the council as described in Minnesota Statues, section 5.059 was sunset in June 2019, per the Laws of 2014, chapter 289. The council, before it was sunset, consisted of certified water and wastewater operators who had practical experience in the day-to-day operation of their facilities. These operators served as a leadership team capable of providing practical feedback on the agencies' regulatory activities.

Also, the U.S. Environmental Protection Agency requires annual program review and suggested rule changes be reviewed by an outside party. The council, prior to its sunset, served as an effective vehicle for providing this review. Not reinstating this council creates a hindrance to the pursuit of changes to Minnesota Rules, chapter 9400, which governs water treatment certification, as Minnesota Statutes, section 115.72, requires that this advisory council must be consulted before any rule changes are proposed.

Both MDH and the MPCA believe that reinstating this committee will help to ensure that system and facility stakeholders have a seat at the table and can collaborate with regulators about the public policy choices that impact their work. In addition, Minnesotans will have the reassurance that rules and actions pertaining to their public water supply and wastewater systems are being advanced with the input of fellow citizens with practical knowledge of water and wastewater operations.

Proposal:

The recommendation reinstates the Advisory Council on Water Supply Systems and Wastewater Treatment Facilities under former Minnesota Statutes, section 115.741. Reinstatement of the statute will support the required external review of MDH's and MPCA's water supply and wastewater treatment programs. The reviews serve to provide feedback to MDH and MPCA on regulatory activities by those who are regulated for rule changes for water treatment certification.

Costs to both MDH and MPCA include approximately 0.05 FTE staff and material and travel costs, all totaling less than $10,000 per year. As appropriations in the state government special revenue fund to implement the council did not expire, the two agencies do not require additional spending authority to reinstate the council.

Impact on Children and Families:

This advisory council plays a key role in protecting public health through community water and wastewater systems that are operated effectively and efficiently by competent water professionals. The council also promotes this field as an opportunity to participate in a profession that contributes to community health and prosperity.

Equity and Inclusion:

MDH and MPCA agree there is a legitimate need for a formal advisory council to serve as an external review of the governance of the water supply and wastewater treatment programs.

Reinstating this committee will benefit Minnesota by serving as the formal interagency mechanism to:

- Identify and address stakeholder concerns in the water supply system and wastewater treatment facility classification, operation, and certification arenas.
- Support the communities of Minnesota that rely on the water and wastewater treatment industries and competent professionals to keep them safe and healthy.
- Create a venue where system and facility stakeholders have a seat at the table and can collaborate with state regulators about public policy choices that impact their livelihoods and their constituents' health and environment.

Reinstating this council will create an inclusive leadership team to advise MDH and MPCA that is representative of water supply and wastewater facility operators, municipalities, the state, the public (one being a representative of academia), and metro and outstate representation.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

None

Results:

Reinstating the council will allow the annual water and wastewater operator program review and suggested rule changes to be completed by an outside party as required by the Environmental Protection Agency. Review of rules and actions pertaining to their public water supply and wastewater systems is accomplished with input of fellow citizens with practical knowledge of water and wastewater operations.

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quantity	Number of council meetings held	0/year	4/year	FY 2024 FY 2025

Statutory Change(s):

Reinstatement of Minnesota Statutes, section 115.741. Advisory Council on Water Supply Systems and Wastewater Treatment Facilities.

Change Item Title: Emergency Preparedness Response Sustainability, Strategic Health Care Stockpile and COVID-19 Transition Activities

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	16,825	16,662	15,141	15,141
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	16,825	16,662	15,141	15,141
FTEs	**15.5**	**15.5**	**12.5**	**12.5**

Recommendation:

The Governor recommends a state investment for sustaining a health care strategic stockpile warehouse, transitioning the COVID–19 response, and increasing emergency response capabilities at the state, local, and tribal levels. Of the total appropriation, $8,400,000 annually is for grants. This investment will allow MDH to continue the work required to manage public health preparedness, planning, response, and recovery so that MDH, local public health, and tribal health can support the needs of the public during public health emergencies. The investment will also continue the work of the COVID-19 response through demobilization to include closeout activities of transitioning ongoing activities to existing programs, completing after action reports and improvement plans, and archiving documentation.

Rationale/Background:

The COVID-19 response has confirmed the need to restructure the MDH response organization and modernize the preparedness approach with our partners. MDH has planned for, and responded to, two or more public health emergencies every year since 2005. Federal preparedness funding has decreased over time and not kept up with rising costs of doing business. During large disasters (e.g., H1N1 Pandemic in 2009 and COVID Pandemic in 2020), public health received additional response funds for 1-3 years during which time preparedness and planning activities ceased. The return to standard funding levels is not enough to support the pre-response level of readiness let alone the demonstrated need for greater investments to enhance and maintain the appropriate level of response readiness. Core preparedness activities at the state and local levels are entirely funded by federal resources, two cooperative agreements—from the Centers for Disease Control and Prevention (CDC) and Office of the Assistant Secretary for Preparedness and Response (ASPR), over which the state has little control. These awards are provided to states with set activities and deliverables for planning and preparedness, including dispensing funds to the local and tribal jurisdictions. They do not deliver the depth of support needed to provide a solid structure for MDH to quickly stand up a response to a pandemic or other catastrophic, long-term public health crisis.

Investment in modernizing the department's emergency preparedness and response structure will increase the capability and capacity of MDH and our local public health partners to reengage in preparedness and planning as well as respond to emergencies. This initiative will assist the department in rebuilding a response structure that captures the innovations from COVID-19 and other responses and addresses identified improvements, is inclusive of all MDH divisions and offices, provides training and exercises, invests in the software and systems to support coordinated response work, and applies continuous improvement practices to build efficiencies and increase

effectiveness. Our capacity has shrunk for planning and coordinating response activities for health emergencies at the state level, just as the number of extreme weather events, new infectious diseases, and security threats is increasing. As noted, federal support for preparedness does not cover response or recovery activities that are critical for protecting Minnesotans.

This investment will also strengthen the Hospital Preparedness Program (HPP) which has experienced several large decreases in funding since the program began. During COVID-19, HPP program staff at MDH and healthcare coalitions responded to demands outside the current scope of their federally funded program. The current MDH preparedness and response structure does not receive any state funding to support planning for, and response to, emergencies impacting the health of Minnesotans.

The COVID-19 pandemic response, beginning in January 2020, identified gaps in the public health response structure because of inadequate resources. Public health response has been strained by several major responses: Ebola in 2014, highly pathogenic avian influenza in 2015 and again in 2022, opioid crisis and homeless health in 2016, measles outbreak in 2017, and response to vaping related illness in 2019. Critical gaps in preparedness and response include the need for more public health staff trained in response and tested through exercises, dedicated staff to implement response improvement plans and initiate agency response when an emergency occurs, and staff who will work with other health care components of MDH to assure stronger and coordinated health care systems engagement. We do not have a dedicated emergency preparedness and response data team to consistently receive, analyze, and report on core preparedness and response measures. We also experienced during COVID-19 the detrimental effects of not maintaining a critical supplies warehouse. Dedicated funding was not provided to maintain the MDH critical health care personal protective equipment and medical supply cache established during the 2009-10 H1N1 response resulting in no immediately available personal protective equipment and other supplies to protect health care and other partners during the early months of COVID-19.

Proposal:

Regularly occurring health emergencies require a strong public health response structure built upon the lessons learned over the past few years supported by updated planning, training, and tools to prepare us for future public health crises. This proposal will provide the needed funding to address the gaps listed above through the development of a modernized MDH response and incident command structure, long term critical care supply strategy, and a transition and close out plan for COVID 19 response activities. The activities outlined in this proposal will bring the MDH Public Health Emergency Preparedness and Response Program to the next level of readiness and this initiative will address identified gaps in MDH's ability to prepare for, respond to, and recover from health emergencies. These specific activities will enhance existing efforts supported by federal grants.

Based on our experiences with the COVID and other recent responses we need to update, strengthen, and bolster our public health response system. These core positions will support the agency's ability to respond to emerging public health issues, ensure availability of a cache of critical care supplies to support health care response, and provide essential information and access to data needed to make effective response decisions. Disasters and public health emergencies have a significant impact on MDH and its core services. Providing ongoing review and updating of plans and mitigation efforts allows MDH and our partners to sustain our mission, core essential functions, and services for responding to potential crisis/surges with space, expert staffing, equipment, and supplies. The goal is to ensure continuity of operations, effectively response to emerging health incidents, strengthen incident command capacity and facilitate operational and community recovery.

COVID Transition:

Response structure team

This investment will engage new partners and expand relationships with public health partners, health care coalitions, enterprise partners and others to support response and recovery from public health emergencies. This response structure team will be charged with embedding preparedness into all MDH positions, revising all

response plans as well working with Homeland Security and Emergency Management (HSEM) on a state pandemic plan as part of the Minnesota Emergency Operations Plan (MEOP). In addition, this funding will support the transition of COVID 19 functions. We will strategically step down the non-traditional activities supported by MDH during COVID-19 and transition those functions back into the health care, private sectors, or within new MDH programs for long-term support. We will maintain operational plans, including staffing and resource lists, should MDH need to reactivate any functions such as state-run testing or mass vaccinations in the future. We will continue the public inquiry hotline, responding to COVID-19 questions and concerns as well as expanding the scope to include other public health issues and provide equitable access to information and resources.

Strategic Stockpile:

Critical care supply resource
We will establish an ongoing critical care supply resource. The use of the federal Strategic National Stockpile (SNS) system during the COVID-19 response highlighted the importance of maintaining a secure storage facility and a process for rapid distribution of supplies as SNS resources are not intended for and not sufficient to meet large response needs. COVID-19 demonstrated once again the need for Minnesota to maintain a medical cache containing various amounts of personal protective equipment (PPE) and other medical supplies. Developing and maintaining private-public partnerships are needed to provide the backbone for a medical cache system in addition to funding for procurement, resupply, and storage of critical supplies.

EPR Sustainment:

Emergency response team
The past few years of public health emergencies, combined with the incident management requirements of COVID-19, has demonstrated the need for an agency emergency response team who will prepare for, and be able to immediately respond to, any emergency incident, such as infectious disease outbreaks, natural disasters, or an interruption of business operations. Select MDH staff will be designated and trained before an incident occurs. We will work with our key partners such as Homeland Security Emergency Management to exercise together across the enterprise following redesigned protocols and actions to mitigate the negative effects of the incident. The redesigning of protocols and actions will modernize public health response for the 21st century by incorporating lessons learned from COVID-19 and new published best practices from public health and emergency management.

Data team
We will build a preparedness and response data team to address the gap of not having the right data needed to inform response decisions. There will be an increasing need for data to assist state and federal leaders in making data driven decisions, and our partners will expect us to maintain the breadth and depth of data provided during COVID-19. We will add a data lead who will coordinate data for MDH response activities as well support the ongoing need for public health and health care emergency preparedness and response data by our stakeholders and partners. This position will provide ongoing quantitative and qualitative analysis of Public Health Emergency Preparedness (PHEP), hospital preparedness program (HPP), and agency response data to include inspecting, cleansing, transforming, and modelling data with the goal of discovering useful information, informing conclusions, and supporting decision-making.

Grants to Local Public Health and Tribal Health
This proposal will support a robust response to emergencies by providing $8,400,000 annually to support local public health and tribal health planning and response. Currently, Minnesota's Public Health Emergency Preparedness (PHEP) activities are funded by grants from the federal government, with no state-level investment. Past proposals to redistribute PHEP funds and a series of funding cuts highlight the vulnerability of federal funding and have compromised local public health's ability to respond to emergencies such as COVID-19. Although there has been increased federal investment due to COVID-19, historically, federal funding has been cut drastically

(from nearly $16 million in 2002 to $9.2 million in 2019) and funding expectations were not realigned to reflect the cuts.

Impact on Children and Families:

Expanded staffing will allow for the strengthening of the relationships established during COVID focusing specifically on children and families. We will continue to work with Minnesota Department of Education and the Children's Cabinet so that the innovative and comprehensive work of this response will endure into the future, better positioning all agencies involved to better serve our children and their families.

Equity and Inclusion:

Part of this project and the division's expansion will be to strengthen the role equity in response. The department will streamline efforts across the agency to assure that equity and inclusion are front and center during all response activities. The additional positions will allow for dedicated staff time to work across the agency and with partners to embed equity in preparedness and response activities.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

None

Results:

This investment will reduce injuries and mortalities resulting from emergencies with a public health impact. We will achieve this goal by establishing a more robust and comprehensive response structure better positioned to response to all public health incidents. We will revise the agency response plans including a stronger focus on equity and inclusion. We will have a sustainable critical care supply strategy to meet the evolving and changing critical care supply needs of health care. MDH will have a strategic approach to the sustainment, transition and close out of the COVID 19 response structure.

Type of Measure	***Name of Measure***	***Current***	***Future***	***Dates***
Quantitative	All MDH response plans will have been reviewed and updated based upon lessons learned from COVID-19 and emergency response best practices.	40%	100%	FY2023 FY2025
Quantitative	Establishment of MDH Emergency Response Team who will prepare for and be able to immediately respond to any public health-related emergency incident.	25%	100%	FY 2023 FY 2025
Quantitative	MDH will have a sustainable SNS plan to meet the changing critical care supply needs including management of an ongoing cache of critical healthcare supplies.	NA	Finalized plan for a sustainable critical care supply plan	FY2023 FY2025

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Qualitative	Partnership preservation: MDH outreach and communications will establish ongoing meetings with key partners assuring an enhanced level of readiness to respond to all incidents that impact the public's health.	30%	100%	FY2023 FY2025
Qualitative	Sustain, transition and close out the COVID 19 Bureau	NA	All COVID activities transitioned to appropriate division or ended	FY2023 FY2025

Statutory Change(s):
None

Change Item Title: Extend Prescription Drug Price Transparency

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	837	643	613	613
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	837	643	613	613
FTEs	**1.5**	**3.0**	**3.0**	**3.0**

Recommendation:

The Governor recommends a general fund appropriation for technical updates and clarifications to the Minnesota Prescription Drug Price Transparency Act (PDPTA), MS 62J.84, and an extension of the program to include pharmacy benefit managers (PBMs), pharmacies, and wholesalers. This proposal is intended to provide a better understanding of the rebates and markups that occur along the supply chain that influence what prices they pay for prescription drugs and where it goes.

Rationale/Background:

The Minnesota Legislature passed the PDPTA in 2020, which requires the Minnesota Department of Health (MDH) to develop a system for collecting and reporting data from drug manufacturers on high and quickly increasing prescription drug prices. The reporting requirement began on January 1, 2022 to (1) promote transparency; (2) enhance understanding of pharmaceutical spending trends; and (3) assist payers in the management of pharmaceutical costs. Upon implementing this program, MDH has identified the need to apply technical corrections to the statutory language. These adjustments will eliminate areas of duplication and update or correct federal code references and industry definitions. These revisions need to be addressed to accurately collect the required data from drug manufacturers, strengthen compliance, and clarify legal authority.

MDH also identified a significant limitation to the PDPTA in that it requires data submission only by manufacturers. The prescription drug supply chain is complex, and prices are largely hidden from consumers and policymakers. Under its current form, the PDPTA adds some transparency to manufacturer prices (“list prices”) but does not shed light on the role other supply chain participants—namely wholesalers, PBMs, and pharmacies—have on prices, nor does it provide transparency on other price information, such as rebates. This proposal would advance prescription drug price transparency by also collecting pricing information from wholesalers, PBMs, and pharmacies and focus on net prices (rather than just list prices) across the whole prescription drug market. This is intended to provide a better understanding of the rebates and markups that occur along the supply chain that actually influence the prices paid for prescription drugs and to whom. The additional information will also shed light on how a price change for one drug impacts the prices of equivalent alternatives.

Proposal:

This proposal includes technical corrections to MS 62J.84 relating to statutory references to United States Code for brand name drug definition and generic drug definition. The proposal also makes technical clarifications that provide clarity and reduced reporting burden for manufacturers and lowers the risk that concerns may be raised by data submitters based on lack of specificity that hinders effective implementation of the PDPTA. These

clarifications include adding new definitions, improving specificity for some data elements, time periods, and reporting requirements, and adding biosimilars to the scope of drugs that may require reporting.

The proposal adds a new requirement to MS 62J.84 for reporting from manufacturers, wholesalers, PBMs, and pharmacies on a select group of prescription drugs identified as having a substantial public interest to better understand the rebates and markups throughout the supply chain. Quarterly, MDH would determine and post on its website, using expedited rulemaking, the list of drugs identified as being in the public interest. MDH will publicly report the information reported (except data classified by law as trade secret or not public) and its impact on transparency and managing prescription drug costs. This reporting would protect entities' competitive information by collecting the information at the drug or drug class level, which aggregates information across individual plans (or negotiations).

Impact on Children and Families:

It is our expectation that strengthening the department's ability to collect and publish quality data on prescription drug pricing promotes information transparency and is a key step towards making prescription drugs affordable for children and families.

Equity and Inclusion:

Affordability of health care in general, and drugs in particular, disproportionately impacts low-income residents. This proposal does not directly impact people of color, Native Americans, people with disabilities, people in the LGBTQ community, other protected classes, or Veterans.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts	350,000	25,000				
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)	20,740	4,560	4,560	4,560	4,560	4,560
Total						
MNIT FTEs	0.10	0.10	0.10	0.10	0.10	0.10
Agency FTEs						

Results:

Performance measures

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quality	Number of drugs requiring price reporting.	368	9/19/2022	600 – 900	1,000 – 2,400	
Quality	Compliance rate.	45%	9/19/2022	75%	90%	
Quality	Share of reports requiring follow up with manufacturers to verify and correct data.	~95%	9/19/2022	70%	40%	
Quality	Estimate the net prices paid for prescription drugs of special interest and therapeutically equivalent products.	Not feasible with current data.	9/19/2022	MDH can estimate this for 0% of drugs on which we currently receive reporting.	[Depends on the % of special interest drugs MDH requires reporting for are therapeutically equivalent--I.e. intended for this type of drug market analysis.]	

Statutory Change(s):

MS 62J.84

Change Item Title: Family Planning Special Projects

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	6,952	6,952	6,952	6,952
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	6,952	6,952	6,952	6,952
FTEs	**3**	**3**	**3**	**3**

Recommendation:

The Governor recommends a general fund investment to increase access to voluntary family planning services throughout Minnesota through the existing Family Planning Special Projects (FPSP) grant program for both new and existing grantees. These funds are essential to support continued statewide access to culturally appropriate, evidenced based family planning services including counseling and education, contraception services, preconception care, supporting healthy pregnancies, and sexually transmitted infection (STI) screening and treatment. Family planning is the voluntary planning and action taken by individuals to prevent, delay, or achieve a pregnancy.

Rationale/Background:

Services provided at publicly supported family planning clinics in the United States reduce the incidence and impact of preterm and low birth rates, STIs, infertility, and cervical cancer. According to a peer-reviewed study by the Milbank Quarterly, a multidisciplinary journal of population health and health policy, this investment saves the government billions of public dollars, equivalent to an estimated taxpayer savings of $7.09 for every public dollar spent.

With the implementation of reproductive health restrictions in bordering states, Minnesota is a safe harbor for reproductive health care, and 51% of rural counties in Minnesota have no sexual health clinic location in the county itself, which requires residents to travel to receive essential health care. Many family planning providers, including clinics supported by FPSP grants, expect an increase in demand for culturally appropriate, low-cost, and evidenced based family planning counseling and education, contraception services, and sexually transmitted infection (STI) screening and treatment. With an expansion of the eligibility requirements, the department expects to see an increase in applications. If preventive health care provisions of the federal Affordable Care Act are overturned by judicial review, health insurers would no longer be required to provide free birth control methods and contraceptive counseling to insured individuals, which will result in new financial burdens for low-income individuals in Minnesota. The FPSP grantees could see an immediate increase of clients seeking assistance and financial support for their pre-pregnancy family planning needs.

STI rates remained at historic highs in Minnesota in 2021 (33,706 cases). Many of these cases are among adolescents and young adults, and one out of every three cases of chlamydia occurred in Greater Minnesota. STIs such as chlamydia and gonorrhea often lack symptoms but left untreated can lead to complications including pelvic inflammatory disease and infertility, as well as a higher risk of HIV infection.

The current FPSP program provides $6,353,000 per fiscal year in grants to eligible organizations, funded by state general funds and TANF funds to serve low-income, high-risk individuals with pre-pregnancy family planning. Minnesota Statues, section 145.925 and Minnesota Rules 4700.1900-4700.2500 currently govern FPSP. Funding is distributed through a regional formula with a separate competitive awards process within each of eight regions. Cities, counties, community health boards, and nonprofit organizations are eligible applicants and provide family planning services, including STI screening and treatment, in communities located throughout the state. FPSP funds cannot be used for abortion services nor to provide any family planning services.

Proposal:

This recommendation builds upon the current FPSP program and increases the funding for the FPSP grants to meet the current reproductive service needs of Minnesotans using state general funds. MDH will distribute an additional $6,353,000 in fiscal year 2024 and ongoing to current FPSP grantees and new grantees, including Tribal Governments, through a revision to the statutory eligibility criteria in an effort to modernize the program.

This increase in funding will allow FPSP grantees to lengthen clinic hours for clients, reduce patient wait times, provide more one-to-one family planning counseling, stock more medications for STI testing and treatments, maintain telehealth technology and security, maintain and increase language translation services, and meet the clients' needs. The rulemaking requirement from 1997 will also be removed which severely impacts the process of allocating grant funds. In order to issue these grants, it requires a planner principal state to provide subject matter expertise to the grantees and oversight of grantee workplans; a grants specialist senior to execute award modifications, monitor grantee performance and spending, and compliance with grant requirements and state regulations; and a management analyst to process grantee invoices.

Impact on Children and Families:

The funding will allow low-income, high-risk individuals statewide to continue to access comprehensive family planning, STI treatment, and other essential health services. Additional family planning information and services will help individuals maintain their overall health and improve family and community health by supporting people to avoid unintended pregnancies, treat STIs, improve overall and preconception health, and attain the healthiest pregnancies possible. This work, in turn, leads to better birth outcomes and healthier children.

Equity and Inclusion:

Minnesota has seen an accelerated decline in birth rates among adolescents since 2007, yet people of color continue to have higher birth rates and STI rates than white populations, suggesting unequal and inequitable access to reproductive health care education and services. FPSP funds focus on higher risk populations including people who have difficulty accessing family planning services because of barriers related to poverty, racism, ethnic discrimination, age, disability, culture, language, lack of insurance, lack of transportation, or concerns about confidentiality.

The FPSP grants support individuals who would have difficulty accessing family planning, STI screening and treatment, and other essential health services because of barriers such as poverty, lack of insurance, or transportation. FPSP grantees serve a wide range of populations with inequitable access to quality family planning and STI services including rural Minnesotans, LGBTQ+ people, low-income people, young adults, and Black, American Indian communities, and other communities of color. FPSP is governed by statute which ensures that all family planning decisions are voluntary, noncoercive, and offer a full range of options, with all decisions guided by the client. In fiscal year 2021, 54% of FPSP beneficiaries had incomes below 100% of the federal poverty guidelines, and 80% were below 200%. Eighty-nine percent of FPSP beneficiaries who received a contraceptive method were 18 or older, with 62% between ages 18 and 29.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Tribal governments, specifically Tribal Public Health, are not currently eligible for FPSP grants. Under this proposal, a change to the Minnesota Statues, section 145.925 is required to include Tribal governments as eligible applicants.

Minnesota Department of Health briefed tribal and urban Indian health directors on this proposal through the regular quarterly update from the State. The department has briefed individual tribal public health leaders during site visits occurring in the Fall of 2022.

Results:

The FPSP program currently publishes and anticipates continuing to publish a statistical report each year using established performance measures aligned to the program's family planning services components. Current performance measures include:

Type of Measure	***Name of Measure***	***Current***	***Future***	***Dates***
Quantity	# of FPSP clients accessing counseling on reproductive life planning and contraceptive options (per state fiscal year)	20,000	44,864	FY 2021 FY 2026
Quantity	# of FPSP clients of childbearing age accessing a family planning method of their choice (per state fiscal year)	17,049	31,000	FY 2021 FY 2026
Results	Statewide cases of chlamydia decrease per state fiscal year	22,578	20,000	FY 2021 FY 2026

FPSP incorporates several strategies with strong existing evidence that will improve outcomes for Minnesotans. Long-acting reversible contraceptive (LARC) methods, including interuterine devices (IUDs) and birth control implants, are provided through FPSP grantees, and in 2021, 20% of FPSP clients voluntarily selected one of these highly effective methods. Evidence suggests that voluntary use of LARCs will result in increased use of contraception, reduced teen pregnancies, and reduced unintended pregnancies per the University of Wisconsin Population Health Institute. Additionally, reproductive life plans are a structured format for clients to discuss goals and action steps based on personal values and resources about when to become pregnant and when to have (or not have) children. Evidence suggests this strategy will result in increased preconception planning, improved reproductive health, improved birth outcomes, and improved health-related knowledge.

Statutory Change(s):

Minnesota Statues, section 145.925; Minnesota Rules 4700.1900-4700.2500

Change Item Title: Federal Funds Oversight

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	530	530	530	530
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	530	530	530	530
FTEs	**3**	**3**	**3**	**3**

Recommendation:

The Governor recommends funding for federal funds oversight. The funds requested for this proposal would fund one auditor position and two centralized grants management positions that would provide monitoring, training, and technical assistance to MDH grant managers and grantees to ensure compliance with all state and federal regulations. This is a coordinated multi-agency effort to strengthen controls over grant making and management activities within state agencies.

Rationale/Background:

The department receives federal funding annually and following an internal controls review, we have identified areas in our grants oversight where internal control weaknesses are present. Ongoing review of internal controls and assessment of risk helps to protect public resources. In order to ensure continued responsible stewardship of public funds, this proposal will fund three positions dedicated to addressing gaps in the internal control and grant management processes. This recommendation will address inadequate internal controls highlighted by the Feeding our Future fraud at the Minnesota Department of Education in coordination with Minnesota Management and Budget.

Proposal:

This proposal is a new initiative aimed at mitigating an identified internal controls weakness in the department's grant management activities. It will add staff positions at MDH to strengthen grant management oversight. One of the three positions will audit the MDH grantee's oversight of their grant funds, providing assurance that the grantees are spending funds for the intended purpose and achieving the appropriate programmatic outcomes. Additionally, the periodic audits of MDH's grants management process will provide assurance that MDH and its grantees are in compliance with both state and federal laws, rules, policies, and procedures.

This funding will cover two positions within the MDH Grants Office to improve organization systems and processes as well as provide stronger grants management oversight:

- Having a grant financial expert and a grant management expert on staff would provide needed and wanted resources for MDH grant staff. The experts would provide training and consultation on financial and grant management tasks with which MDH staff currently struggle.
- The proposed positions would enhance and improve MDH staff knowledge, skills, and capabilities to oversee their grants financials and programmatic activities. They would provide consistency in the procedures and information MDH grant staff use to conduct their grant tasks, thereby reducing MDHs risk of noncompliance. They would also create standardization within MDH which could be used to build a grant management system in the future.

- The proposed positions will also have a direct impact on grantees and potential grantees, all of which are working on fundamental public health goals. The technical assistance and training these positions will be able to provide to grantees and potential grantees ability to be successful partners and meeting the goals of the agency and federal funders.

Success for the audit position proposal would be measured by the number of identified grantees that have undergone oversight reviews by the person hired for this position, and the correction of findings and recommendations found during the audits, as well as improved internal controls within MDH for grants oversight and fewer external audit findings. Success for the grant management positions would be measured by MDH staff being more knowledgeable in conducting both financial and programmatic oversight, and increased knowledge and compliance with state and federal regulations. This would reduce audit findings and questioned costs for both MDH and its grantees. There would be less use of fiscal agents and grantees would be successful in obtaining other funds.

Impact on Children and Families:

This budget proposal will strengthen the department's compliance and internal control frameworks, providing assurance that limited program funds are spent efficiently on desired program outcomes. Reducing waste and misspending of government programs increases the amount of funds available to help children and families obtain the help and services they need.

Equity and Inclusion:

Frequently MDH executes outgoing grants with entities that have long standing grants experience with MDH and other state agencies. This makes it difficult for new organizations to compete against experienced, well-established entities. The newer, smaller applicants are commonly community-based organizations that have the intimate relationships with the communities MDH is trying to reach, but they are not always able to submit a winning application. One pain point is in the financial arena of grants.

Grant money comes with a bevy of rules, regulations, laws, and requirements that can be daunting for the most experienced grantee. If MDH had additional resources to assess and improve internal controls at the grantee level, to be focused on the financial and oversight aspects of grants that was available to both MDH staff and external partners, like the small community-based organizations, it would give those small entities a better chance of submitting quality applications and increase their chances of being awarded grant funds. Once awarded, these positions could continue to build capacity with the grantees, thereby positioning them to be more successful to obtain other funding opportunities to engage with their communities needing the most support and have better outcomes.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

n/a

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	The number of financial reconciliations completed	783	FY 2022	783	861	FY 2025
Quantity	The number of external audit findings	5	FY 2022	5	0	FY 2025

Statutory Change(s):

n/a

Change Item Title: Health Equity Advisory and Leadership (HEAL) Council

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	65	65	65	65
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	65	65	65	65
FTEs	**0.3**	**0.3**	**0.3**	**0.3**

Recommendation:

The Governor recommends a general fund investment to support the Health Equity Advisory and Leadership (HEAL) Council created under the authority of the Commissioner. The purpose and intended results are to ensure that there is accountability and integration of systems change within the agency in order to remove barriers to health equity.

Rationale/Background:

In 2014 the Minnesota Department of Health (MDH) published the "Advancing Health Equity" report. The report engaged thousands of Minnesotans regarding barriers to health equity. One of the main findings was that structural racism is one of the greatest barriers to achieve health equity in Minnesota. As a result, MDH's 2015-2019 strategic plan included the creation of an external advisory council to advise the agency on the implementation of health equity across systems, policies and practices. The purpose and intended results are to ensure that there is accountability and integration of systems change within the agency in order to remove barriers to health equity.

In January 2018, MDH created the Health Equity Advisory and Leadership (HEAL) Council under the authority of the Commissioner. The council is comprised of 25 diverse members statewide representing communities most impacted by health inequities. The purpose of the council is to advises the agency on implementation of health equity strategies. It is tied to the Eliminating Health Disparities Initiative (EHDI), Minnesota Statute, section 145.928 requirement for community-based consultation to address health disparities. However, the current statute does not indicate the type of council structure nor the longevity of the HEAL Council. The council has never been compensated for their time to to advise the agency on the implementation of health equity across systems, policies and practices. This proposal recommends funding to support council, deleting old EHDI statute language, and creating new statutory language for the council.

Proposal:

This proposal will establish the HEAL Council in statute and support its function of advising the agency on the implementation of health equity across systems, policies and practices.

The proposal will fund staff to support HEAL's administrative needs, including scheduling meetings, preparing agenda items, and taking meeting minutes. The proposal also helps cover miscellaneous costs like perdiem to attend regular council meetings and reimburse mileage costs.

Impact on Children and Families:
The council was modeled after and created in consultation with the Department of Human Services Cultural and Ethnic Communities Leadership Council (CECLC). The recommendations and guidance from the HEAL Council impact multiple areas of the agency, including ensuring equity in data practices, community engagement and systems change. These systems changes will have direct impact on children and families and ensuring the agency is centering communities most impacted as we consider policy decisions, systems change and practices.

Equity and Inclusion:
The sole purpose of the council is to ensure equity is embedded throughout the agency. Council members represent the following communities: people of color, American Indian, disability communities, LGBTQ communities and rural communities. Positive impacts on the identified groups are that they have voice and representation on an advisory body which informs and influences agency policy. Potential negative impacts are that members will be committing time to council participation and receiving minimal compensation.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs:
None

Results:

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quantity	Number HEAL meeting conducted	4	12	09/30/2026
Quantity	Number of advision session conducted	2	6	09/30/2026

Statutory Change(s):
Creation of HEAL Council in statute.

Change Item Title: Healthy Beginnings, Healthy Families

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	12,052	11,853	11,798	11,798
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	12,052	11,853	11,798	11,798
FTEs	**12**	**13**	**13**	**13**

Recommendation:

The Governor recommends a general fund investment to build equitable, inclusive, and culturally and linguistically responsive systems that ensure the health and well-being of young children and their families through the following efforts: sustaining the Minnesota Perinatal Quality Collaborative, establishing the *Minnesota Partnership to Prevent Infant Mortality*, increasing access to culturally-relevant developmental and social-emotional screening and connections to services during the early childhood period, and sustaining and expanding the *Jail Model Practices Learning Community* in Minnesota jails. Of the total recommendation, $8,750,000 annually is for grants.

Rationale/Background:

The early years of a child's life significantly impact lifelong health and well-being. During these years, the brain rapidly develops, building the foundation for future learning and life success. In addition to genetics, nutritional status, and environmental factors, a child's experience with parental and caregiver nurturing and responsive care is vital to healthy brain development. To positively nurture their child, parents and caregivers need appropriate and easily accessible support and resources. Access to health care, mental health services, early care and education – prenatally and throughout childhood – helps ensure healthy child development and enables children to reach their full potential.

However, Minnesota faces significant challenges in implementation of a coordinated, equitable, and efficient system of care for young children and their families, particularly those most at risk of adverse outcomes. Across the lifespan, cumulative risk compounds, negatively impacting children's brain development, learning ability, and lifelong health and well-being. While no single risk factor determines a child's developmental trajectory, cumulative risk is the most predictive of adverse outcomes in childhood and across the lifespan.

While Minnesota has relatively strong overall maternal and infant health outcomes, women and infants of color and American Indian women and their infants are disproportionality burdened in every perinatal measure. Black women have higher risk of adverse perinatal outcomes as compared to their white counterparts, according to national studies.[1] American Indian women experience the highest rate of preterm births in Minnesota, and nearly

[1] Webster LM, Bramham K, Seed PT, Homsy M, Widdows K, Webb AJ, Nelson-Piercy C, Magee L, Thilaganathan B, Myers JE, Chappell LC. Impact of ethnicity on adverse perinatal outcome in women with chronic hypertension: a cohort study. Ultrasound Obstet Gynecol. 2019 Jul;54(1):72-78. doi: 10.1002/uog.20132. PMID: 30318830.

three times the rate of infant mortality as compared to white women and infants.2 System-level quality improvement interventions must address these and other perinatal disparities and help prevent racial inequities that compound to create poor health-related quality of life.

While infant mortality rates for all racial groups in Minnesota have declined over time, the disparities have remained constant for over 20 years. Births to African American/Black and American Indian mothers have twice the rate of infant mortality compared to births of non-Hispanic white mothers. Infant mortality is a complex issue with many potential causes. Infants who are born prematurely or at a lower birth weight are more likely to experience mortality before their first birthday than those who are born at the recommended gestational period or weight. For instance, though babies born before 37 weeks represent just under 10% of all births in Minnesota, they represented 33.7% of all infant deaths in 2020. Persistent racial and ethnic inequalities contribute to the overall rates of premature birth – in 2020, approximately 13.7% of American Indian and 10% of Black pregnant women gave birth prematurely compared to 8.6% of white pregnant women.

In 2019-2020, around 90% of children under five years old had at least one preventive health care visit in the last 12 months, but Black, Asian, and Hispanic children were less likely to receive such visits as compared to all children. Children who were uninsured, who lived in households that spoke a language other than English, those from single parent households, and those living in poverty were also less likely to have had a preventive visit. The COVID-19 pandemic only exacerbated these differences, with many families having missed out on routine health care due to clinic closures, prioritizing emergency care and restructuring to reduce potential exposures. Though around 15-17% of children under age six have been estimated to have one or more developmental disabilities,[3] under 5% of children in that same age group were served by early intervention or early childhood special education services.[4] This gap signifies that children are not being screened, assessed, and referred for intervention or support when needed – particularly those who are from more diverse and rural communities. Minnesota faces significant obstacles in ensuring that all children are appropriately screened for developmental delays and provided early intervention services so that they enter kindergarten healthy and ready to learn. Early screening and intervention can mediate harm among children with adverse childhood experiences. For every dollar spent on high-quality early learning programs, there is an average of $8.60 in benefits —and the younger the child served, the wiser the investment.[5]

Children with incarcerated parents are at elevated risk for mental health problems and suicide attempts, substance abuse, and poor academic outcomes. When parental incarceration occurs during the early childhood period, children and parents may miss out on important opportunities for promoting parent-child bonding and attachment with a lifelong impact on the child's social-emotional development. In Minnesota, more than two-thirds of adults in jail are parents with minor children, and most lived with one of their minor children before their arrest. One in six Minnesota youth (17%) report a history of parental incarceration. Minnesota youth of color are disproportionally impacted by parental incarceration. Systematic challenges to addressing the needs of incarcerated parents and their children are complex, especially for local jails. County jails often have fewer resources than state prisons and thus fewer opportunities to offer evidence-based programming to families over an extended period. Jails have limited capacity to build local coalitions or partnerships. In comparison to prisons, most jails have more restrictive visiting environments that were not designed with children in mind.

[2] Minnesota Department of Health (2022) Infant mortality: MN Public Health Data Access - MN Dept. of Health - MN Data (state.mn.us) (accessed Sept. 21, 2022)
[3] Wilder (2013) Statewide School Readiness Report Card. Retrieved from https://www.wilder.org/sites/default/files/imports/SchoolReadinessFactSheet_2_10-13.pdf.
[4] MDE Data Center (2020). Child Count Data. Retrieved from https://public.education.mn.gov/MDEAnalytics/DataTopic.jsp?TOPICID=455.
[5] The Economics of Early Childhood Investments. (2014). Executive Office of the President of the United States. Retrieved from https://obamawhitehouse.archives.gov/sites/default/files/docs/the_economics_of_early_childhood_investments.pdf.

Proposal:

Comprehensive, culturally responsive systems can help reduce the number of infants who die before their first birthday. They can help monitor whether children are meeting developmental milestones and ensure that those not meeting those milestones are linked with needed services and supports. They can improve perinatal outcomes for populations at greatest risk of poor health-related quality of life. They can also help to build supports around children and families who experience parental incarceration.

This recommendation creates a comprehensive, collaborative, multi-sector approach to ensure healthy outcomes for Minnesota's youngest children and families by building systems to address the factors that contribute to the poor outcomes and the disparities that exist within Black, American Indian, non-white communities of color, and rural communities in Minnesota.

African American, Asian Pacific, Latino, communities of color, and tribal communities report cultural and community strengths that mitigate the effects of cumulative risk. Communities that experience systemic inequities in access to supportive childhood services benefit from culturally responsive supports. These supports create safe, stable, and nurturing relationships at home, school, and in the community and promote healthy development and well-being for young children.

Minnesota Perinatal Quality Collaborative

MDH will provide a grant to the Minnesota Perinatal Quality Collaborative (MNPQC), which is an unparalleled network of representatives of healthcare systems, multidisciplinary healthcare providers, academic institutions, local and state agencies, families, and community partners invested to improve pregnancy and infant outcomes through evidence-based population-level quality improvement initiatives. The MNPQC provides the unique platform for healthcare facilities to monitor evidence-based interventions through rapid data collection and applying system changes to improve care in perinatal health while allowing local, state, and community partners to align strategies for a population-level impact. The Centers of Medicaid and Medicare Services (CMS) requires hospitals to participate in a perinatal quality collaborative initiative aimed to improve maternal outcomes to meet their CMS Maternal Morbidity Structural Measure. The Minnesota Maternal Mortality Review Committee (MMRC) relies on MNPQC as a critical implementation arm for their key clinical recommendations to reduce maternal mortality. Current quality improvement initiatives include early infant hearing detection and substance-use disorder in pregnant women. The unique, hybrid design of the MNPQC delivery of quality improvement practices with a combined intentional community-focused leadership structures will ensure a population-level, equitable perinatal approach that improves outcomes within the continuum of care across Minnesota communities.

Through multidisciplinary, collaborative efforts that focus on quality improvement in key indicators of perinatal and infant health, like perinatal hypertension, preterm birth, and perinatal substance abuse, Minnesota can significantly improve the health outcomes and health-related quality of life of pregnant women and their infants. Such quality improvement efforts provide opportunity for perinatal healthcare professionals from a variety of settings to increase their knowledge and skills and enable these professionals to provide individualized, culturally responsive perinatal and infant care that ultimately improves perinatal outcomes on a population level.

The Minnesota Perinatal Quality Collaborative portion of the recommendation includes grant funding to host the Minnesota Perinatal Quality Collaborative beginning in fiscal year fiscal year 2024 and annually thereafter and staff to execute the grant, provide oversight of all state regulations and process invoices.

Minnesota Partnership to Prevent Infant Mortality

MDH will establish a Minnesota Partnership to Prevent Infant Mortality, a statewide multi-sectoral partnership including the state government, local public health, tribes, private sector, and community organizations, to function as an implementation platform for the Minnesota's Infant Mortality Reduction Initiative. The Partnership's activities will include community engagement, exchange of best practices, data management and advocacy. Success will be defined by the improvement of infant health outcomes, driving infant mortality

reduction, including extreme preterm birth, sleep-related infant death, and congenital malformations. Alongside the Partnership, MDH will administer 31 infant mortality reduction catalyst grants to community organizations, tribes and local public health entities who create data-informed roadmaps to improve maternal and infant outcomes among Black, American Indian, and communities of color in Minnesota. These competitive grants will support culturally based, multisectoral, and upstream approaches, including social and environmental determinants of health. Combined, this approach addresses the factors that impact relationships and environments for pregnant and parenting families with young children in the communities in which they live. Community engagement, an exchange of best practices, and grants to community organizations, tribes, and local public health entities, will support community-driven and culturally relevant approaches to address social and environmental determinants of health and improve maternal and infant outcomes among Black, American Indian, rural and communities of color in Minnesota.

The Minnesota Partnership to Prevent Infant Mortality portion of the recommendation includes:

- Staff to coordinate the efforts of the Partnership, including facilitating meetings, engaging stakeholders and communities collecting and analyzing data, writing reports, and engaging communities most impacted by disparities in infant mortality.
- Contracts for organizations to host the Partnership and provide support to participants, convene an annual state perinatal health summit, provide technical assistance to grantees, and build a public-facing dashboard on maternal and infant health data.
- Grant funding for 11 tribes, 5 American Indian serving organizations (non-tribal), and 15 community-serving organizations for infant health

Developmental and Social-Emotional Screening with Follow-up

Developmental and social-emotional screening identifies children who are at risk for developmental delays so their needs can be further assessed and addressed by linking them with services and supports as early as possible. Screening can help to identify children who are experiencing delays in cognition, fine and gross motor skills, communication, independence, emotions, and interactions with other people. Ongoing developmental monitoring, screening, and follow up is especially important for children who are born preterm or with a low birthweight or those who are from underserved populations (poverty, culturally and linguistically diverse, among others.). By identifying risks and responding early, we can positively impact the trajectory of a child's development and reduce adverse outcomes. This recommendation supports ongoing universal access to voluntary, culturally-relevant electronic developmental and social-emotional screening for children birth to 6 years of age using the evidence-based Ages & Stages Questionnaires (ASQ) tools, and providing grant funding for community-based organizations, local public health, and Tribal governments to provide follow-up services (i.e., linkage to needed services and supports) for children and families when concerns are identified through screening. To promote equity within the screening and follow-up, grant funding will also be provided to organizations to use cultural liaisons to help families navigate the screening and follow-up in a culturally and linguistically responsive manner. The ongoing nature of tracking developmental milestones, screening, and follow-up will serve to follow families during their child's early years up to the child's transition to kindergarten, ensuring that concerns are identified and families are linked with supports as soon as possible.

The Developmental and Social-Emotional Screening with Follow-up portion of the recommendation includes:

- Staff to provide direction to and support the expansion including development, implementation, and evaluation of electronic screening system for early childhood providers, local public health, tribes, and families statewide.
- Contract to support the implementation of an electronic screening system platform to complete approximately 50,000 screens per year.
- Development and maintenance of a data system to manage screening and follow-up information.
- Grant funding for community-based organizations, local public health, and tribal governments to provide follow-up when concerns are identified.

Model Jails Practices for Incarcerated Parents

MDH staff will partner with fifteen county jails to implement an evidence-based parent education curriculum, build community partnerships, train staff, adopt other model jail practices (intake, environmental changes), and leverage state agency partnerships (e.g., housing, child welfare) to expand services and supports for justice-involved families. Funding will allow each jail to hire a community coordinator to help implement these actions and directly connect families involved in their jail. Jails will also be able to make small facility improvements that support parent-child contact and mitigate the trauma that children often experience when a parent is incarcerated (e.g., expanding visiting opportunities, creating separate visiting spaces for children). MDH will also offer competitive small grants to community organizations located in the same communities as the jail grantees to incentivize building new connections and partnerships that improve support for incarcerated parents, caregivers and children impacted by incarceration.

Components of the expansion of the Model Jails project expansion portion of the recommendation include:

- Staff to develop partnerships with county jails and support the implementation of parent friendly practices, including implementation of a parent education curriculum, hosting a community of practice, and building partnerships to expand services and supports for justice-involved families.
- Contract for subject matter experts to support, train staff, and evaluate the initiative
- Contract for evidence-based parenting education
- Grant funding for 15 jail sites and 15 community sites.

Impact on Children and Families:

This proposal complements and provides opportunities for synergy in coordination of care and referral to resources that support a child's healthy start in life and the family's well-being. Combined, the components of this recommendation significantly improve child well-being outcomes for families experiencing the greatest burden of health, economic, and racial inequities. Success will ultimately be defined by the powerful impact on multiple family and child indicators, including reductions in infant and maternal mortality, child maltreatment, increases in utilization of timely early intervention and supports, family self-sufficiency, and a child's success in school.

In addition, the combined impact of the proposed funding will build community and systems capacity to better serve families and children where they live in culturally responsive ways. The four components of this proposal (i.e., the Minnesota Perinatal Quality Collaborative, the Partnership to Prevent Infant Mortality, the Developmental and Social-Emotional Screening with Follow-Up, and the Model Jails Practices for Incarcerated Parents) focus on using authentic partnerships with the community to co-create solutions. Developing authentic partnerships drives sustainable change and equitably supports healthy development and well-being for families with young children. An intentional focus on families and communities experiencing racial, geographic, and economic inequity assures that their strengths will be part of solutions.

Together, these efforts will move Minnesota forward in assuring healthy development of children and families. This work will support multi-sector partnerships across agencies with upstream approaches, addressing social and environmental determinants of health. This plan will provide social, emotional, health, and parenting support to families, and link them to appropriate resources.

Equity and Inclusion:

Health inequities start early in Minnesota, as demonstrated by the significantly higher infant mortality rates experienced by American Indian and African American/Black families. The COVID-19 pandemic has disproportionately impacted communities of color, exacerbating the significant decades old disparities experienced by families with young children. This proposal is centered on providing support and resources to the communities most impacted by disparities – disparities which are a result of years of systemic discriminatory, ableist policies and practices. Building upon the invaluable knowledge and cultural wisdom within the community is at the core of eliminating disparities. This recommendation will create an equitable, inclusive, and culturally and linguistically responsive investment in a multi-pronged, comprehensive early intervention approach that can

impact families for generations, particularly those of color or who live in poverty. Accomplishing this work will strengthen the fabric of families and the community so they can build upon their assets to ensure the well-being of their children and families, therein securing Minnesota's future.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Under the Minnesota Partnership to Prevent Infant Mortality, grant funding is set aside for all federally recognized Indian Tribes and for at least five Indian-serving organizations, including the Urban Indian Organization. Under the Developmental and Social-Emotional Screening with Follow-Up component of the proposal, grant funding may be provided to Minnesota Tribal governments to provide follow-up services to families whose child is identified with a concern during the screening process.

MDH anticipates engaging with Tribal governments through existing networks and opportunities. This may include receiving tribal consultation via conversations during site visits with Tribal public health leaders (2022); participation in the Tribal and Urban Indian Health Directors meeting; and participation in the Minnesota Tribal Resources for Early Childhood Care workgroup, Tribal Early Head Start/Head Start workgroup, and Dream Catcher Project.

IT Costs:

Category	***FY 2024***	***FY 2025***	***FY 2026***	***FY 2027***	***FY 2028***	***FY 2029***
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)	321,0464	72,544	72,544	72,544	72,544	72,544
Total						
MNIT FTEs						
Agency FTEs						

Results:

Performance measures

Minnesota Perinatal Quality Collaborative

Type of Measure	***Name of Measure***	***Current***	***Future***	***Dates***
Quantity	Number of Quality Improvement Initiatives Launched	2	5	FY2023 FY2025
Quantity	Percent of Birthing Facilities Participating in MNPQC Quality Improvement Initiatives	30%	85%	FY2023 FY2026
Quantity	Number of Birthing Facilities Reporting on Quality Improvement Initiatives	0	25	FY2023 FY2026
Result	Stillbirth rate - the number of fetal deaths (after 20 weeks gestation) per 1,000 live births plus fetal deaths	MN Total: 5.2 White: 4.7 Black/African American: 8.2 American Indian: 11.5	MN Total: 4.2 White: 3.8 Black/African American: 6.5 American Indian: 9.2	FY 2018-2020 FY 2026-2028

Minnesota Partnership to Prevent Infant Mortality

Type of Measure	***Name of Measure***	***Current***	***Future***	***Dates***
Quantity	Number of Partnership Meetings	0	6/year	FY 2023 FY 2025
Result	Infant mortality rate - the number of infant deaths per 1,000 live births	MN Total: 4.8 White: 3.7 Black/African American: 7.9 American Indian: 10.3	MN Total: 3.84 White: 2.96 Black/African American: 6.32 American Indian: 8.24	FY 2016-2018 FY 2026-2028
Result	Stillbirth rate - the number of fetal deaths (after 20 weeks gestation) per 1,000 live births plus fetal deaths	MN Total: 5.2 White: 4.7 Black/African American: 8.2 American Indian: 11.5	MN Total: 4.2 White: 3.8 Black/African American: 6.5 American Indian: 9.2	FY 2018-2020 FY 2026-2028

Developmental and Social Emotional Screening

Type of Measure	***Name of Measure***	***Current***	***Future***	***Dates***
Quantity	Number of electronic developmental screenings performed annually	No baseline currently available	35,000	FY2025
Quantity	Number of electronic social-emotional screenings performed annually	No baseline currently available	15,000	FY2025
Quantity	Number of families receiving anticipatory guidance materials (to learn about developmental milestones)	No baseline currently available	TBD	FY2027
Quantity	Number of referrals to resources/interventions for children with identified concerns on screening	No baseline currently available	TBD	FY2027
Quantity	Percent of families who receive a referral to early intervention services/supports who are found eligible for services	No baseline currently available	TBD	FY2027
Quantity	Number of families receiving culturally responsive support in screening and follow-up	No baseline currently available	TBD	FY2027

Model Jails

Type of Measure	***Name of Measure***	***Current***	***Future***	***Dates***
Quantity	Total and average number of parent- child contacts with an incarcerated parent in one of the participating jail facilities per family.	Avg. 3.5 per family (preliminary baseline data)	15,000 contacts, Avg. 10 per family	12/30/25
Quantity	Number of incarcerated parents, co-parents, and caregivers who participate and complete Parenting Inside Out education program through participating jails and community partners.	15	2,000	12/30/25
Quality	Number of model practices that are implemented in partnering jails.	21	75 (including additional jails)	12/30/25
Results	Improved parent-child relationships and co-parenting relationships based on parent and co-parent surveys.	No baseline currently available	TBD	12/30/25

Statutory Change(s):

New statute.

FY 2024-25 Biennial Budget Change Item

Change Item Title: Help Me Connect

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	463	921	921	921
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	463	921	921	921
FTEs	**1**	**2**	**2**	**2**

Recommendation:
The Governor recommends a general fund investment beginning in fiscal year 2024 for partial funding then full funding in fiscal year 2025 to support continued oversight, improvements, and sustainability for the MN Help Me Connect (HMC) electronic navigator after the federal Preschool Development Grant ends in December 2023. This will allow the department to preserve the level of support needed to maintain and improve the website, which includes reliable access to local program information (over 12,000 individual program data profiles) and a referral mechanism that connects families to services. It will also allow for the future addition of a toll-free phone number and/or online chat feature to provide one-on-one support to families needing additional navigation services.

Rationale/Background:
Help Me Connect (HMC) is an interagency initiative between the Minnesota Department of Health (MDH), the Minnesota Department of Human Services (DHS), the Minnesota Department of Education (MDE), and the Governor's Children's Cabinet that is led by MDH. The Preschool Development Grant (PDG), which ends December 30, 2023, provides funding for development and implementation of the website. It is the result of multiple years of collaborative planning with state and local agency partners across health, education, and human services, in response to Title V Maternal and Child Health Services Block Grant and PDG needs assessment findings from families and local providers asking for a centralized resource that connects to the numerous early childhood and family support programs.

Minnesota faces significant challenges in implementing a coordinated, equitable, and efficient system of care for children and their families. The array of early childhood programs is complex and fragmented due, in part, to differences in who offers programs, how they are funded, and variation in their eligibility and other requirements. Tribal nations and community-based organizations offer culturally relevant services, but these are often unknown or not regarded as potential referral resources by outside providers. Statewide providers consistently indicate that services are unavailable, unknown, or hard to access, and there is no statewide data that defines actual service gaps and barriers. Many projects and grants over the last ten years have started working to improve comprehensive early childhood systems across governmental agencies. Formal recommendations from local partners to the state in 2016, along with the results of a 2018 audit by the Office of Legislative Auditor, confirmed the need for a centralized system for resource navigation, referral and follow-through, and documentation of gaps and barriers in the system. During the 2019 Preschool Development Birth to Five Grant Needs Assessment and strategic planning process, parents and providers shared their perspectives on the current assets and barriers that affect families who are experiencing racial, geographic, and economic inequities.

HMC launched in May 2021 in response to this unmet need. It is designed as an early childhood services online navigator to help expectant families and those with children from birth to 8 years of age connect to services in their local communities that support healthy child development and family well-being. Since its launch in 2021, 110 trainings have been provided to state and local early childhood professionals and families, and over 96,000 unique visitors have used the website from all areas of Minnesota and neighboring states.

With appropriate funding and sustainability strategies, Help Me Connect will serve as an early childhood and family support one-stop-shop for families and providers to access and explore numerous available services closest to their homes. Collaboration with local community agencies is a key priority to assure culturally diverse services are reviewed and new services are added into Help Me Connect frequently based on feedback. Based on current data, we expect over 100,000 new visitors to use the navigator and will add 1,500 new service listings each year. The electronic referral mechanism will allow providers to connect the families they are working with to community-based services, such as food support, early education and parenting opportunities, county-based services (WIC, Parent Support Outreach Program, Family Home Visiting), and early childhood mental health providers.

Proposal:
This proposal seeks funding to provide ongoing support for Help Me Connect (HMC) as the Preschool Development Grant ends in December 2023. Partial funding is needed in fiscal year 2024 to continue MDH MNIT staffing, external IT contracts, marketing contracts and outreach activities, and a State Program Admin Coordinator and Planner Intermediate to provide programmatic oversight, training, and technical support as families and partners navigate the online resources. Full funding for these positions, contracts, and programmatic activities is needed beginning in fiscal year 2025. The coordinator role serves as the internal and external community partner liaison through coordination of professional development and outreach, communications development, policy development, and continuous improvement activities based on feedback from collaborative agencies and providers regarding access and referral to resources available through the HMC website. The coordinator provides technical assistance and education to community sites as the website is updated or new features are added. This work is shared with MNIT to make the necessary technical changes. The planner will work with the coordinator to triage communication and accountability measures between the MNIT developers, the external IT contracts, analytical operations and the referral form development and maintenance to assure the accuracy of the information on the website, as well as assist with the logistics and coordination of trainings.

The original vision of Help Me Connect included a toll-free phone number and online chat mechanism to support individuals that preferred to talk with someone versus navigating an electronic resource on their own. Usage over the past year indicates this is still a need as families are using the general email address found on Help Me Connect to ask for individualized assistance. Staff have investigated options to include this type of functionality in the future, such as contracting with an external vendor and partnering with existing community organizations that specialize in early childhood and family support. Funding in this proposal will support phone and/or online chat enhancements to assure families have a variety of supportive options to connect to resources in their local communities.

Help Me Connect works in partnership with the current MN Help Me Grow (Part C and Part B of the Individuals with Disabilities Education Act) system which is administered by MDE to identify children that are experiencing developmental and/or behavioral concerns and refer families to local special education services. Over 22,000 families access the Help Me Grow website and referral form each year with the intent to talk with a professional about their child's development. Help Me Connect and Help Me Grow are collaborative entry points for families and providers to connect to local services, with Help Me Connect supporting access to hundreds of additional services that support the whole family beyond special education.

Help Me Connect works in partnership with the PDG Community Resource Hubs, which are grants administered by DHS to local community-based organizations. DHS is submitting a legislative proposal that will provide sustainable funding to maintain a community resource hub infrastructure that supports staffing within local agencies to provide short term navigation, referral support, and follow up to families with young children. Community Resource Hub navigators serve as early childhood experts within a family's county or local community and can develop a relationship with each family over time to assure the family doesn't fall through gaps. The Community Resource Hubs use Help Me Connect to support their outreach to families and referral connections with local agencies. They provide valuable feedback to navigator improvements, as well as the development and testing of the provider referral form.

Evaluation of Help Me Connect consists of several current and future strategies:

- Number and demographics of visitors to the site
- Number of individual resources available on the site
- Number of training sessions requested/provided to local provider stakeholders
- Social media analytics (Facebook and Instagram data)
- Navigator satisfaction feedback gathered through community engagement focus groups and widespread surveys
- Collaborative state and local partnerships maintained and newly developed
- Number of provider accounts created
- Number of referrals generated to local community organizations

Impact on Children and Families:
The enhancement and continuation of the Help Me Connect website is meeting a unique identified need to facilitate referrals and access to community-based resources, which are culturally relevant. With this funding, families and providers will be able to maintain access to current information and a referral mechanism to specific resources located within their community. Maintenance of this navigation system will help families of young children continue to access coordinated, comprehensive, culturally relevant, family-centered services.
Both electronic and human aspects of this system will support families and early childhood providers connect to resources through a coordinated online referral, service provision, and follow-up communication system.

Help Me Connect removes the confusion that many families experience of not knowing where to start or having to navigate 3-4 different websites to piece together supportive services. The site brings together the variety of early childhood and family support programs that are currently administered or supported by MDH, MDE, DHS, Department of Commerce, Office of Higher Education, as well as many community-based services, under one umbrella. Resources to support food and housing security, domestic violence, mental health, developmental screening, and many others are found in one location. Ongoing feedback is routinely collected from local providers and families about ways to improve the site to be more user friendly and inclusive of additional community level services that serve the diverse needs of families.

Equity and Inclusion:
Health inequities start early in Minnesota, as demonstrated by the significantly higher infant mortality rates experienced by American Indian and African American/Black families. In 2018, American Indian children were 17 times more likely to experience out-of-home care than white children in the state. Data from the Early Childhood Longitudinal Database shows that, in 2019, 84.7% of African American/Black and 79.4% of American Indian/Alaska Native kindergarteners received economic assistance and/or food assistance, while only 23.3% of White kindergartners received assistance. Economic assistance through the Minnesota Family Investment Program (MFIP) or Diversionary Work Program (DWP), and food assistance through the Supplemental Nutrition Assistance Program (SNAP) and/or Free or Reduced Price Lunch program are indicators of income and display the inequities in financial stability in Minnesota's communities.

American Indian, Black, and other non-white children have fewer opportunities to succeed in school and this starts with access to early childhood opportunities. In Minnesota, children are not guaranteed access to early childhood education, which means that this education is most often financed by parents' tuition payments to private programs. With large income disparities by race, this further disadvantages Black, Indigenous, Hispanic, and other non-white children. The median family income in Minnesota for American Indian, Black, and Hispanic families with children is $34,000 to $52,900, compared to $108,600 for white families with children. Research shows that early childhood education is associated with greater school readiness. Minnesota's children experience racial disparities in school readiness as well, with American Indian and Hispanic students having the lowest rates of school readiness at 62% and 68%, respectively. Efforts to assure access and referral to culturally relevant services are strategies to improve these disparities.

The Help Me Connect navigator includes a wide variety of services available across the state including disability resources, immigrant and refugee programs, tribal nation and urban American Indian services, and homeless resources. The navigator's key word search and specialization filter allows users to identify culturally relevant services for Hispanic/Latino, Hmong, and Somali families, to name a few. Upcoming changes will include resources that support military families and those impacted by incarceration.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Representatives from all eleven tribal nations have been consulted over the years during the Help Me Connect development phase. Based on feedback from these discussions, the navigator launched with a category specifically focused on American Indian families and resources, as well as specialization filters to narrow results to American Indian/Native American specific services. Since its launch in May 2021, feedback and improvement ideas have been collected from multiple tribal nation partners and urban American Indian community-based organizations. Federal PDG funding has provided a variety of tribal supports, including a full-time Tribal Nations lead, Indigenous evaluation of the grant, and multiple tribal nations that are serving as, or partnering with, one of the Community Resource Hubs. Future consultation includes focused community engagement with tribal nations and American Indian providers and families, connections with the MDH, MDE, and DHS tribal liaisons and program-level tribal staff, connections with Community Resources Hubs, and relationships with Minnesota Tribal Resources for Early Childhood Care (MNTRECC). Information about this proposal will be shared with the tribal and urban Indian health directors in November.

IT Costs

Category	***FY 2024***	***FY 2025***	***FY 2026***	***FY 2027***	***FY 2028***	***FY 2029***
Payroll						
Professional/Technical Contracts	60,000	120,000	120,000	120,000	120,000	120,000
Infrastructure						
Hardware						
Software	2,500	5,000	5,000	5,000	5,000	5,000
Training						
Enterprise Services						

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Staff costs (MNIT or agency)	130,083	260,165	260,165	260,165	260,165	260,165
Total	**192,583**	**385,165**	**385,165**	**385,165**	**385,165**	**385,165**
MNIT FTEs	0.7	1.4	1.4	1.4	1.4	1.4
Agency FTEs						

Results:
There are several performance measures currently used to evaluate and prioritize improvements to Help Me Connect. Most noteworthy are the website analytics regarding number of visitors, topics of most interest, and number of outreach and training events. Since the site's launch in May 2021, there have been 95,975 unique visitors.

Moving forward, we will implement two types of widespread usability satisfaction surveys. The first survey will be placed on the Help Me Connect home page for all types of users to access and provide feedback about the navigator. A second survey will focus on the role of local providers that are serving families with young children to identify common trends and barriers to supporting families, as well as usability and improvement recommendations for Help Me Connect. With the upcoming development of the electronic referral mechanism, there will be focus groups of providers brought together to identify functionality needs, provide testing feedback, and serve as first users of the system.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	# of users accessing HMC	96,000	As of 9/1/2022	70,000	100,000 annually	FY 2024 and ongoing
Result	Percentage of user survey results expressing high satisfaction after using HMC and high likelihood of returning to HMC in the future.	0	FY 2022	0	>75% with incremental growth	By FY 2025
Quantity	Number of community organization requests to improve existing program listings.	~500 requests	9/1/2022	500	1,000 annual improvement requests	By FY 2025
Quantity	Number of community organization requests to add new program listings.	12,000 current listings	9/1/2022	500	1,500+ annually	By FY 2025
Quantity	Number of training and outreach events to early childhood professionals and navigators (health care, child care, education, county staff)	110+	9/1/2022	25	50+	By FY 2025

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	# of family/child referral requests submitted through HMC.	0	FY 2022	10,000	25,000	By FY 2025
Quantity	# of successful referral connections to services completed through HMC with confirmed enrollment.	0	FY 2022	5,000	20,000	By FY 2025

Statutory Change(s):
Minnesota statues, sections 144.xxx and 145.xxx

Change Item Title: Home Visiting

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	15,000	15,000	15,000	15,000
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	15,000	15,000	15,000	15,000
FTEs	**8.0**	**8.0**	**8.0**	**8.0**

Recommendation:

The Governor recommends an investment from the general fund to increase prevention-focused family home visiting services to families with children under age five. The recommendation will expand family home visiting services to pregnant women, families, mothers, fathers, and other caregivers of young children so that more families have service access. Nearly 90%, or $13,375,000, of requested funds will be distributed to community health boards, tribal nations, and non-profits via grants for the delivery of home visiting services by qualified home visiting professionals.

Rationale/Background:

Family home visiting is a voluntary service for pregnant women and child caregivers most in need of support. A trained home visiting professional conducts home visits that ideally begin prenatally or shortly after the baby is born and continue until the family is stable and well-connected to supportive resources. Home visits link pregnant women with quality prenatal care, support parents early in their role as a child's first teacher, ensure that very young children develop in safe and healthy environments, and impart parenting skills and support that decrease the risk of child abuse. Decades of scientific research on evidence-based home visiting in the United States demonstrates health and economic benefits. Home visiting programs improve prenatal health, reduce childhood injuries, prevent subsequent unplanned pregnancies, improve school readiness, increase intervals between births, and increase maternal employment.

The need for additional investments in family home visiting is significant. The 2020 MN Maternal, Infant and Early Childhood Home Visiting (MIECHV) Needs Assessment indicated that the number of Minnesota families in need of home visiting services is approximately 76,000 and of that amount, nearly 65,000 (85%) of these families reside within at-risk counties. The proportion of families in need that are currently receiving services differs greatly by county and ranges from 1-43% with an average of 10%.

There remains a need to address the health inequities and resulting health disparities in our state. There are significant gaps in the amount, choice, and longevity of home visiting services provided to American Indian, Black or African American, and Hispanic or Latino families. The limitations and challenges that home visitors and agencies encounter when implementing evidence-based models further exacerbates these inequities.

Minnesota is home to large communities of African and Asian immigrants. A goal of MDH's state-funded home visiting program is to build the capacity of nonprofits and community health boards to implement innovative and culturally appropriate evidence-informed home visiting programs to serve the needs of immigrant and refugee

families which are often distinct from native-born families. These families face additional barriers to accessing home visiting or other health services in their language of origin.

In addition, incarcerated, homeless families, teen parents, and children with special health needs have been particularly challenged to find supportive services that can adapt to their unique needs and living situations. Services in this proposal will focus on priority populations for evidence-informed and innovative home visiting programs and services.

Children who are born with special health care needs may need extra support to reach their maximum potential. Health care and other support systems can be confusing and difficult to access and often families are unaware of the services and resources available to help their child. The purpose of Home Visiting for families of children newly identified with Special Health Needs/Disabilities (age 2 months – 8 years) is to provide a systematic assessment of the family's strengths, risks and needs, to offer supportive guidance on a wide variety of child and infant health, conduct physical or developmental assessments, relay the appropriate information to the family's health-care providers, and to connect families with the additional community resources and services that meet their individual needs.

Proposal:

This proposal seeks to address current gaps in services by expanding services to more families and creating greater flexibility to serve Minnesota's high priority populations. Currently, Minnesota is only serving approximately 10% of eligible families who would benefit from home visiting services. Proposed home visiting services will seek to serve 3,000 families each year, focusing on home visiting to priority populations (the homeless, incarcerated families, and children and youth with special health needs). Services will include evidence-based, promising practices, and evidence-informed. This new method of delivery for home visiting services will include funding for home visiting designed to meet the needs of families that need more mid-range services as compared to short-term or long-term services. Mid-range home visiting services will provide services to 3,000 families each year. This home visiting initiative provides pregnant and parenting families with access to mid-range services typically lasting from 2 months to 1 year.

The home visiting expansion will build upon current federal and state funding to increase access to services for families in need of home visiting services, as well as improve the standard of care provided. This funding will complement and provide opportunities for synergy in coordination of care and referral to services provided by other programs such as Child Protection, Head Start, Oral Health, Violence and Injury Prevention, and Women, Infants and Children (WIC).

Grants to community health boards, tribal governments, and non-profits will total 15 million in each fiscal year. MDH staff at 8.0 FTEs are necessary for oversight and administration of the home visiting program expansion. Staff will focus on providing training and technical assistance to grantees on best practices and program structure. Local programs rely on MDH expertise for all aspects of implementation, including guidance on budgeting, service provision, meeting fidelity requirements of home visiting programs, and providing training for home visitors. MDH will also contract to evaluate evidence-informed home visiting services. Overall administrative costs are approximately 10% of the total recommendation.

Impact on Children and Families:

Family home visiting is a voluntary, preventive intervention that supports pregnant women and families with young children through a two-generation approach. By strengthening families in their communities, family home visiting has repeatedly demonstrated powerful impacts on multiple family and child outcomes, including positive pregnancy outcomes, school readiness, child abuse prevention, and family self-sufficiency.

Family home visiting is a proven strategy to address the factors that impact relationships and environments for pregnant and parenting families with young children in the communities in which they live. Home visiting services

have demonstrated significant impact on improving child well-being outcomes for families experiencing the greatest burden of health, economic, and racial inequities.

Equity and Inclusion:
The COVID-19 pandemic has disproportionately impacted communities of color, exacerbating existing disparities experienced by families with young children. In addition, communities of color—particularly Black, Latino and American Indian—are disproportionately overrepresented in the priority populations that this recommendation seeks to serve. This recommendation would help to address the health disparities that people experience by creating a more equitable investment in early intervention services that have a multigenerational benefit to families, particularly those of color.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

All tribal nations and non-profits servicing American Indians will be eligible to apply for funding. The department is currently meeting with tribal nations and their family home visiting staff. MDH's tribal liaison has been made aware of this proposal. The proposal will be shared with the tribal and urban Indian health directors. Tribal nations are supportive of increased home visiting funding and the additional flexibility that this proposal allows.

Results:

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quality	For families receiving mid-range home visiting services, percentage of families who received referrals to assist with connections to physical, social, economic and mental health resources.	No baseline	80%	FY2024 FY2027
Results	For children receiving mid-range home visiting services, percentage who are up to date on immunizations per CDC recommendations	No baseline	80%	FY2024 FY2027
Quantity	For families receiving evidence-informed services, increase the number of mothers receiving post-partum screening for depression within first three months of services.	No baseline	55%	FY2024 FY2027
Quantity	For families receiving evidence-informed home visiting services, increase the number of children receiving developmental screenings	No baseline	55%	FY2024 FY2027
Quantity	Number of priority population families receiving mid-range home visiting services	No baseline	4,000	FY2024 FY2027

Statutory Change(s):
None

Change Item Title: Homeless Mortality Study

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	134	149	104	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	134	149	104	0
FTEs	**.75**	**.75**	**.75**	**0**

Recommendation:

The Governor recommends a general fund investment to measure the state's progress in reducing preventable deaths among people experiencing homelessness. This is in follow-up to a first-of-its-kind study the Minnesota Department of Health (MDH) conducted in 2022 comparing deaths among people experiencing homelessness (PEH) in Minnesota to the total state population from 2017-2021. The requested funds would allow MDH to conduct a similar analysis of homeless mortality for 2022-2024 with a report completed in fiscal year 2026. The 2022 homeless mortality report highlighted enormous disparities in mortality rate for people experiencing homelessness, which the department is working to address. Funding to continue collecting and analyzing this data is necessary to measure the department's progress on reducing severe morbidity and death among people experiencing homelessness.

Rationale/Background:

In 2021, the Centers for Disease Control and Prevention (CDC) Foundation funded MDH as one of three national Centers of Excellence (CoE) on Public Health and Homelessness. MDH's Center is focused on reducing severe disease and death among people experiencing homelessness. We contracted with the Hennepin Healthcare Research Institute (HHRI) to conduct the first-ever statewide homeless mortality study.

HHRI's mortality study merged data on the use of statewide homeless programs from 2017-2021 with MDH death certificates on all deaths in the state during the same period. As of September 2022, the study has not been published, but MDH has been briefed on the results and has begun sharing preliminary findings with key partners. The three key takeaways from the first report were:

1. The rate of death is triple for people who experience homelessness (PEH) in MN than the general population. For example, a 20-year-old PEH in Minnesota has the same rate of death as 50 year-old in the general population.
2. American Indian PEH have substantially higher rates of death than other PEH and the general MN population. American Indians have a 1.5x higher death rate than PEH overall, and a 5x higher rate of death than the general MN population.
3. Substance use death rate is 10x higher among PEH than the general MN population. For example, 1 in 10 substance use deaths in MN are among PEH, and 1 in 3 of all deaths among PEH are caused by substance use, especially opiates, including fentanyl.

The data demonstrate an urgent need to address substance use deaths among people experiencing homelessness. MDH is currently collaborating with DHS to develop and implement homeless-specific strategies to reduce fatal opioid overdoses. Currently, MDH does not track housing status at time of death and has no reliable

way to measure year-to-year changes in preventable deaths among people experiencing homelessness. This funding would allow us to measure the progress of new initiatives and to monitor and communicate to partners emerging mortality risks among people experiencing homelessness.

This proposal is part of the interagency Housing Stability package being led by Minnesota Housing and the Minnesota Interagency Council on Homelessness.

Proposal:

This would be a follow-up to MDH's 2017-2021 homeless mortality study, which was funded by a one-time grant from the CDC Foundation. Ongoing state investment is needed to measure our progress in addressing premature deaths among people experiencing homelessness and to maintain awareness of emerging threats and communicate them to our partners.

The original mortality study was done via a contract with the Hennepin Healthcare Research Institute (HHRI) to merge Homeless Management Information Systems data with MDH death certificate data. In this proposal, we've included a small amount for HHRI to advise on the data matching and programming, but the analysis would be done by MDH analysts. By moving this from a contractor to in-house analysts, the department will boost its capacity to integrate homelessness information into our public health data, which is a key priority for the department. It will also be useful to the department to analyze the impact of homelessness on drug overdoses, traumatic brain injuries, and other conditions. It will also be more cost-effective over the long-term because there will be lower indirect costs.

The funding will specifically support staff positions to:

- Negotiate access to the data, manage contracts, supervise data collection and analysis and lead report-writing for the mortality study.
- Clean, merge and and anlyze the data.
- Assist with data access and data merging using a de-identified hashing technique to preserve confidentiality.

This proposal complements the work of the Minnesota Interagency Council on Homelessness (MICH) to update the state plan to end homelessness with a focus on achieving housing, racial, and health justice for people experiencing homelessness. It will also advance work being done across MDH and with DHS on the intersection of homelessness with substance use, violence, and chronic health conditions.

We will use this data to assess the effectiveness of our efforts to reduce preventable deaths among people experiencing homelessness. Without this funding, we will not have data to evaluate our success.

Impact on Children and Families:

Homeless prevention is a critical public health investment, particularly for young adults. The mortality rate for a 20-year old person experiencing homelessness in Minnesota was comparable to a 50-year old in the general Minnesota population.

Stable housing is critically important to improve and extend the lives of youth and families.

Finally, the continuing to measure homeless mortality will help sustain momentum to reduce preventable deaths among people experiencing homelessness. Youth, ages 18-24, experiencing homelessness have mortality rates that are 3.5 times higher than all Minnesotan youth, ages 18-24. We won't be able to make progress on this issue if we don't commit to measuring it.

Equity and Inclusion:

This proposal aims to reduce inequities for people of color, Native Americans, people in the LGBTQ community, veterans groups, and all groups that experiencing homelessness and housing instability at a higher rate than the general population. Native Americans experiencing homelessness have mortality rates five times higher than the general Minnesota population and 1.5 times higher than other people experiencing homelessness in Minnesota. MDH is currently working with tribal representatives and urban Indian groups on how we can support programs to address those disparities. Continued data collection is vital to measuring our progress.

The proposal will have a positive effect on Native Americans and other groups disproportionately impacted by homelessness and housing instability. The data highlights the impact of homelessness on premature mortality and provides compelling reason to act. There is always a risk, depending on how the data is presented, that it will perpetuate stigma among marginalized groups. However, we would address this risk by doing extensive engagement with impacted groups throughout the project.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

None

Results:

Overall, we will measure that the report is thorough and can be used to successfully measure trends and results will be publication of the final report.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Completion of Homeless Mortality Study	1	9/22	1	2	9/24

Statutory Change(s):

None

Change Item Title: Improving the Health and Well-Being of People with Disabilities

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,278	1,278	1,434	1,434
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,278	1,278	1,434	1,434
FTEs	**4**	**4**	**6**	**6**

Recommendation:

The Governor recommends a general fund investment to improve the health of Minnesotans with disabilities. These funds will support a comprehensive, cross-agency, interdisciplinary approach to improving disability-related health disparities; collect and apply high-quality data; publish a health report that includes a health surveillance plan and a community needs assessment; distribute community health improvement grants that help establish evidence-based chronic disease prevention and management services to address identified gaps and disparities; implement inclusive health trainings; and promote authentic engagement and relationships.

Rationale/Background:

MDH has identified comprehensive disability health planning and inclusive chronic disease prevention and management services as a critical unfilled gap. To achieve MDH's mission, we must address the unmet needs of people with disabilities. People with disabilities are three times more likely to have arthritis, diabetes, or have a heart attack and are five times more likely to report a stroke, chronic obstructive pulmonary disease, and depression (National Council on Disability, 2022). Minnesota data shows adults living with disabilities are more likely to be inactive, have hypertension, smoke, and be obese (BRFSS, 2019). People with disabilities experience lower life expectancies and difficulty accessing dental, oral, vision, hearing, sexual, and mental health care, as well as chronic disease prevention and management services. They also have higher emergency room utilization and hospitalization compared to people without disabilities (Commonwealth Fund). Disability (particularly intellectual and developmental disabilities) is a key indicator of hospitalization and death among COVID-19 cases (CDC, 2022). In Minnesota, more than one in five, or approximately 960,000 adults identify as having a disability (BRFSS, 2019). Our data describing the wellbeing of Minnesotans with disabilities has many gaps, however, the available national and state data make clear that people with disabilities experience a far higher burden of chronic disease and many of their needs are going unmet. In the absence of high-quality data and public health infrastructure, health inequities experienced by people with disabilities will persist, as was the case for aspects of the COVID-19 response.

This proposal will better equip MDH to work with people with disabilities among diverse communities across Minnesota in addressing the gaps in health outcomes and health care services. Left unfunded, Minnesotans with disabilities remain at risk of worsened health outcomes and MDH will not be adequately resourced to develop and advance a holistic disability health strategy.

Proposal:

This proposal will advance the values and legal obligations of the 2015 Minnesota Olmstead Plan to ensure that all people with disabilities have equal access to live their fullest lives in the community of their choice. Governor's

Executive Order 19-13 directs the Olmstead Subcabinet to engage communities with the greatest disparities in health outcomes for individuals with disabilities and work to identify and address barriers to equitable health outcomes.

Funding from this proposal will build the capacity of every department at MDH to better serve and improve the lives of Minnesotans with disabilities. This recommendation sustains and builds upon the momentum built during the COVID-19 response to expand and nurture relationships, collaborations, and infrastructure.

Strategy 1. MDH will improve data collection, sharing, and reporting for people with disabilities and evaluate systems of care across the lifespan. Resources will permit MDH to work with the disability community to ensure a robust and inclusive surveillance system and better inform targeted public health interventions and preventive health programing. MDH will sponsor a public disability data dashboard to report on health outcomes for people with disabilities to inform the work of state and local public health officials, community-based organizations, and health care providers. Data will inform health goals and wellness benchmarks for the Health Department to prioritize programming targeting people with disabilities.

Strategy 2. MDH will expand comprehensive health planning for people with disabilities by analyzing health outcomes and setting ambitious and measurable health goals. Health strategies will include a community needs assessment and the development and implementation of a health surveillance plan.

Strategy 3. MDH will offer community-based grants to fund inclusive evidence-based chronic disease prevention and management services to address disability heath disparities. The initiative will promote policy, systems, social, and environmental changes to implement disability-inclusive practices in community programs.

Strategy 4. MDH will lead and collaborate with other state agencies, health care providers, and community organizations to improve the health of Minnesotans with disabilities through systems reform and coordinated public health programming and interventions. MDH will contract with a provider to broaden health improvement and preventive health-care navigation services.

Strategy 5. MDH will establish an external community advisory group comprised of people with disabilities, trusted community organizations, and other partners to guide community-focused disability health equity programs and initiatives. The advisory group will foster collaboration to integrate an intersectional disability justice lens within the work of MDH. Community engagement will empower MDH to build authentic relationships and improve communication with people with disabilities.

Strategy 6. MDH will implement disability inclusion health trainings for agency staff, local public health, health care providers, and community organizations to upend paternalistic and ableist medical model approaches to serving people with disabilities. Trainings will implement the disability justice framework that centers and empowers Minnesotans with disabilities to make their own informed health choices.

Infrastructure: Staff dedicated to improving the lives of people with disabilities in Minnesota will be hired to fill the void existing at the MDH to facilitate comprehensive improvements across the agency and in our communities to improve health and wellbeing of members of the disability community. This proposal includes four key positions in FY24-25 and ramp up to six positions in FY26-27 and ongoing to work across agencies and divisions to continue convening stakeholders to complete a vision-setting process, needs assessment, comprehensive disability health planning, enhanced data collection and dissemination, and disability inclusive public health training. The work will be done in concert with the disability community through authentic engagement and involvement.

Impact on Children and Families:
While disability is positively associated with age, approximately 2,000 children born in Minnesota have a birth defect. An estimated 222,000 children and youth in Minnesota (or nearly 20% of children aged 0-17 years old)

have disabilities or special health needs (National Survey of Children's Health, 2019). One in five children report having a mental, emotional, developmental, or behavioral disability. This budget proposal will strengthen the Health Department's programs serving children and families in Minnesota to improve systems of care for children and youth with special health needs and their families.

Equity and Inclusion:
Investing in people with disabilities is a critical investment in Black, Indigenous, communities of color, and queer communities. Disability spans every age, race, ethnicity, sexual orientation, social and economic class, geographic location, political ideology, religion, immigration status, and other intersectional identities. Rural communities, American Indians, and communities of color, particularly Black Minnesotans, experience a higher disability prevalence (MN Compass, 2019; American Journal of Preventative Medicine, 2019) and face compounding negative health disparities. Additionally, nearly 40% of transgender individuals report having one or more disability.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Results:

The proposal will achieve the following functions:

1. **Build capacity and infrastructure** to better understand and address the needs of people with disabilities and build a culture of inclusion
2. **Improve data collection and dissemination** to inform data-driven planning, programming, and communications
3. **Build sustainable collaboration across state agencies and with community partners** to address barriers and improve the health and wellbeing of people with disabilities.

Type of Measure	*Name of Measure*	*Current Value*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Creation of comprehensive state plan for people with disabilities with stakeholder engagement	0	0	1	FY 2023 FY 2027
Quantity	# of trainings for MDH staff on disability inclusion	0	0	TBD	FY 2023 FY 2027
Quantity	Number of community grants that are implemented with quality	0	0	10	FY 2023 FY 2027
Quality	Public disability data dashboard includes relevant data for community stakeholders	0	0	1	FY 2023 FY 2027
Result	Establishment of public disability data dashboard	0	0	1	FY 2023 FY 2027
Result	Disability community has participated in and is supportive of state plan	0	0	TBD	FY 2023 FY 2027

Type of Measure	*Name of Measure*	*Current Value*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Result	Satisfaction with statewide coalition	0	0	TBD	FY 2023 FY 2027
Result	Participant satisfaction with trainings	0	0	TBD	FY 2023 FY 2027
Result	Public disability data dashboard is used by community to track outcomes	0	0	1	FY 2023 FY 2027
Quantity	# of people with disabilities reached and who participate in evidence based chronic disease programs	0	0	TBD	FY 2023 FY 2027
Quantity	Increase number of people with disabilities connected to inclusive, preventive healthcare services and chronic disease prevention programs	0	0	TBD	FY 2023 FY 2027

Statutory Change(s):

New statute

Change Item Title: Increase Joint Initiative Funding

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
Environmental Fund				
Expenditures	400	400	400	400
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	400	400	400	400
FTEs	**2.5**	**2.5**	**2.5**	**2.5**

Recommendation:

The Governor recommends an appropriation of $400,000 in FY2024 and each subsequent year from the Environmental Fund to the Minnesota Pollution Control Agency's (agency) Environmental Analysis and Outcomes Division. This appropriation will increase joint initiative funding for biomonitoring and address other environmental health risks posed by contaminants in the air. The increased funding will be passed through to the Minnesota Department of Health (MDH) to support additional toxicology work to develop and review health benchmarks, for additional epidemiology work for health tracking, and communications support in the areas of air pollution and climate.

This recommendation will be less than 1% of the agency's biennial budget.

Rationale/Background:

Cumulative impacts, air toxics and environmental justice continue to be major concerns for Minnesota, the agency, MDH, and the Environmental Protection Agency (EPA). At the state level, these concerns are addressed through a joint state agency effort. The agency's effectiveness depends on its ability to estimate air toxic-related health impacts, which informs better understanding of human health risk, and improved communication to address disproportionate health impacts. The MDH support is foundational to the success as they maintain the functional expertise and authority to review and develop health benchmarks, a critical feature of risk assessment and integral to Minnesota's air toxics risk-screening tool (MNRISKS) development. Increasingly, MDH is tasked with defending these benchmarks as facilities question the need for emission reductions. These areas of expertise are currently understaffed at MDH.

Currently, funding for this joint initiative between the agency and MDH is provided from the Environmental Fund (*2021, 1st Special Session, Chapter 6, Article 1, Sec. 2, Subd. 2g*), which provides $926,000 each year to continue biomonitoring in higher risk communities, as recommended by the Environmental Health Tracking and Biomonitoring Advisory Panel, and to address other environmental health risks, including air quality. The agency passes $689,000 of this appropriation annually to the MDH to fund the work. Approximately $239,000 is used to fund 1.5 positions at the MDH to support development and communication of air toxics. These staff review and develop air toxics health benchmarks for the agency to then use in its work. Health benchmarks are used to calculate risks and help drive risk reduction, particularly in designated areas of concern. MDH staff also created partnerships and communications, particularly around health impacts from air toxics. The MDH does not have dedicated funding for this work and the agency does not currently have the expertise or resources to develop and review air health risk benchmarks. The current funding has not been increased for multiple years while costs have continued to increase. Additional funding would allow MDH to provide additional and faster air toxic pollutant

reviews and in turn allow the agency to better estimate risk and protect vulnerable communities. Additional funds would also provide the MDH resources to better partner to create advice, messaging, reports, and community outreach regarding the impacts of climate change and air toxics on human health.

Funding would also support the recently released Climate Action Framework. Climate change is the biggest health threat facing humanity. Some of the known direct health impacts of climate change include more heat-related illnesses due to heat waves; injuries, deaths, and contaminated drinking and recreational waters from extreme precipitation and flooding; increases in disease transmission from animals and vectors; increased and exacerbated respiratory and cardiovascular diseases, such as asthma attacks from wildfire smoke and pollen; food insecurity from crop failures and rising food prices; mental health impacts from experiencing extreme weather events, climate-related instability, and other changes to the places we call home; and increasing societal and healthcare costs from more emergency department visits, hospitalizations, and premature deaths. Without additional funding through this proposal, MDH has limited ability to confront the impacts of a changing climate.

This proposal did not directly originate in one of the Governor's designated work groups. However, the proposal supports the Governor's Executive Order 19-37 on climate change action and is recommended by specific priority actions in Goal 5 of the Climate Action Framework that was developed through feedback from the public, the Healthy Lives and Climate Equity Workgroup, and the Governor's Advisory Council on Climate Change.

Proposal:

This proposal is for additional funding to support joint agency work to address environmental health risks, including air quality. Funding will allow the agency to pass additional funding to MDH for an additional 2.5 positions to provide increased and faster reviews of air toxic pollutants, allowing for better estimation of risk and protection of vulnerable communities. MDH would also have the resources to better partner in the creation of advice, messaging, reports and community outreach regarding the impacts of climate change and air toxics on human health. The proposed positions include an additional toxicologist to develop/review health benchmarks, a partial FTE for supervisory oversight, and an epidemiologist for health tracking and communications support in the areas of air pollution and climate.

Impact on Children and Families:

Air toxics benchmark development includes a focus on early childhood development. MDH's focus on children helps the agency to better understand and respond to the risks of air pollution, particularly in vulnerable communities.

Also, having an additional MDH staff person to focus on the human health impacts of climate change would help improve resources and better support children and families. Climate change impacts everyone, but some people are more susceptible to climate change, particularly children. Studies have shown that children are more impacted by extreme weather events and are more sensitive to heat stress and air pollution. Research also shows that our youth are already being impacted by mental health issues associated with climate change. Additionally, low-income families will struggle with keeping their families safe and recovering from increases in extreme weather, such as keeping their homes cool in extreme heat, abating mold growth from flooding and extreme precipitation, and ensuring that their indoor air is safe when wildfire smoke makes outdoor air unhealthy to breathe.

Equity and Inclusion:

The agency has focused its efforts on reducing risk from air pollution on areas with current disproportionate impacts. Often MDH support is needed to understand and communicate risk. Additional resources would allow for more comprehensive and on-going support.

Additional support is also needed around human health impacts from climate change. Social, economic, historical, and political factors shape the ability of some communities to prepare for, cope with, and recover from climate change impacts. Existing inequities based on race, age, gender, geography, economic status, existing health conditions, and more place some communities at greater risk. Black, Indigenous and people of color have demonstrably poorer health due to unequal access to health care, biased housing practices that placed them closer to sources of pollution, and other factors. Climate change amplifies these existing health disparities. For example, American Indian and African American middle and high school-aged kids are more likely than other students to have been diagnosed with asthma. Asthma is exacerbated by poor air quality and wildfire smoke. Historically racist housing policies (such as redlining) are associated with urban heat islands and lack of tree canopy in low-income neighborhoods of color, which suffer more from extreme heat as a result. Communities that already lack resources are burdened by the costs of preparing for and recovering from climate-related events.

Tribal Consultation:

☒Yes
☐ No

Tribal Nations are considered by the agency as within environmental justice areas of concern and bear disproportionate impacts of pollution. MDH and MPCA consult with each respective tribal nation on potential health and environmental impacts. Biomonitoring has been done in partnership with some tribal nations. The data and information gathered from this proposal would be of interest to tribal nations as they have tribal/community members that reside throughout the state.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	# of Health Based Values developed for chemicals in ambient air	2-3 per year	FY2022	2-3 per year	4-6 per year	FY 2025
Quantity	# of health, exposure, climate, and equity indicators developed for and integrated with Air and Health Initiative projects	1	FY2022	0-1 per year	2-3 per year	FY 2024

Statutory Change(s):

None

Change Item Title: Lead Remediation in Schools and Child Care Centers

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	500	500	500	500
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	500	500	500	500
FTEs	**1.0**	**1.0**	**1.0**	**1.0**

Recommendation:

The Governor recommends a general fund appropriation to establish a grant program targeting reduction of lead in drinking water in schools and child care facilities, require testing in child care settings, make lead testing data easily accessible to the public, and create a threshold for corrective actions when lead is found in drinking water. Total grant awards will be $146,000 in fiscal year 2024 and $239,000 in fiscal year 2025 and each year thereafter. Resulting reductions in exposure to lead in water will improve the health and safety of Minnesota's children through enhanced brain development and lifetime productivity. There are approximately 8,000 child care facilities serving 270,000 children and just under 2,500 educational facility buildings serving 870,000 students in Minnesota.

Rationale/Background:

There is no safe level of exposure to lead. Reducing exposures in all settings, including drinking water in educational facilities, is a public health priority. The department is committed to reducing childhood lead exposure in schools and child care facilities through testing and remediation of lead in plumbing and fixtures. While testing for lead in water at schools and child care facilities has been a recommendation since the 1980's, a KSTP news investigation, originally published in 2016, found that many schools were not keeping up with the voluntary guidance to test. As Minnesota does not have a centralized database to track school compliance, the station contacted over 600 schools and found that 1 in 4 had not tested for lead due to competing maintenance priorities and limited funds.

Child care facilities

Currently, MDH has a program to offer free testing to eligible schools and licensed child care facilities funded by a federal Water Infrastructure Improvements for the Nation (WIIN) grant. However, interest in free testing through the WIIN program was impacted by challenges to child care facilities due to COVID-19 and has been severely limited as there are no corresponding funds for addressing lead discovered through testing. Child care facilities are not currently required to test and are reluctant to voluntarily participate in the WIIN program due to the potential costs of remediation if lead is found. This low response from child care facilities to free testing without additional remediation funds is common across the nation in states where testing is not required for child care facilities. Head Start programs must meet federal requirements which stipulate that they demonstrate that children are not exposed to lead in their facilities, including exposure from water. However, the federal requirement is not specific in how child care facilities should demonstrate that children are not exposed and does not require reporting to parents. Head Start facilities are now requesting test kits through state WIIN programs. The U.S. Government Accountability Office found that federal agencies need to enhance monitoring and collaboration to assure drinking water in child care facilities is safe from lead after a report with a national survey

of Head Start facilities found that 43% of facilities had not tested and 31% did not know if they had tested for lead in drinking water.

Public, charter, and private schools
Since 2017 public and charter schools are required by Minnesota Statutes, section 121A.335 to test for lead all fixtures used to provide water for consumption at least once every five years (testing was to start by July 1, 2018). Private schools are not covered by this statute. If a school finds lead, it must create a plan for reducing lead exposure and make the results of testing available to the public. Public school districts may include lead testing and remediation as part of their Long-Term Facilities Maintenance (LTFM) fund, a ten-year facility plan under Minnesota Statutes, section 123B.595. Private schools and child care facilities do not have access to this fund. While most eligible schools use the LTFM to fund lead testing, follow up remediation actions must compete with other maintenance needs, potentially preventing schools from taking more effective steps to reduce lead exposure such as replacing lead plumbing components for less reliable and less expensive methods such as daily flushing.

Lead threshold for corrective actions
There is no safe level of lead. All levels of lead come with risk and to protect children's health the strategy is to reduce risks from lead in drinking water as much as practically possible. Once schools and child care facilities test for lead it is important to provide them with clear direction so that they can respond efficiently to the results and take concrete actions to reduce exposure. The MDH Model Plan and the Environmental Protection Agency's 3Ts are guidance documents that provide a series of options rather than establishing a state level that triggers specific required actions. Lack of a clear threshold can cause confusion, delays, and disparities in responses among schools and child care facilities based on access to technical and financial resources. During the 2022 legislative session, SF3956 and HF3265 proposed 5 parts per billion (ppb), a remediation level based on regulations and policies in several other states. This proposed 5 ppb threshold is not a health-standard but is based on technically feasible actions to reduce lead levels at the tap, utilizing a variety of strategies available to schools and child care facilities. Most recently New Hampshire joined the ranks of states like Illinois, Michigan, and Washington, D.C. which use this 5 ppb as a trigger for schools to implement lead hazard reduction or provide notification. Health Canada has proposed this value as their new Maximum Allowable Concentration. The proposed 5 ppb threshold is also the International Bottled Water Association (IBWA) Bottled Water Code of Practice finished water quality product standard.

Public access to lead testing results
As lead testing in schools is a concern for parents across the nation, most states that require testing also require that the schools make results publicly available. In Minnesota, Statute 121A.335 includes the requirement of "making results publicly available." This does not ensure parents are notified and leads to widely varying practices by school and districts. Parents and staff must search the Web or call to find the results because they may only be "available upon request" rather than readily accessible on a website. States such as Washington and Montana maintain a list of schools that have sampled and test results.

Proposal:

This proposal seeks to 1) establish a grant program for projects targeting reduction of lead in drinking water in public school districts, charter schools, private schools, and licensed child care facilities; 2) add a testing requirement for child care settings; 3) ensure that data from testing at public school districts, charter schools and licensed child care facilities is easily accessible to the public; and 4) ensure actions are taken to reduce lead exposure when lead is found, including the creation of a specific lead concentration which triggers corrective actions.

Lead reduction grant program
MDH proposes to start a grant program for public and private schools and child care facilities to fund projects that will result in reduction of lead in drinking water in schools and/or child care facilities. Examples of eligible drinking

water lead reduction activities to support this include removing or replacing drinking water fixtures, fountains, or outlets; replacing plumbing materials; and installing automatic flushing devices to reduce stagnation which can contribute to elevated lead levels. Grant scoring criteria for grants will prioritize documentation of the lead hazard through testing, expected reduction of lead, disadvantaged communities, the number of students served, and the potential for lead reduction. Reduction of lead levels following the remediation activities will be documented by follow-up testing. Follow-up testing may be eligible for WIIN funds.

Grant size may vary due to different remediation needs for schools and child care facilities based on complexity of plumbing, number of buildings served, and number of drinking water fixtures that need remediation. We estimated for fiscal year 2024 that up to 6 grants to schools of $15,000 would be awarded and up to 7 grants to child care providers of $8,000 would be awarded. During fiscal year 2025 and beyond, that number would be 9 public schools and 13 child care providers. Grants awards will be optimized to maximize use of available funds and prioritized to maximize impact.

Strengthening testing, reporting and reduction actions
This proposal is designed to accelerate testing and remediation of lead in drinking water in schools and child care facilities. Schools are currently required to conduct testing at all drinking water taps at least once every five years and this proposal would add the same frequency for sampling for child care facilities. Child care facilities and schools would be required to report the results to MDH and remediate if lead is found to exceed the action threshold of 5 ppb. The addition of a reporting component provides transparency and public accessibility in one central location. Lead testing results will be displayed on the department's website. Furthermore, centrally reporting results will also make it easier to understand state-wide trends in lead exposure from drinking water in educational facilities and improve the accountability of schools and child care facilities to parents and families. This proposal would also clarify when public and charter schools would be required to remediate by establishing an action threshold rather than relying on voluntary actions selected from a list of options. In combination with access to funding through grants, the action level provides for an equitable response statewide.

The 1.0 FTE staff in the proposal will prepare and manage the grants, gather testing data, provide follow-up and technical assistance, and develop web tools for public communications.

Impact on Children and Families:

A safe supply of drinking water is a foundational element that supports Minnesota's vision to provide a world class education for her students and may reduce the need for future health care. In a 2019 report co-authored with University of Minnesota, MDH estimated that for every dollar spent on addressing lead in drinking water, there will be at least two dollars in benefits. Reductions in exposure to lead in water will improve the health and safety of Minnesota's children through enhanced brain development and lifetime productivity. Improvements made by facilities to reduce lead in drinking water will improve infrastructure serving the populations most vulnerable to lead exposure and build a partnership between the state, schools, and child care facilities to ensure drinking water is safe for all Minnesotans.

Equity and Inclusion:

The same groups that are likely to be attending schools or child care facilities with lead in drinking water often live in areas where housing stock has lead service lines or lead paint, increasing the probability of exposure to lead from multiple sources. These same groups face economic and educational challenges that compound to limit their life choices and negatively impact their well-being. Children spend a significant portion of their day at schools and/or child care facilities and may consume most of their food and water while at these locations. Reduction of lead in drinking water at these facilities is a cost-effective strategy to improve health equity for these groups. Providing education to communities that serve groups impacted by lead exposure can empower them to reduce lead exposure from other sources.

Creating a consistent, transparent, publicly available repository of test results and a clearly-defined action threshold will help ensure that communities in all areas of the state are equitably benefiting from the assessment, and remediation, of the presence of lead in school drinking water.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll	123,711	30,710	30,710	30,710	30,710	30,710
Total	123,711	30,710	30,710	30,710	30,710	30,710
MNIT FTEs						
Agency FTEs						

Results:

Establishing performance measures to evaluate the results of the proposed grant and the impact of centralized results reporting will be important for transparency regarding the effectiveness of the grant and testing requirements. The centralized reporting of testing results requested in this proposal will help provide data for performance evaluation. The initial year would provide baseline data for the grant program. As school and licensed child care facilities test for lead under state and federal statutes there will be more available information on the need for, and extent of, grant dollars. Performance measures in the table below will provide accountability and a metric for ensuring the funds are contributing to the reduction of lead in drinking water and consequently a reduction in exposure to lead from drinking water sources.

Performance Measures

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	# of grants to schools # of grants to child care facilities	0	9/29/2022 2	0	6 to schools 7 to child care facilities	7/1/2024
Quality	Percent of schools and child care facilities reporting their lead results through a centralized website.	0	9/29/2022	0	Child care facilities – 100% Schools - 100%	7/1/2027 7/1/2027
Quantity	Number of children served by schools that have implemented lead reduction activities	0	9/29/2022	0	14,000 children in schools/yr 1,000 students in child care facilities/yr	7/1/2025

Through administration of this grant, we will be able to track the progress of approved projects and require information on the details of the projects to ensure that projects prioritize the reduction of lead exposure to children from drinking water. In addition to creating a centralized reporting hub for results from school and child care facilities, a webpage for the grant can be developed to make the outputs and results of the grant program easily accessible and transparent to interested parties.

Statutory Change(s):
Minnesota statutes, section 121A.335 and a new statute

Change Item Title: Lead Service Line Inventory

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	3,000	3,000	0	0
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	3,000	3,000	0	0
FTEs	**2**	**2**	**0**	**0**

Recommendation:

The Governor recommends a general fund appropriation to community water systems to inventory the materials used for water service lines and include that inventory in a broader asset management plan. Of the total amount annually, $2,678,000 will be provided in grants. These grants will help the community water systems meet the requirements for a lead service line inventory that is part of the U.S. Environmental Protection Agency's proposed Lead and Copper Rule revision as well as provide the public with information about the location of lead service lines.

Rationale/Background:

Lead is a toxic metal for which there is no safe level of exposure. Dramatic reductions in addressing lead exposures to children from paint dust has allowed public health scientists to turn attention to other sources of lead for children, including water consumed during pregnancy and infancy. The most significant contribution of lead to drinking water is leaching from water service lines made of lead (lead service lines or LSLs) that connect water mains with homes and plumbing (solder and fixtures) in homes.

A recent estimate suggests there are 100,000 LSLs in Minnesota. The MDH/University of Minnesota report on Lead in Minnesota Water found that there is a benefit of two dollars for every dollar invested in reducing lead in drinking water. This report also proposed incremental removal of all lead service lines (LSLs) over a 20-year timeline, noting it as a cost-effective way to reduce Minnesotan's exposure to lead in drinking water by almost half. Currently, many community water systems across Minnesota do not know the material type of the water service lines that serve their residents. Since some of these water service lines may be made of lead, it is very important that they be identified.

The EPA has recently finalized the Revised Lead and Copper Rule that requires all community water systems to create verified LSL inventories that are available to the public within a limited time frame.

Proposal:

This recommendation will create a grant program to provide funding to community water systems to conduct a lead service line (LSL) inventory and complete asset management plans as needed. This inventory will identify the composition of the lines; unknown lines will be considered to contain lead until they can be verified. To locate, verify, and create an inventory of these service lines can be time consuming and costly, and is a prerequisite for the eventual replacement process. Recent passage of the federal Infrastructure Investment and Jobs Act (IIJA) means that significant funds specifically dedicated to LSL replacement will come to Minnesota and be awarded through the Drinking Water State Revolving Fund administered by the Public Facilities Authority.

The information gathered during the inventory process should be tracked in the community water systems' asset management plan. If a water system does not have an asset management plan, one should be completed at the time of the water service line inventory. Costs to complete the asset management plan would be eligible for this grant program. As some community water systems in Minnesota have begun developing inventories in the last year, cost estimates now reflect actual experience. Costs for verifying the service line material, geocoding, and data management average $100 per service line or an average of $100,000 per system.

Additionally, the United State Environmental Protection Agency has set a deadline for LSL inventories to be completed by October 16, 2024. Our experience shows that many service lines will be classified as "unknown" to meet this deadline and will require follow up to determine the specific material, so inventory development will continue past the deadline.

The results of the service line inventory can be entered into the MDH database as well as the University of Minnesota's Infrastructure Transparency Tool, which will allow residents the ability to check the material type of the service line connecting their home. The tool will be able to provide general information about lead in drinking water as well as potential funding information if homeowners would like to replace their lead service line. Staff in the proposal will also help ensure inventory information is properly uploaded to the database of lead service lines and/or the Infrastructure Transparency Tool.

Impact on Children and Families:

Identifying the location of lead service lines is the first step in removing this source of lead exposure which disproportionally affects children living in older housing stock. These same children may also be subject to lead exposure from house paint dust. Bottle-fed infants in these homes are particularly at risk from lead in drinking water due to their high intake of fluids and vulnerable stage of development. The report cited above estimates that for every dollar spent on addressing lead in drinking water, there will be at least two dollars in benefits from enhanced brain development and lifetime productivity.

Equity and Inclusion:

Lead service line replacements will reduce Minnesotans' lead exposures through drinking water. This supports MDH's commitment to equity as often lead service lines are more prevalent in older housing in low-income neighborhoods.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes

☒No, we do not have regulatory authority for the tribes, and they work directly with EPA or Indian Health Service. We recently had requests for information from some of tribes through their engineer firms related to funding lead service line replacements, but not inventories.

IT Costs

None

Results:

Results can be tracked and made publicly available through the Infrastructure Transparency Tool (current Minnesota State Auditor and University of Minnesota project in collaboration with MDH). Individual community water system asset management plans will also provide metrics for cities and their citizens.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quality	% of community systems with completed LSL inventories	0	09/28/22	0	100%	10/31/24
Quality	% of water service lines that were made of unknown materials that are now known and resolved.	0	09/28/22	0	50%	06/30/22
Quality	% of community water systems whose LSL data is available to the public on the UofM Infrastructure Transparency Tool	0	09/28/22	0	100%	06/30/22

Statutory Change(s):
None

Change Item Title: Legalizing Adult-Use Cannabis

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Cannabis Management Office Expenditures	15,430	14,841	13,980	13,711
DEED Expenditures	10,400	6,700	0	0
Health Expenditures	8,115	8,115	8,115	8,115
Public Safety Expenditures	4,175	2,662	2,662	2,662
Revenue Expenditures	3,673	3,118	3,138	3,153
Human Services Expenditures	2,260	6,476	6,476	6,476
Cannabis Expungement Board Expenditures	921	844	844	844
Pollution Control Expenditures	607	496	70	70
Supreme Court Expenditures	545	545	0	0
Higher Education Expenditures	500	500	500	500
Agriculture Expenditures	411	411	338	338
Natural Resources Expenditures	338	0	0	0
Education Expenditures	180	120	120	120
Labor and Industry Expenditures	132	132	132	132
Commerce Expenditures	75	283	569	799
Corrections Expenditures	(177)	(345)	(407)	(458)
Tax Aids, Credits, and Refunds Revenues	5,800	31,000	79,300	130,800
Cannabis Management Office Revenues	1,996	3,330	4,000	6,000
State Government Special Revenue Fund				
Health Expenditures	(3,424)	(3,424)	(3,424)	(3,424)
Health Revenues	(7,411)	(10,879)	(12,973)	(19,223)
Trunk Highway Fund				
Public Safety Expenditures	5,608	1,668	1,668	1,668
Outdoor Heritage Fund				
Tax Aids, Credits, and Refunds Revenues	(3)	96	330	594
Arts and Cultural Heritage Fund				
Tax Aids, Credits, and Refunds Revenues	(2)	57	198	356
Clean Water Fund				
Tax Aids, Credits, and Refunds Revenues	(3)	96	330	594
Parks and Trails Fund				
Tax Aids, Credits, and Refunds Revenues	(1)	41	142	257
Net Fiscal Impact = (Expenditures – Revenues)	49,393	19,401	(36,546)	(84,672)
FTEs	**92**	**98**	**104**	**104**

Recommendation:

The Governor recommends funding for the safe and responsible legalization of cannabis for adults in Minnesota. A new Cannabis Management Office will be responsible for the implementation of the regulatory framework for adult-use cannabis, along with the medical cannabis program, and a program to regulate hemp and hemp-derived products. This recommendation also includes funding for grants to assist individuals entering the legal cannabis market, provides for expungement of non-violent offenses involving cannabis, and implements taxes on adult-use cannabis.

Rationale/Background:

Prohibiting the use of cannabis in Minnesota has not worked. Despite the current prohibition, marijuana is widely consumed across Minnesota. The most recent Minnesota Survey on Adult Substance Use conducted in 2014-2015 found that nearly half (44%) of Minnesota adults reported using marijuana at some point during their lives. The maturation of the market for hemp-derived cannabinoid products following the 2018 Farm Bill culminating in the 2022 legislation authorizing hemp-derived THC edible cannabinoids have created urgency for comprehensive regulation and reform at the state level.

Regulating cannabis for use by adults will replace the abundant illicit market with a tightly regulated system with controls similar to those currently accepted for the sale of alcohol. This proposal will allow for the monitoring and regulation of its cultivation, processing, transportation and sale, activities currently occurring to the profit of drug cartels and criminals and without consumer protection guardrails.

Importantly, this proposal will begin to address racial inequities our current system has created. Despite survey data suggesting that Black and white Minnesotans use cannabis at similar rates, in 2021 Black Minnesotans were over four times more likely than their white counterparts to be arrested for marijuana according to data from the Bureau of Criminal Apprehension.

Marijuana prohibition additionally leaves potential tax revenue uncollected and furthers an opportunity for economic growth in the underground market. This proposal will bolster amounts available the General Fund for policymakers to prioritize while grant programs administered by DEED and the Office of Cannabis Management will further ensure Minnesotan entrepreneurs have the best opportunity to become the new adult-use market.

Finally, this approach is now well-tested across the country. Nineteen states and the District of Columbia have passed laws to legalize and regulate cannabis for adults. In Colorado, the first state to adopt this approach, legal sales began in January 2014 so there is now nearly a decade of implementation experience in other states to help craft this proposal for Minnesota.

Proposal:

This proposal creates a new agency, the Cannabis Management Office, which would be responsible for the implementation of a new regulatory framework for adult-use cannabis. The Office of Medical Cannabis will also move from the Department of Health to join this new agency. The office will be headed by a director appointed by the Governor and receive advice from a Cannabis Advisory Council with representatives from experts, local governments, the cannabis industry and relevant state agencies. The core duties of the office will include:

- to develop, maintain, and enforce an organized system of regulation for the lawful cannabis industry
- to establish programming, services, and notification to protect, maintain, and improve the health of citizens.
- to prevent unauthorized access to cannabis by individuals under 21 years of age.
- to establish and regularly update standards for product testing, packaging, and labeling.
- to promote economic growth with an emphasis on growth in areas that experienced a disproportionate, negative impact from cannabis prohibition.
- to issue and renew licenses.
- to impose and collect civil and administrative penalties.
- to authorize research and studies on cannabis, cannabis products, and the cannabis industry.

Adult-use cannabis will be subject to a new 15% gross receipts tax and state sales tax with retail sales beginning January 1, 2025. A new 15% gross receipts tax would also be imposed on the retail sale of edible cannabinoid products with retail sales beginning October 1, 2023.

The proposal authorizes three grant programs to support the establishment of cannabis businesses in Minnesota. Cannabis grower grants administered by the Office of Cannabis Management will provide farmers with assistance navigating the new industry and regulations along with subsidized loans for expanding into legal cannabis. Administered by the Department of Employment and Economic Development industry navigation grants and industry training grants will assist individuals in setting up a legal cannabis business through technical assistance and navigation services while providing grants to organizations and individuals for training on cannabis jobs.

The proposal provides for automatic sealing of dismissals, exonerations, convictions, or stayed sentences of petty misdemeanor and misdemeanor marijuana offenses by the Bureau of Criminal Apprehension, which will provide notice of the expungement to local law enforcement agencies as well as the Judicial Branch for compliance purposes. It also provides for the establishment of a Cannabis Expungement Board to review other cannabis convictions to consider eligibility for expungement or resentencing.

The proposal authorizes the Governor to enter into compacts with Minnesota Tribal governments on issues related to medical cannabis and adult-use cannabis.

The proposal finally provides significant resources to address substance use disorders. The proposal includes initial funding for grants directed by the advice of a Substance Use Disorder Advisory Council convened by the Department of Human Services. Five percent of the revenue from the cannabis gross receipts tax would flow into this fund to support these grants into the future.

Appropriations necessary for its implementation include:

- $30,271,000 in FY2024/2025 and $27,691,000 in FY2026/2027 to establish and begin operations of a new Cannabis Management Office responsible for the implementation of the new regulatory framework.
- $822,000 in FY2024/2025 and $ 676,000 in FY2026/2027 to the Department of Agriculture for food safety and pesticide enforcement lab testing and rulemaking related to changes in cannabis laws.
- $1,765,000 in FY2024/2025 and $1,688,000 in FY2026/2027 for a newly created Cannabis Expungement Board for staffing and other expenses related to reviewing criminal convictions and issuing decisions related to expungement and resentencing.
- $358,000 in FY2024/2025 and $1,368,000 in FY2026/2027 for the Department of Commerce for staffing and other expenses to complete scale, and packaging inspections.
- A reduction of $522,000 in FY2024/2025 and $865,000 in FY2026/2027 to the Department of Corrections' base budget to account for an expected reduction in marijuana-related incarcerations.
- $300,000 in FY2024/2025 and $240,000 in FY2026/2027 for the Department of Education to support schools and districts in accessing resources on cannabis use and substance use.
- $17,100,000 in FY2024/2025 for the Department of Employment and Economic Development for cannabis industry navigator and startup grants.
- $16,230,000 in FY2024/2025 and $16,230,000 in FY2026/2027 for the Department of Health for education of women who are pregnant, breastfeeding, or who may become pregnant; data collection and reports; and youth education.
- $8,736,000 in FY2024/2025 and $12,952,000 in FY2026/2027 for the Department of Human Services to implement the substance use disorder treatment and prevention grant program and process background studies relevant to the work of the Cannabis Expungement Board.
- $264,000 in FY2024/2025 and $264,000 in FY2026/2027 for the Department of Labor and Industry to identify occupational competency standards and provide technical assistance for developing dual-training programs.
- $338,000 in FY2024/2025 for the Department of Natural Resources for training of DNR Conservation Officers relating to the new cannabis regulatory system and requirements, recognition of impairment, and for the enforcement of the purposed environmental standards adopted by the Cannabis Management Office.

- $1,000,000 in FY2024/2025 and $1,000,000 in FY2026/2027 for the Office of Higher Education for Dual Training Competency Grants to employers in the legal cannabis industry.
- $1,103,000 in FY2024/2025 and $140,000 in FY2026/2027 for the Pollution Control Agency for rulemaking to establish of water, energy, odor, and solid waste environmental standards for cannabis businesses and provide technical assistance for small businesses.
- $6,837,000 in FY2024/2025 and $5,324,000 in FY2026/2027 for the Department of Public Safety Bureau of Criminal Apprehension for identifying and sealing records, forensic science services, and investigations.
- $7,276,000 in FY2024/2025 and $3,336,000 in FY2026/2027 for the Department of Public Safety Minnesota State Patrol from the Trunk Highway Fund for additional Drug Recognition Expert (DRE) troopers, crash reconstruction specialist troopers, and replacement drug detection canines.
- $6,791,000 in FY2024/2025 and $6,291,000 in FY2026/2027 for the Department of Revenue to collect and administer the tax requirements.

Impact on Children and Families:

The current widespread underground market for marijuana provides no controls against the sale and access to children. This proposal provides age restrictions to prevent the sale of cannabis to those under 21. Additionally, the biannual Healthy Kids Colorado Survey found no increase in the use of marijuana from 2011 to 2015 in the period where legal sales initiated in the state, a finding that has been consistent in Washington, Oregon, Alaska, California, Massachusetts, Maine, and Nevada. The proposal additionally provides funding for MDH to conduct a long-term, coordinated education program to raise public awareness about and address adverse health effects associated with the use of cannabis or cannabis products by persons under age 21.

Equity and Inclusion:

This proposal seeks to begin to address the inequities the current system of marijuana prohibition has created, beginning with the expungement of nonviolent marijuana offenses. A Division of Social Equity at the Office of Cannabis Management will work to further promote the consideration of equity and inclusion in the development and implementation of cannabis regulatory systems. The proposal additionally requires the prioritization of social equity applicants in cannabis license selection along with the cannabis grower and industry training and navigation grant programs.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Minnesota tribal governments, in particular the Red Lake Nation and the White Earth Nation, have raised significant concerns about the current interactions between their medical cannabis programs and current restrictions in statute. This proposal will provide broad authority for the Governor or designated representatives to negotiate compacts with an American Indian tribe regulating cannabis and cannabis products including medical cannabis.

Results:

The proposal requires Department of Health to engage in research and data collection activities to measure the prevalence of cannabis use and the use of cannabis products in the state by persons under age 21 and persons age 21 or older.

Statutory Change(s):

13.411, by adding a subdivision; 13.871, by adding a subdivision; 152.02, subdivisions 2, 4; 152.022, subdivisions 1, 2; 152.023, subdivisions 1, 2; 152.024, subdivision 1; 152.025, subdivisions 1, 2; 181.938, subdivision 2; 181.950,

subdivisions 2, 4, 5, 8, 13, by adding a subdivision; 181.951, by adding subdivisions; 181.952, by adding a subdivision; 181.953; 181.954; 181.955; 181.957, subdivision 1; 244.05, subdivision 2; 256.01, subdivision 18c; 256D.024, subdivision 1; 256J.26, subdivision 1; 273.13, subdivision 24; 275.025, subdivision 2; 290.0132, subdivision 29; 290.0134, subdivision 19; 297A.67, subdivisions 2, 7; 297A.99, by adding a subdivision; 297D.01, subdivision 2; 297D.04; 297D.06; 297D.07; 297D.08; 297D.085; 297D.09, subdivision 1a; 297D.10; 297D.11; 609.135, subdivision 1; 609.531, subdivision 1; 609.5311, subdivision 1; 609.5314, subdivision 1; 609.5316, subdivision 2; 609.5317, subdivision 1; 609A.01; 609A.03, subdivisions 5, 9; 624.712, by adding subdivisions; 624.713, subdivision 1; 624.714, subdivision 6; 624.7142, subdivision 1; 624.7151; proposing coding for new law in Minnesota Statutes, chapters 3; 17; 28A; 34A; 116J; 116L; 120B; 144; 152; 289A; 295; 604; 609A; 624; proposing coding for new law as Minnesota Statutes, chapter 342; repealing Minnesota Statutes 2020, sections 152.027, subdivisions 3, 4; 152.21; 152.22, subdivisions 1, 2, 3, 4, 5, 5a, 5b, 6, 7, 8, 9, 10, 11, 12, 13, 14; 152.23; 152.24; 152.25, subdivisions 1, 1a, 1b, 1c, 2, 3, 4; 152.26; 152.261; 152.27, subdivisions 1, 2, 3, 4, 5, 6, 7; 152.28, subdivisions 1, 2, 3; 152.29, subdivisions 1, 2, 3, 3a, 4; 152.30; 152.31; 152.32, subdivisions 1, 2, 3; 152.33,
1.38 subdivisions 1, 1a, 2, 3, 4, 5, 6; 152.34; 152.35; 152.36, subdivisions 1, 1a, 2, 3, 4, 5; 152.37; 297D.01, subdivision 1; Minnesota Rules, parts 4770.0100; 4770.0200; 4770.0300; 4770.0400; 4770.0500; 4770.0600; 4770.0800; 4770.0900; 4770.1000; 4770.1100; 4770.1200; 4770.1300; 4770.1400; 4770.1460; 4770.1500; 4770.1600; 4770.1700; 4770.1800; 4770.1900; 4770.2000; 4770.2100; 4770.2200; 4770.2300; 4770.2400; 4770.2700; 4770.2800; 4770.4000; 4770.4002; 4770.4003; 4770.4004; 4770.4005; 4770.4007; 4770.4008; 4770.4009; 4770.4010; 4770.4012; 4770.4013; 4770.4014; 4770.4015; 4770.4016; 4770.4017; 4770.4018; 4770.4030.

Change Item Title: Maintain Current Service Levels

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	7,859	9,576	9,576	9,576
Revenues	0	0	0	0
State Government Special Revenue Fund				
Expenditures	3,650	6,179	6,179	6,179
Revenue	0	0	0	0
Health Care Access Fund				
Expenditures	657	1,098	1,098	1,098
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	12,166	16,853	16,853	16,853
FTEs	**57.07**	**57.07**	**57.07**	**57.07**

Recommendation:

The Governor recommends additional funding of $7,859,000 in fiscal year 2024 and $9,576,000 in each subsequent year from the general fund, $3,650,000 in fiscal year 2024 and $6,179,000 in each subsequent year from the state government special revenue fund, and $657,000 in fiscal year 2024 and $1,098,000 in each subsequent year from the health care access fund to maintain the current level of service delivery at MDH.

Rationale/Background:

Each year, the cost of doing business rises—employer-paid health care contributions, FICA and Medicare, along with other salary and compensation-related costs increase. Other operating costs, like rent and lease, fuel and utilities, and IT and legal services also grow. This cost growth puts pressure on agency operating budgets that remain flat from year to year.

Agencies face challenging decisions to manage these costs within existing budgets, while maintaining the services Minnesotans expect. From year to year, agencies find ways to become more efficient with existing resources. MDH relies disproportionately on federal and other funds to support its central operations, which reduces the value to the state of money for infectious disease detection and prevention, public health laboratory analysis, chronic disease prevention, and support for local communities.

However, cost growth typically outstrips efficiencies, and without additional resources added to agency budgets, service delivery erodes.

For MDH, operating cost pressures exist in multiple categories—increases in compensation and insurance costs at the agency, increasing costs to maintain our current staff complement in a challenging labor market, and increasing IT costs. If an operational increase is not provided, MDH will be unable to provide the current levels of service to Minnesotans.

Proposal:

The Governor recommends increasing agency operating budgets to support maintaining the delivery of current services. For MDH, this funding will allow the department to maintain human resource systems to support a highly skilled workforce, use information technology solutions to improve efficiency and public accessibility, and adequately manage financial and data resources with the necessary controls and oversight.

The requested increases allow the department to maintain full-time equivalent staffing levels in the general fund, state government special revenue fund, and health care access fund, based on projected increases in salary and wages that are expected to grow due to a combination of pay adjustments, employer contribution to insurance, and bargaining unit step increase. The requested change is to maintain 20.88 FTE staff in the general fund at $2,483,000 in fiscal year 2024 and $4,200,000 each year thereafter, to maintain 30.67 FTE staff in the state government special revenue fund at $3,650,000 in fiscal year 2024 and $6,179,000 each year thereafter, and to maintain 5.52 FTE staff in the health care access fund at $657,000 in fiscal year 2024 and $1,098,000 in fiscal year 2025. The biennial total to maintain staffing levels for is $18,267,000 for all three funds.

Information technology costs represented by this request are comprised of those required to maintain existing levels of service, as identified by MNIT services. Costs to maintain agency applications and Microsoft products, MNIT staffing, and IT security services represent a 13.8% increase over fiscal year 2022 projected expenses, or $3,149,000 per year beginning in fiscal year 2024. Cost to maintain MNIT enterprise services to the agency including servers and storage, enterprise software, network connections, and MNIT administrative costs and mobile device management represent a 45.6% increase over 2022 – 2023 projected expenses, or $2,227,000 per year beginning in fiscal year 2024. The total cost increase to maintain existing levels for MDH's information technology services is $5,376,000 per year beginning in fiscal year 2024, for a 2024 – 2025 biennial total in the general fund of $10,752,000.

Results:

This proposal is intended to allow MDH to continue to provide current levels of service and information to the public.

Change Item Title: Minnesota One Health Antibiotic Stewardship Collaborative

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	312	312	312	312
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	312	312	312	312
FTEs	**1.5**	**1.5**	**1.5**	**1.5**

Recommendation:

The Governor recommends state support for the operations and activities of the Minnesota One Health Antibiotic Stewardship Collaborative (MOHASC). Funding will support technical expertise and partner coordination, education through the MOHASC annual meeting, and direct support and education for antibiotic stewardship implementation in agricultural and companion animal clinical settings.

Rationale/Background:

Since 2016, the Centers for Disease Control and Prevention (CDC) has included in the workplan for health department funding a mandate to improve antibiotic stewardship in human health care settings. Recognizing that the problem of antibiotic resistance is driven by antibiotic use in all sectors, Minnesota made a 2016 interagency commitment, establishment of MOHASC, to support stewardship initiatives in animal and environmental health sectors as well as health care. Given the breadth of federal obligations to health care stewardship initiatives, there must be additional state support dedicated to ensuring that the operations of MOHASC continue and that there are human and material resources available to meet stewardship obligations in other critical sectors of the One Health spectrum.

Minnesota is in an antibiotic-resistance era, in which some infections cannot be treated effectively with antibiotics. Antibiotic resistance impacts every area of medicine, including intensive care, surgery, oncology, and transplant medicine. The CDC has called antibiotic resistance one of our most serious health threats. A 2019 CDC report estimated that antibiotic-resistant bacteria cause infections in nearly 3 million people each year in the U.S., with over 35,000 associated deaths. Combatting antibiotic resistance is a major priority of CDC, the United Nations, and the World Health Organization.

Minnesota, like the wider U.S., has made gradual progress to combat the problem of antibiotic resistance through infection prevention and by improving antibiotic use, a major driver of the problem of antibiotic resistance. During 2013–2017, deaths for antibiotic resistance decreased overall in the U.S. However, in 2020, a significant increase was seen nationally in both antibiotic-resistant infections and the use of antibiotics. CDC surveillance shows increases in some of the most dangerous resistant pathogens, and hospital-onset infections and deaths caused by resistant bacteria increased by at least 15%. MDH surveillance has detected thousands of antibiotic-resistant infections in Minnesotans, and 2022 was a record year in Minnesota for the highly resistant CRE superbug. Driven by strained infection prevention teams and lapses in appropriate antibiotic use, we must redouble efforts now in the coming years to make up for this lost progress.

Resistant bacteria in animals also have serious implications for people. Resistance to multiple classes of antibiotics is not uncommon in *Campylobacter* and non-typhoidal *Salmonella*, the most common causes of foodborne disease. In 2022, the CRE superbug was detected for the first time in a Minnesota veterinary setting. Investigation led to detection of additional related CRE-positive dogs in multiple settings. We must prepare veterinary professionals to prevent, detect, and respond to such a situation in Minnesota.

Because both appropriate and inappropriate use of antibiotics can drive antibiotic resistance, one important action to prevent resistance is "antibiotic stewardship"—ensuring that antibiotics are used correctly, and only when needed, to treat clinical infection. Currently**,** 30–75% of antibiotic use is estimated to be unnecessary or inappropriate across health care settings.[1]

Antibiotic use in any sector, including health care, veterinary medicine, and industry, can contribute to resistant infections in all health settings. Antibiotics and resistant bacteria can accumulate in the natural environment, further complicating the problem in ways that are not yet fully understood. Daily interactions among people, pets, food, and water in our communities ensure that the health of people depends on the health of animals and the environment. Thus, a holistic, or "One Health," approach to antibiotic stewardship is needed. In July 2016, Minnesota agencies and organizations developed the *Minnesota One Health Antibiotic Stewardship Strategic Plan* and made a public commitment to working together to improve antibiotic use.[2] Today, the Minnesota One Health Antibiotic Stewardship Collaborative (MOHASC) is composed of over 100 professionals from dozens of organizations working to meet strategic plan goals. This recommendation summarizes a request for critical state-funded support to continue MOHASC operations and impact the problem of antibiotic resistance in Minnesota.

Proposal:

This recommendation will put dedicated state funding to continue antibiotic stewardship services. This recommendation will accomplish the following:

This investment maintains MOHASC leadership. The investment supports the Director of One Health Antibiotic Stewardship (Epidemiologist Principal, 1.0 FTE), a subject-matter expert in antibiotic stewardship with background in one or more health sectors.

Leadership investment will support a synergistic return in novel initiatives, new grant funding opportunities, and, ultimately, improved health of Minnesotans. MOHASC fosters networking, professional research, and information sharing.

This investment ensures that MDH, through MOHASC, can engage, educate, and provide antibiotic stewardship technical expertise and education to professionals throughout Minnesota, urban and rural, who prescribe antibiotics.

MOHASC is a state-focused interagency initiative that benefits from and contributes to the daily activities of MDH, Minnesota Department of Agriculture, Minnesota Pollution Control Agency, Minnesota Board of Animal Health, and other state boards.

Managing MOHASC and its activities is a full-time job that can best be completed when the Director has flexibility to focus on it fully and expertise to ensure all partners feel heard and understood. Given CDC's growing

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[1] Nicolle LE, Bentley D, Garibaldi R, et al. Infect Control Hosp Epidemiol 2000; 21:537–45.
Lim CJ, Kong DCM, Stuart RL. Clin Interven Aging. 2014; 9: 165-177.
Fridkin SK, Baggs J, Fagan R, et al. MMWR Morb Mortal Wkly Rep. 2014;63(9):194-200
Fleming-Dutra KE, Hersh AL, Shapiro DJ, et al. JAMA 2016;315:1864–73

[2] Minnesota One Health Antibiotic Stewardship Five-Year Strategic Plan. Available at: http://www.health.state.mn.us/onehealthabx/about/plan.html.

expectations for healthcare-focused activities, MDH cannot adequately support One Health initiatives with a staff member who is responsible for federally funded obligations.

This investment enhances MDH activities on infection prevention and control and antibiotic stewardship in companion animal veterinary settings by supporting a Health Program Representative Intermediate (0.5 FTE) to provide technical assistance through the MDH Veterinary Occupational Health and Infection Control Assessment (VOHICA) program.

This investment to expand the reach of the VOHICA program will increase access to antibiotic stewardship technical assistance for clinics throughout Minnesota, not just those who already benefit from advanced training and expertise.

Unlike in human health care, there are no regulatory or financial requirements or incentives in companion animal medicine to drive practice change related to antibiotic use. It is imperative that public health facilitate application of antibiotic stewardship principles in these settings.

This investment supports antibiotic stewardship for Minnesota's food producers by funding the Minnesota Department of Agriculture Drug Residue Prevention Program (DRPP), which supports farmers and veterinarians to use antibiotics responsibly. Prevention of antibiotic residues in food-animal products, like milk, ensures a safe food supply and makes producers operationally stronger.

Minnesota Department of Agriculture (MDA)is a critical partner in MOHASC, and on-farm programs like DRPP have been an effective way for MDA to educate and influence practice change.

This funding will help maintain the impact of DRPP and will tangibly align MDA and MDH objectives in the interagency supported statewide strategic plan.

Impact on Children and Families:

In the largest outbreak of its kind in Minnesota to date, one Minnesota nursing home has experienced 14 cases of the CRE superbug during 2020–2022. This type of outbreak will only become more common if the problem of antibiotic resistance is not curbed through antibiotic stewardship. Resistance affects the most vulnerable among us, including the elderly and children, and those who are hospitalized and immunocompromised.

Antibiotic stewardship programs have been shown to improve antibiotic prescribing appropriateness and decrease rates of antibiotic resistance and adverse patient outcomes.[3]

Antibiotic use can have adverse impacts on individuals exposed to these drugs. There are emerging compelling data on the potential negative impact of antibiotics on the neonatal and infant gut microbiome, health, and development outcomes (e.g., obesity, asthma).

Nationally, 48% of acute respiratory infections, including pediatric ear infections, are not treated with first-line antibiotics. Improvement of antibiotic use for a common condition like ear infections could prevent many individual antibiotic courses, and the unknown effects that they might bring. MDH is using the Minnesota All Payer Claims Database to explore appropriateness of antibiotic use for Minnesotans, including for children's ear infections. MOHASC provides a network to ensure findings from studies like this are disseminated and that best-practice resources are available to all prescribers.

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[3] CDC. Overview and Evidence to Support Appropriate Antibiotic Use. Available at https://www.cdc.gov/antibiotic-use/healthcare/evidence.html.
Ohl CA, Dodds Ashley ES. Antimicrobial stewardship programs in community hospitals: the evidence base and case studies. Clin Infect Dis. 2011 Aug;53 Suppl 1:S23-8; quiz S29-30.

This work aligns with other MDH efforts to protect our vulnerable populations, including efforts to improve infection prevention and control and reduction of healthcare-associated infections in nursing homes and acute care facilities.

Antibiotics are a shared resource. Because our widespread use of these drugs drives the problem of bacterial adaptation and clinical resistance, the use of antibiotics at one point in time impacts the ability to use them in the future. This is a problem that will only grow and become more tenacious for future generations if we do not intervene now. Stewardship initiatives will not only protect the health and wellbeing of children and families, but they will ensure that these lifesaving drugs are available when needed for generations to come.

MOHASC annual direct engagement with over 12,000 members of the public at the Minnesota State Fair, including many children and families, has informed our approach to raising public awareness and has illustrated how much desire there is for this knowledge, especially by families.

Equity and Inclusion:

Although Minnesota is considered one of the healthiest states in the country, statewide assessment has found that Minnesotans with less money, populations of color, and American Indians have consistently fewer opportunities for health and experience worse health outcomes.

Peer-reviewed literature indicates that some ethnic and racial populations might experience more infections and different antibiotic prescribing practices than others. Studies have also shown differences in antibiotic prescribing across geographic areas, which might be related to prescribing behavior and differences in access to care.

MDH is using the Minnesota All Payer Claims Database to explore appropriateness of antibiotic use for Minnesotans with acute respiratory infections. The analysis will explore differences in appropriate treatment across Minnesota geography and social vulnerability index quartiles. MOHASC provides a network to ensure findings from studies like this are disseminated and that best-practice resources related to practice gaps are available to prescribers.

A goal of MOHASC is to get providers to use antibiotics correctly for everyone. This means use for the correct medical indication, at the right time, in the right amount, and for the right duration. As prescription of these powerful medications in Minnesota becomes increasingly based on the principles of stewardship, *all* Minnesotans will benefit from more clinically appropriate decision-making and a decreased risk of acquiring an antibiotic-resistant infection and improved patient safety.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Although we have not consulted with tribal governments about this proposal, professional and public engagement for tribal populations is part of this proposed work. We will engage with MDH's tribal liaisons and with tribal public health staff to ensure public messaging and clinical resources are acceptable and impactful.

IT Costs

None

Results:

Proposed Activity	*Performance Measure*	*Type of Measure*	*Collection*	*Communication*
Maintain MOHASC leadership with state funds.	Number of individual members and organizations represented; Tribal and rural health represented	Quantity	Routine activity tracking	Annual MOHASC activity report
	Annual meeting and quarterly calls yearly	Quantity Quality	Routine activity tracking Meeting evaluation	Annual MOHASC activity report
Ensure antibiotic use awareness and education messages are delivered to prescribers and public.	Estimated number of educational messages (e.g., email, social), events (e.g., webinars), resources (e.g., reports, tools)	Quantity	MDH	Annual MOHASC activity report
	Estimated number of visitors to MOHASC State Fair booth	Quantity Quality	Routine activity tracking Volunteer notes, evaluations	Annual MOHASC activity report
Enhance MDH activities on infection prevention and control (IPC) and antibiotic stewardship in companion animal veterinary settings.	Number of clinics receiving IPC or AS support (virtual, in-person)	Quantity	Routine activity tracking	Annual MOHASC activity report
Support antibiotic stewardship programs for Minnesota's food producers.	Number of producers and veterinarians receiving direct consultation through DRPP	Quantity	Routine activity tracking	Annual MOHASC activity report MDA DRPP reporting

Statutory Change(s):

New statute

Change Item Title: No Surprises Act Enforcement

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,210	1,090	855	855
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,210	1,090	855	855
FTEs	**3.60**	**4.00**	**3.15**	**3.15**

Recommendation:

The Governor recommends a general fund appropriation to implement state enforcement of the federal No Surprises Act. This proposal clarifies and augments the authority of the department to enforce the federal No Surprises Act provisions for health plans the department regulates. The proposal also provides authority for the department to enforce the Act for providers and facilities. Enforcement includes reviewing health plan, facility and provider compliance, investigating consumer complaints, providing consumer education, and coordinating with federal counterparts. The law provides sweeping reforms that protect enrollees in group health plans and group and individual health insurance coverage from surprise medical bills. These protections apply to emergency services, as well as non-emergency services from in-network and out-of-network providers at participating facilities, and air ambulance services from out-of-network air ambulance providers, under certain circumstances. The law also adds protections for uninsured or self-pay patients.

The proposal also includes one-time funding to assess feasibility and stakeholder commitment to develop, manage, and maintain a statewide shared heath care provider directory. This directory would be available to consumers, multiple state agencies (e.g., MDH, DHS, SEGIP, MNsure), as well as health plans and health systems serving Minnesotans.

Rationale/Background:

The federal No Surprises Act largely surpasses existing state law to protect consumers from surprise medical bills. This proposal synchronizes the No Surprises Act and applicable state law and provides enforcement authority and related resources needed for the department to implement and enforce the Act and associated federal rules and guidance. As is the case with other federal laws regulating managed care, the expectation is that states will take on most of the enforcement of these provisions through their regulatory processes. The Act also creates stringent requirements for health plans and health providers to maintain accurate, up-to-date consumer-facing provider directories.

The No Surprises Act provides broad consumer protections against most surprise medical bills (a form of balance billing), establishes a process for determining provider reimbursements for certain out-of-network services, gives uninsured and self-pay patients the right to a good faith estimate in advance of scheduled care and offers a dispute resolution process for them, adds requirements related to consumer transparency about what billing is allowable under the law, and institutes some policy and coverage requirements for health plans in their contracts with providers. Establishing state-based enforcement of the No Surprises Act will ensure consumers are fully protected under the law and that enforcement integrates seamlessly with existing state regulatory structures.

Provider directories are a necessary administrative component of the health system but managing them is very time and resource intensive. The information can be very dynamic as providers enter and exit the market, change organizations, change names/addresses, etc. Currently state agencies develop, or pay to access, provider databases with much duplication of effort for information that is often inadequate for their needs. And each health plan manages their own directory, as do many health systems. This is especially burdensome for provider practices when they need to update their information with multiple health plans and multiple state programs. Furthermore, having multiple directories with no "single source of truth" inevitably means they have conflicting information and therefore create downstream errors and inefficiencies. Without a shared common directory, consumers will need to potentially navigate multiple directories to find the information they need.

Proposal:

The department requests authority, staffing and IT resources to implement and enforce the federal No Surprises Act, which became effective January 1, 2022, and one-time funding for the department to engage stakeholders to determine feasibility and specific needs for a shared statewide solution, and identify requirements for usability, information technology, decision-making processes, and operations. Staffing resources for this critical work to protect consumers are needed to address and resolve consumer complaints regarding provider, facility or health plan surprise billing issues; provide technical assistance to health plans and providers implementing the law, manage complaints between health plans and providers regarding reimbursements and coverage policy, including out-of-network payment requirements established in the Act; conduct random and complaint-based audits of correct implementation of payment policy defined in the Act; respond to consumer inquiries and inform consumers about their rights under the law. A contract for consumer education and outreach will ensure new consumer transparency and notification requirements are met.

Initial costs will include developing or purchasing an IT application to manage complaints and appeals and staffing and contracting for the provider directory assessment. Lower ongoing funds are required for staffing and IT maintenance. Costs for staff attendance at trainings associated with implementing the new federal regulations are expected to be higher in the first two years.

Impact on Children and Families:

The consumer protections from surprise billing will protect children and families, as well as others, from the devastating financial consequences surprise medical bills can bring. Two-thirds of all bankruptcies filed in the United States are tied to medical expenses. Researchers estimate that one of every six emergency room visits and inpatient hospital stays involve care from at least one out-of-network provider, resulting in surprise medical bills.

A statewide provider directory will have a positive impact on children and families. It will be a transformational, comprehensive, user-friendly tool for consumers to help identify their provider options and avoid out-of-network fees by understanding what providers are currently available under their coverage.

Equity and Inclusion:

For many communities that experience financial disparities, this proposal offers financial protections and consumer transparency that should improve understanding of health care access and reduce financial burdens associated with health care costs.

A statewide provider directory can have technical capabilities for providers to include their cultural competencies and language fluency, providing a tool that enables the State to monitor availability of these providers and for consumers to identify providers accordingly.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll	65,000	48,000	20,000	20,000	20,000	20,000
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software	380,000	250,000	250,000	250,000	250,000	250,000
Training						
Enterprise Services						
Staff costs (MNIT or agency)						
Total	**445,000**	**298,000**	**270,000**	**270,000**	**270,000**	**270,000**
MNIT FTEs	0.25	0.20	0.08	0.08	0.08	0.08
Agency FTEs						

Results:
Minnesotans will experience decreased financial hardship from surprise medical bills. The department will enforce all aspects of the federal requirements in a timely manner. The department will develop measures which will be finalized in 2023, once the federal rules are finalized.

This proposal includes an assessment of the current state for: number of provider directories; number/percent of providers registered in these directories; and accuracy and comprehensiveness of provider information. This will be baseline information for future measures.

Statutory Change(s):
62J.5X, 62Q.021, 62Q.55, 62Q.556, 62Q.56, 62Q.73, 62J.9

Change Item Title: Office of African American Health

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	2,182	2,182	2,182	2,117
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	2,182	2,182	2,182	2,117
FTE	**7.00**	**7.00**	**7.00**	**7.00**

Recommendation:

The Governor recommends establishing an Office of African American Health (OAAH) at the Minnesota Department of Health to address the root causes of health inequities that disproportionately impact Minnesota's African American communities. The recommendation includes funding to support the following initiatives:

- Establish and convene an African American Health State Advisory Council (AAHSAC) to advise the Commissioner of Health on issues and to develop specific, targeted policy solutions to improve the health of US born Black Minnesotans.
- Based upon input from and collaboration with the AAHSAC, health indicators, and identified disparities, conduct analysis and develop policy and program recommendations and solutions targeted at improving Black health outcomes.
- Coordinate and conduct community engagement across multiple systems, sectors and communities.
- Establish and award African American Health Special Emphasis grants to health and community-based organizations to develop programs and effective solutions to address identified system issues.
- Develop and administer MDH immersion experiences for students in secondary education and community colleges to improve diversity of the public health workforce and introduce career pathways that contribute to reducing health disparities.

Rationale/Background:

MDH's commitment to advancing health equity was formalized in 2013 with the creation of the Center for Health Equity (CHE) to address specific health inequities in focused communities that experience the highest inequities in the state, including communities of color, American Indians, and lesbian, gay, bisexual, transgender and queer (LGBTQ+) communities, and communities living with disabilities, in both metropolitan and rural Minnesota. Since its inception in 2013, CHE and other MDH programs have advanced initiatives that aim to reduce racial disparities in chronic diseases, sexually transmitted diseases, HIV, and maternal and infant mortality primarily through data collection and analysis, managing programs to facilitate access to care (e.g., cancer screening), and by providing grants to community-based organizations. At the same time, MDH has increasingly recognized the unique issues and needs of multigenerational African American Minnesotans arising from cumulative disadvantage due to discrimination in housing (e.g., residential segregation, redlining), persistent racial gaps in education achievement and employment, and exposure to high levels of concentrated poverty. Unfortunately, because several major social determinants of health are consistently less favorable for African American Minnesotans, Minnesota is now frequently ranked as one of the worst places for African Americans to live. The social, psychological, and economic costs are dire for wellbeing of Black individuals, their families, and communities, contributing to excess morbidity and mortality both now and into the future, as recognized by the burgeoning research on intergenerational effects of health inequities.

U.S.-born Black Minnesotans are predominately descended from individuals and communities subjected to chattel slavery, Jim Crow segregation and mass incarceration (which has been described as the "New Jim Crow"). Historical trauma affects individuals, families, and communities, manifesting in persistent issues with economic inequality, racism, and poverty. Exposure to these stressors contribute to the onset of chronic diseases, such as diabetes; developmental biology and thereby the health of children over their life course; and to the incidence of depression and anxiety. In addition, duration of exposure to such stressors matters greatly. As noted in the Minnesota Department of Health's 2019 report on culturally responsive care, the data "mask disparities impacting U.S.-born Blacks. This is in some part due to a healthy immigrant effect – a well-known phenomenon where immigrants are on average healthier than those who were born in the United States. The disparities are also attributable to structural racism and historical trauma that have negatively impacted outcomes across generations. We see these disparities between U.S. and foreign-born Black populations in Minnesota across education and health outcomes, such as: Minnesota Comprehensive Assessment test scores, high school graduation rates, infant mortality, and birth outcomes."

In order to change to improve African-American health and wellbeing, MDH must address these upstream social factors that disproportionately impact US-born Black Minnesotans. This requires building new multisectoral partnerships, which can collaboratively identify and develop feasible strategies to interrupt the complex, intersecting pathways that contribute to downstream health outcomes. This work complements current efforts by the MDH Center for Health Equity, recognizing the urgent and unique challenges experienced by Black Minnesotans in maintaining healthy lives.

Proposal:

- **Establish an Office of African American Health (OAAH):** MDH will create a stand-alone office to address the unique health needs of Black citizens and work to develop solutions to systems to address identified disparities in Black health arising from a context of cumulative and historical discrimination and disadvantages in multiple systems, including but not limited to housing, education, employment, gun violence, incarceration, environmental factors and health care discrimination. The program goals and operations would be led and managed by 1.0 FTE program manager. A 1.0 FTE would assist with communications and support grants and contract management.
- **Establish an African American Health State Advisory Council:** MDH will establish in state statute an African American Health State Advisory Council (AAHSAC) to advise the Commissioner and MDH on addressing health issues specific to Minnesota's US-born Black population. An advisory council would provide guidance and recommendations on specific policy solutions and public health approaches that would improve Black health outcomes. Membership on the 15-20-member AAHSAC would include: Black community leaders; Black youth and Black elders, academics, and health and human service professionals. Council coordination, activities and communications will be conducted by a 1.0 FTE Planner Principal State.
- **African American Health Special Emphasis Grants:** This proposal establishes a $1,000,000 grant program awarding up to 10 grants, maximum $125,000 annually, to community-based and health organizations to plan and develop programs targeted to improving Black health outcomes, based upon needs identified by the Council, health indicators, and identified disparities, with a focus in Year 1 and Year 2 on addressing historical trauma and systems of US born Black Minnesotans. Grants would be managed by a .5 FTE planner.
- **Community engagement across multiple systems, sectors and communities**
    - **Coordination and engagement across state enterprise**, including DEED, MDE, DHS, Corrections, given racial disparities in health related to labor force participation, educational achievement, and involvement with the criminal justice system that impact African-American health and well-being. This work would be conducted by a 1.0 planner.
    - **Conduct community conversations and community engagement** in order to develop innovative, high impact solutions that are reflected in and supported by policy, grants and research activities. This work would be conducted by a .5 planner.

- **Data analysis and research to support policy goals and solutions** and conduct evaluation studies will be conducted by 1.0 FTE senior research analyst. In addition, MDH will extend a 3-year contract to an academic partner to provide more methodically complex modeling and simulation of potential strategies and estimate potential short and long-term impacts, $60,000 annually.

- **Develop and administer MDH immersion experiences for students in secondary education and community colleges to improve diversity of the public health workforce and introduce career pathways that contribute to reducing health disparities.** Includes financial support to support two student interns and related expenses, $15,000.

Impact on Children and Families:

This proposal builds upon the work of the existing MDH Center for Health Equity's policy, outreach and grants to specifically target the needs of Minnesota's African American communities, children and families to achieve improvements in health outcomes. Numerous studies have found a strong and consistent relationship between child adversity and a variety of health outcomes. According to the CDC, adverse childhood experiences (ACEs) are potentially traumatic events that occur in childhood as well as the conditions in the child's environment that can undermine their sense of safety and stability. Although the original ACEs studies focused on adversities in the home like abuse, neglect, and other household challenges, scholars now agree that child adversity includes other experiences, such as discrimination, race-related stigma, minority stress, and historical trauma.

Equity and Inclusion:

The central purpose of this proposal is to improve the health of African American Minnesotans by addressing inequities and developing solutions targeted to ensure equity and inclusion.

MDH has conducted outreach to Minnesota's African American communities directly by the MDH Assistant Commissioner of Health Equity and through efforts of the Center for Health Equity.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒**No**

Results:

Type of Measure	***Name of Measure***	***Current Value***	***Date***	***Projected Value***	***Date***
Quantity	Develop African American Health State Advisory Council	0	2022	1	2025
Quantity	Meetings with African American Health State Advisory Council	0	2022	12	2025
Quantity	Number of high school and college students engaged in immersion experiences	0	2022	10	2025
Quantity	Number of African American Health Special Emphasis grant projects fund	0	2022	24	2025

Statutory Change(s):

New statute

Change Item Title: Office of American Indian Health

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	2,089	2,089	2,089	2,089
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	2,089	2,089	2,089	2,089
FTEs	**7.00**	**7.00**	**7.00**	**7.00**

Recommendation:

The Governor recommends continued investment into the Office of American Indian Health (OAIH) to further address specific needs of American Indians in Minnesota. In May 2021, with funding from the CDC Health Equity Grant and the CDC COVID 19 Vaccine Implementation Grant, MDH established OAIH. Of the total amount, $1,000,000 annually is for grants. The proposal continues to build upon current OAIH capacity and addresses unmet needs, as follows:

- Provide new grants to address continuing and persistent health disparities specific to Minnesota's American Indian (AI) population.
- Provide workforce development for MDH staff to more effectively work with Minnesota's AI population and Tribal Nations.
- Build capacity through workforce development and technical assistance to AI Community-Based Organizations and Tribal Nations to address the very complex needs of a highly traumatized population, both historically and currently with COVID 19.
- Address unmet communications, fiscal management, administrative and data analysis needs of the OAIH to better serve the Minnesota's tribal communities.

Rationale/Background:

American Indian women, children, and families experience some of the largest health disparities both nationally and in Minnesota. These health disparities are related to state and federal policies which created many of the modern systemic barriers to opportunities. These systemic barriers have widespread effects on various Social Determinates including access to adequate healthcare, high-quality culturally affirming education, sustainable employment, and food & nutrition insecurity. Coupled with historical underfunding of programming, the result is, Native Americans experience the highest rate of poverty, highest rate of health disparities, smallest graduation rates, high unemployment, and lowered access to nutritional foods. According to the CDC, this disproportionality was highlighted by the COVID-19 pandemic to clearly show how the systemic barriers continue to have a profound impact on the delivery of Native American and Alaska Natives public health.

The losses experienced by American Indian people are not confined to a single catastrophic period but rather they are ongoing and present in their lives. The American Indian experience of historical trauma is both a source of intergenerational trauma responses and a potential causative factor for long-term distress and substance abuse

among communities[1]. Anxiety/affective disorders and substance dependence have shown to be correlated with historical loss associated symptoms[2]. Another link in the chain of intergenerational trauma is perpetuated through gestational stress, which can be caused by difficult life events, depression and anxiety, economic inequality, racism, and poverty, among other factors[3]. Stress experienced in this way modifies the developmental biology in offspring, increasing their risk for everything from diabetes and heart disease to obesity, and lowering their ability to be resilient and handle stress well[4]. In adulthood, they may find that any stress compounds the mental and physical impact of that early stress.

Proposal:

This proposal builds upon and strengthens capacity of the MDH Office of American Indian Health (OAIH) to work with Minnesota's American Indian tribal communities to address long-standing health disparities, including the underlying structural and systemic issues that have created and sustained poor health outcomes and persistent health disparities among American Indians in Minnesota. The OAIH will work in partnership with MN tribal and urban American Indian organizations to support the development and/or maintenance of American Indian public health approaches *by and for* American Indians in MN to address the underlying causes of health disparities and advance health equity. The OAIH will provide overall leadership for the development of holistic health and wellness strategies to improve health and support tribal/urban American Indian public health leadership and self-sufficiency. The OAIH will also provide technical assistance to tribal and American Indian urban community leaders to develop culturally appropriate activities to address public health emergencies (e.g., disease outbreaks, natural disasters, cyber-attacks, and other public health emergencies). Components of this proposal:

1. **American Indian Special Emphasis Grants:** This proposal establishes a $1,000,000 grant program awarding up to 10 grants, maximum $125,000 annually, to Minnesota's Tribal Nations and Urban American Indian Community Based Organizations to plan and develop programs targeted at improving American Indian health outcomes, based upon needs identified by the Council, health indicators, and identified disparities, with a focus in Year 1 and Year 2 on addressing historical trauma and systems. Grants would be managed by a .5 FTE planner.
2. **MDH Division-Specific American Indian expertise:** This effort will ensure that all MDH program areas incorporate and employ strategies that focus on improving American Indian health. OAIH will provide consulting, evaluation, expertise and training to program areas including environmental health, infectious disease, child and family health, health promotion and chronic disease, health systems and health care access, and aspects of MDH operations. In addition to program-specific consultation services, OAIH develop and coordinate an AI/Tribal Nations Community of Practice to support division and program-level change in addressing the systemic disparities seen in the AI population. This work is supported by 1 FTE planner and .5 senior research analyst.
3. **Workforce Development and TA for Tribal and AI CBO capacity:** As requested or needed, MDH will provide TA and Training on Quality Improvement, Health Assessment, staffing capacity development for Tribal Nations and AI CBO, with resources such as internal OAIH staff and external Public Health Americorp and other training programs for Public Health. This work is supported by .5 FTE planner and .5 senior research analyst. Required in-state travel to support tribal capacity is budgeted at $20,000.
4. **Administrative or programmatic capacity:** Program leadership, communications and management support will require 1 FTE program manager, 1 FTE administrative support and 1 FTE analyst to support

[1] Les Whitbeck, B., Chen, X., Hoyt, D. R., & Adams, G. W. (2004). Discrimination, historical loss and enculturation: culturally specific risk and resiliency factors for alcohol abuse among American Indians. Journal of studies on alcohol, 65(4), 409–418. https://doi.org/10.15288/jsa.2004.65.409

[2] Ehlers, C. L., Gizer, I. R., Gilder, D. A., Ellingson, J. M., & Yehuda, R. (2013). Measuring historical trauma in an American Indian community sample: contributions of substance dependence, affective disorder, conduct disorder and PTSD. *Drug and alcohol dependence*, *133*(1), 180–187. https://doi.org/10.1016/j.drugalcdep.2013.05.011

[3] https://www.heart.org/en/news/2021/05/06/prenatal-stress-can-program-a-childs-brain-for-later-health-issues

[4] Beals, J., Novins, D. K., Whitesell, N. R., Spicer, P., Mitchell, C. M., & Manson, S. M. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: mental health disparities in a national context. The American journal of psychiatry, 162(9), 1723–1732. https://doi.org/10.1176/appi.ajp.162.9.1723

capacity building, communications and outreach, ongoing operations and grants management and reporting.

5. **Develop and administer MDH immersion experiences for students in secondary education and community colleges to improve diversity of the public health workforce and introduce career pathways that contribute to reducing health disparities.** Includes financial support to support two 0.25 FTE student interns and related expenses and a .5 FTE planner to develop and oversee program and conduct student outreach in high school, middle schools, and elementary schools.
6. **Other operating costs:** Budgeted supplies and expenses of $25,000 include staff instate travel, room rentals for community meetings and associated meeting costs, incentives to support advisory council member participation.

Impact on Children and Families:

Improving the overall population heath will impact AI Children and Families in all areas. American Indian children and families need opportunities to build resilience from the significant and often toxic stress and trauma experienced by genocide and colonization. Providing opportunities for AI children and families to learn skills for self-regulation, social connection, cultural identity, as well the opportunity to grieve as a community are critical for everyone. Experiencing healthy outlets for grief and recovery will help children build a positive identity, self-determination, and self-efficacy. This recommendation will afford the historic opportunity to not just mitigate the impact of the trauma endured by children, but create stronger communities that will foster resilience, connection, and cultural healing.

Equity and Inclusion:

This project fully and directly aligns the state's goals for equity and inclusion, and in fact, builds capacity specifically around equity and inclusion.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Tribal Health Directors and Tribal Elected Leaders (through MIAC) have been informed about the 2021 creation of an Office of American Indian Health and this capacity-building request. The MDH Tribal Liaison is scheduling individual Tribal Consultation meetings with each Tribal Nation to conduct a formal Tribal Consultation on the OAIH between September and December 2022.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Future Value*	*Date*
Quantity	MDH programs engaged in efforts to more effectively serve AI and Tribal Nations.	25%	2022	80%	2025
Quantity	Percent of AI representation in MDH leadership	2	2022	5%	2025
Quantity	Percentage of Tribal and AI CBO's requesting TA from MDH	0	2022	75%	2025
Quantity	Number of implemented 'healing from historical trauma' strategies per each focus community	0	2022	At least 5 strategies	2025

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Future Value*	*Date*
Quantity	Number of participants per each grantee by activity	0	2022	12-15 participants annually	2025

Statutory Change(s):
New statute

Change Item Title: Public Health System Transformation

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	17,120	17,120	17,120	17,120
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	17,120	17,120	17,120	17,120
FTEs	**5.5**	**5.5**	**5.5**	**5.5**

Recommendation:

The Governor recommends an ongoing general fund investment in the state, local, and tribal governmental public health system to fulfill foundational public health responsibilities. This request would substantially enhance the public health system to have the skills and resources needed to prevent and control infectious diseases, address environmental health threats, improve the health of communities, and improve access to health care services. Of the total amount each year, $15,750,000 will be provided in grants to local public health and tribes and $500,000 will be for a grant with a Minnesota AmeriCorps organization.

Rationale/Background:

Public health protection should not be conditional or determined based on one's locality. State, local, and tribal public health departments have a unique responsibility and play an important role in diagnosing, preventing, and responding to public health challenges. Health care systems, schools, businesses, and community-based organizations rely on public health departments for health data and information, partnership development, health guidance, and policy analysis, among other things. Over time, eroding funding, emerging health threats, widening health inequities, and the need for new skills and capabilities has left Minnesota with a public health system of state, local and tribal health departments that can best be described as a patchwork quilt of programs and activities. COVID-19 only highlighted the gaps that MDH has documented in several reports including inability to carry out foundational public health responsibilities, insufficient funding, and an inadequate workforce. Currently only 51% of Minnesota's population is covered by a health department that has demonstrated their ability to carry out foundational public health responsibilities as demonstrated by national public health accreditation.

While it is challenging to estimate the cost needed to fully fund Minnesota's public health system, national estimates indicate there is a $32 per person gap between what local health departments spend now and what they would need to spend to fully meet public health responsibilities. Studies done in the states of Washington, Oregon, and Ohio also found a significant funding gap. Minnesota is doing their own cost study with funding from the 2021 legislative session to get a better understanding of Minnesota's state, local, and tribal public health funding needs. Minnesota is also exploring new ways to fulfill public health responsibilities across jurisdictions to capitalize on unique local strengths, address resource constraints, and meet individual community needs. In the meantime, this proposal will serve as a down payment on a fully funded public health system. As we have seen in the past, the influx of one-time, restricted federal funding to respond to specific diseases (Zika Virus, H1N1, COVID-19) will not build the public health capacity needed for the future. Local public health, community health boards, tribal public health, and MDH leaders from across the state believe now is the time to make the entire public health system work better for all communities and move from a patchwork quilt of services and activities

that are driven by a complex mix of inconsistent and inflexible funding to one that every community can expect a basic level of public health protections.

Proposal:

MDH is seeking an ongoing investment in the state, local, and tribal governmental public health system so it can carry out the most basic, foundational public health responsibilities through the following:

- **Funding for Community Health Boards:** $15 million for local health departments to fulfill foundational public health responsibilities. A portion of these funds may be used for new ways to fulfill public health responsibilities across jurisdictions
- **Funding to Tribal Governments:** $750,000 for tribal health departments to fulfill foundational public health responsibilities.
- **Office of American Indian Health:** Staff to support the development and maintenance of tribal public health infrastructure.
- **MDH staff to support local and tribal health departments:** Staff to support local and tribal health departments to fulfill foundational public health responsibilities including regional public health system consultants, subject matter experts in foundational public health responsibilities, and staff to manage the distribution of funding and support the broader development of robust accompanying performance improvement and fiscal management systems.
- **Support for Minnesota's public health AmeriCorps program**: $500,000 for a Minnesota organization to enhance the federally funded Public Health AmeriCorps program and pay the members a living stipend. Public Health AmeriCorps members will enhance the state's public health workforce by increasing its size and diversity.

Impact on Children and Families:

Every child deserves to live in a healthy community. State, local, and tribal health departments have a unique responsibility to protect and promote the health of communities across Minnesota. An investment in the public health system would ensure that health departments across the state can share timely, locally relevant data on maternal and child health trends; bring together community partners and resources; and advance policy, systems, and environmental changes to prevent harm and improve the health of children and families.

Equity and Inclusion:

Minnesota's public health leaders recognize that to address health inequities, significant change is needed. Specifically, state and local health departments need to improve their capacity to collect and use data to advance health equity by engaging with populations most impacted by health inequities; examining and fix their own practices for bias; diversifying their workforce; and informing policies that advance health equity. State, local, and tribal public health leaders recognize the need to work together, yet our systems and structures do not always support working together. Roles and responsibilities are unclear and the state funds that go to Tribal governments for public health are for specific areas of work and do not have the same level of flexibility as the local public health grant. This proposal aims to further efforts to clarify roles and provide tribal governments with the funds needed for building public health capacity.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

This proposal recognizes tribal governments as part of the public health system with support, technical assistance, and funding. It increases MDH's capacity to work with tribal health departments through an Office of American Indian Health. MDH's tribal liaison has been in conversation with tribal health directors and the MN Indian Affairs

Council, and both informally support an Office of American Indian Health and funds to tribal governments. Over the past four years tribal health directors have been working with MDH to strengthen the public health delivery system. Nine of the eleven tribes have already signed agreements to receive funds and work with MDH on developing their own tribal public health systems and identify when and how to coordinate with the state and/or local health departments.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	% of local and tribal health departments with a plan for public health transformation	0%	2021	0%	100%	2025
Quality	% of health departments satisfied with support for transformation planning provide by MDH	N/A	2021	25%	80%	2025
Results	% of MN's population served by a local health department that meets national standards	51%	2021	51%	100%	2028

Statutory Change(s):

Minnesota Statutes, section 145A.131 (Local Public Health Grant)
Minnesota Statutes, section 145A.14, Subdivision 2a (Special Grants, Tribal governments)

Change Item Title: Repeal Women's Right to Know and Positive Alternatives Programs

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	(3,679)	(3,679)	(3,679)	(3,679)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(3,679)	(3,679)	(3,679)	(3,679)
FTEs	**-2.6**	**-2.6**	**-2.6**	**-2.6**

Recommendation:

The Governor recommends repealing the existing language in Minnesota Statutes, sections 145.4235 and 145.4243-44. This repeal will eliminate the Positive Abortion Alternatives grant program and the requirement for the Minnesota Department of Health to produce materials (printed and web-based) on fetal development and a related directory of services for pregnant people by county.

Rationale/Background:

Minnesota Statutes, section 145.4235: In 2005, the Minnesota Legislature, in Minnesota Statutes Section 145.4235, directed the Minnesota Department of Health (MDH) to establish a grant program to fund non-profit organizations that promote healthy pregnancy outcomes and assist pregnant and parenting people in developing and maintaining family stability and self-sufficiency. The Positive Alternative (PA) grantees support healthy pregnancy and parenting outcomes through provision of services such as medical care, nutrition services, housing assistance, adoption services, education and employment assistance, childcare assistance, parenting education and support services. Under Minnesota Statutes, section 145.4235, the PA program explicitly prohibits grantees from counseling on abortion and cannot refer pregnant people to providers or organizations that perform abortions, even if those organizations may provide additional supportive services. In 2021, 27 grants were awarded for 5-year grants with annual total funding of $3,357,000. All grantees are non-profit organizations, and they vary widely from state-wide crib distribution programs to crisis pregnancy centers, also known as pregnancy resource centers, serving local communities in all regions of the state. Each grantee has its own workplan detailing the types of services that are provided in alignment with the statute and grant requirements. Current grantees are included at this site: Positive Alternatives Locations - MN Dept. of Health (state.mn.us).

The PA grantee programs are duplicative of the Minnesota's Family Home Visiting program, which provides evidence-based and evidence-informed pregnant and parenting support services through all 87 counties through local public health, tribal health, and non-profit organizations.

Minnesota Statutes, sections 145.4243-44: In 2003, the Minnesota Legislature passed the Woman's Right to Know Act, and part of this legislation directed MDH make certain information available in print and on a website (Minnesota Statutes, section 145.4243--44). The information provided in the Women's Right to Know booklet is designed to provide basic, medically accurate information on fetal development in two-week intervals from fertilization to birth. As required by the statute, the booklet also includes information on the methods of abortion, the medical risks associated with abortion, and the medical risks associated with pregnancy and childbirth. The booklet was last updated in December 2022. In addition, MDH is required to produce a geographically indexed directory of services to assist pregnant people through pregnancy, upon childbirth, and while the child is

dependent, including adoption agencies. MDH maintains the printed versions of the booklet and directory in English and Spanish as well as a dedicated website (https://www.health.state.mn.us/people/wrtk/index.html) and phone number for individuals seeking these services.

On July 11, 2022, a Ramsey County District Court ruled that part of the Minnesota Women's Right to Know Act—Minnesota Statutes, section 145.4242—violated the Minnesota Constitution (Doe v. State, 62-CV-19-3868). This section previously required health care providers to disclose specific information to a patient at least 24-hours before performing an abortion and share the Women's Right to Know materials with any individual seeking an abortion. Health care providers are no longer legally required to provide this information. However, this ruling did not change the requirement for the MDH to make available the Women's Right to Know materials.

Proposal:

This proposal is to repeal Minnesota Statutes, section 145.4235, which will end the Positive Alternatives grant program. MDH recognizes the importance of supporting comprehensive and accurate reproductive information and health care and in supporting families with young children to thrive. Repeal of this section will end a program that does not support this goal. Because Minnesota's PA program restricts the provision of comprehensive reproductive health counseling, including all pregnancy options, and it is duplicative of the existing, broadly accessibly Family Home Visiting programs, the Governor recommends a repeal of Minnesota Statutes Section 145.4235.

In addition, the Governor seeks repeal of Minnesota Statutes Section 145.4243-44, which requires MDH to maintain and publish the Women's Right to Know materials. Because the information provided under Minnesota Statutes Sections 145.4243-44 fails to ensure that pregnant people and families receive necessary comprehensive, unbiased, and accurate medical information in a manner consistent with national standards of care (individually responsive, culturally, and linguistically appropriate) and because it is duplicative of other dependable and readily accessible information sources, the Governor proposes repeal of Minnesota Statutes Section 145.4243-44.

This proposal reduces the Health Improvement general fund base by $3,357,000 per year in grant expenditures and by $322,000 per year in programmatic expenses.

Impact on Children and Families:

This proposal impacts pregnant people, parents, and children in Minnesota by ensuring that pregnant people are provided with full reproductive information and health care, are not restricted in access to reproductive health care due to their choice of service provider. Moreover, it ensures that pregnant people, parents, and families receive medical information in a shared-decision making-manner, in accord with national standards of care, that is individually responsive and culturally and linguistically appropriate.

Equity and Inclusion:

Pregnant people and families served by the Positive Alternatives grantees are denied access to full reproductive health education, counsel, and referral due to Minnesota Statutes Section 145.4235 prohibition against provision of all reproductive options. Repeal of Minnesota Statutes Sections 145.4243-44 also prevents needless duplication and wasted funds; similarly, repeal of this statute promotes equity and inclusion insofar as medical information can be offered in an unbiased, individually responsive manner.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs
None.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	State dollars used to provide non evidence-based pregnancy care	$3,679,000	FY 2022	$3,679,000	$0	FY 2024

Statutory Change(s):
Minnesota Statutes Section 145.4235 repealed.
Minnesota Statutes Sections 145.4243-44 repealed.

Change Item Title: Revitalize Health Care Workforce

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Health Care Access Fund				
Expenditures	13,350	15,364	14,819	14,818
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	13,350	15,364	14,819	14,818
FTEs	**9.15**	**9.10**	**8.65**	**7.95**

Recommendation:
The Governor recommends a health care access fund appropriation to comprehensively address critical challenges in growing and revitalizing Minnesota's health care workforce to serve our rural and urban underserved families and children. This proposal also addresses persistent shortages, which have been exacerbated by the COVID pandemic. Addressing these shortages requires an array of financial supports, incentives, and systematic research to evaluate needs and program effectiveness. This proposal includes approximately $10,420,000 annually in grants to health care providers and their higher education partners to expand the health care workforce. This request includes the following components:

Rural Training Tracks and Rural Clinicals to grow our rural primary care workforce, by supporting accredited rural training tracks for primary care physicians, credentialed rural tracks or specialized training for nurse practitioners, specialized training for rural physician assistants, and rural fellowships for oral health providers.

Workforce Research to provide needed information on status and causes of workforce shortages, maldistribution of health care providers in Minnesota, and determinants of practicing in rural areas.

International Immigrant Medical Graduate (IIMG) Training to provide additional clinical training opportunities for international immigrant medical graduates to fill a gap in their preparedness for medical residencies or transition to a new career making use of their medical degrees.

Site-based Clinical Training to assist health care systems, hospitals, clinics, and other providers in increasing the availability of clinical training for students, residents and graduate students that reaches beyond the Medicaid constraints of the MERC program and provides assistance for facilities that take on training for new health care provider types or additional trainees.

Mental Health for Health Care Providers to help health care entities establish or expand programs focused on improving the mental health of health care professionals and address structural practices that exacerbate stresses on the workforce, and to evaluate the impact of the programs on health care professional burnout and retention.

Employee Recruitment Education Loan Forgiveness Program for communities in dire need of health care professionals to use loan forgiveness as a recruitment tool, ensuring that qualified successful recruits will receive loan forgiveness awards along with an extended requirement to practice at the facility.

Rationale/Background:

The dominant theme in the pandemic recovery has been labor shortages across all sectors, when pre-pandemic hiring demand had already been at an all-time high and projected to get worse. The health care sector has been uniquely challenged – hospitals, clinics, nursing homes, pharmacies, EMS and others are all struggling to hire, and are finding that new hires are not as prepared for the clinical aspects of their work as is needed, leading to even greater stress on current staff. The pandemic has worsened the availability of clinical training opportunities, the ability of preceptors to take on students in rural areas, and it has heightened the need for deeper workforce research knowledge to address workforce shortage issues more effectively.

Rural Training Tracks and Rural Clinicals

We know that physicians tend to practice where they train. Funding will be used to create and launch rural clinical training opportunities to grow our primary care physician workforce and integrate health equity and population health standards into the curriculum. Investments are needed to launch three new family medicine residency rural training track programs in greater Minnesota and one psychiatry residency rural training track program. Each rural track would train at least two residents, ensuring a continuous primary care physician pipeline in these high-need fields and helping ensure both health and economic vitality of rural areas. Funding will also be used to expand rural rotations and clinical training opportunities for pre-licensure nurse practitioners, physician assistants, and behavioral health students. Three oral health fellowships will also be launched for recent dental graduates to spend 12 months in rural/long-term care sites.

Workforce research

Additional workforce research capacity will enable the state to better understand topics such as: career laddering for licensed practical nurses to registered nurses; projections and forecasting of the health care workforce; quantifying the need for health providers by region and specialty; reasons for long-term care workforce shortage and policy options to increase this workforce; barriers to independent practice for advanced practice registered nurses; and impact of preceptor incentives on preceptor participation. In addition, MDH would collaborate with the University of Minnesota on the determinants of rural practice and how to better shape programs to match interest and incent rural practice.

Immigrant International Medical Graduate (IIMG) Training

The nine-month clinical experience program component of the Immigrant International Medical Graduate (IIMG) program has been successful in preparing IIMGs for U.S. residencies, but it is limited in the number of participants it can serve annually; additional funding will allow the creation of additional clinical training and other opportunities that will enable IIMGs to put their medical backgrounds to work serving Minnesotans.

Site-based Clinical Training

The current Medical Education and Research Costs (MERC) program is effective in providing support for clinical training in the facilities it funds, but it is facing new limiting rules and restrictions by CMS. As a result, it does not have the ability to support some existing or new clinical training sites that specifically address the rural and underserved primary health care training needs in Minnesota. Under this proposal, the state would focus on rural and health equity sites and make funding available to facilities that provide the training that meets this demand.

Mental Health for Health Care Providers

The COVID pandemic has exacerbated the stress on health care providers and led to unprecedented levels of burnout and early retirements. In addition to identifying the services and supports that help practitioners find balance and support for their mental health challenges, health care facilities and systems recognize the need to develop practice models that do not allow service providers to routinely experience the stresses unveiled by the pandemic. This grant program will be evaluated, and the best practices identified will be shared across the health care system.

Employee Recruitment Education Loan Forgiveness Program
Some rural communities find it extremely difficult to recruit primary care providers to their health care facilities. The regular loan forgiveness program, while extremely effective in retaining health professionals in rural areas, does not provide the help in recruitment that these sites need. This proposal would fund a pilot program to identify communities in dire need and allow them to use loan forgiveness as a recruitment tool, ensuring that qualified successful recruits will receive loan forgiveness awards along with an extended requirement to practice at the facility.

Proposal:

The department requests funding to comprehensively address the critical challenges in growing and revitalizing Minnesota's healthcare workforce to serve our rural and urban underserved families and children. This proposal also addresses persistent shortages, which have been exacerbated by the COVID pandemic. Staffing costs to develop and administer the grant programs and conduct the on-going outreach and research needed is included in each item of the proposal. This request includes the following components:

Rural Training Tracks and Rural Clinicals
This includes on-going costs to support rural clinical training opportunities to grow our primary care workforce. This will fund four rural training track medical residency programs located in Greater Minnesota (3 Family Medicine and 1 Psychiatry) to train eight to twelve medical residents, at least two in each program on an on-going basis. By fiscal year 2028, each site will be training at least two first-year residents; two second-year residents; two third-year residents, and two fourth-year psychiatry residents. In addition, it will provide 4-10 week-long rural rotations to 18 physician assistant students in 5 sites; 24 nurse practitioner students in 6 sites; 50 mental health students in 25 sites; and fund three 12-month, rural fellowships for oral health providers.

Workforce Research
This will support research that provides needed information on status and causes of workforce shortages, maldistribution of health care providers in Minnesota, and determinants of practicing in rural areas. In addition, we will update the healthcare workforce data infrastructure and convert to a more streamlined data collection service.

Immigrant International Medical Graduate (IIMG) Training
This will provide one clinical training program and one short-term training opportunity for an additional 15-30 international immigrant medical graduates to fill a gap in their preparedness for medical residencies or transition to a new career making use of their medical degrees.

Site-based clinical training
This additional funding will support health care facilities training approximately 530 additional primary care providers that will not qualify for the MERC program. Additionally, this funding supports initial and on-going updates to the MERC data portal.

Mental Health for Health Care Providers
This includes funding to award grants to health care entities, including but not limited to health care systems, hospitals, nursing facilities, community health clinics or consortium of clinics, federally qualified health centers, rural health clinics, or health professional associations for the purpose of establishing or expanding programs focused on improving the mental health of health care professionals and identifying and modifying structural barriers in health care delivery that create preventable stress in the workplace.

Employee Recruitment Education Loan Forgiveness Program
This includes a pilot program that identifies approximately ten communities in dire need of primary care providers and allows them to use loan forgiveness as a recruitment tool, ensuring that qualified successful recruits will receive loan forgiveness awards along with an extended requirement to practice at the facility.

Impact on Children and Families:
Access to equitable primary, mental and oral health is the prerogative of all residents, families and children included. Each of the initiatives identified above address critical issues along the training and practice continuum of the workforce pipeline that will bring more qualified and prepared healthcare providers in the field.

Equity and Inclusion:
Inadequate access to health is an equity issue. When providers are scarce, rural and underserved populations experience the shortages most severely. These proposals will encourage providers from rural, BIPOC, and other underrepresented communities to practice in Minnesota's rural and underserved communities, thereby improving access to culturally competent and concordant care. Emphasis on health equity and population health needs will yield providers skilled and empathetic to the needs of the people they serve and address disparities in rural care availability.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

Category	***FY 2024***	***FY 2025***	***FY 2026***	***FY 2027***	***FY 2028***	***FY 2029***
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software	336,050	212,050	154,550	154,550		
Training						
Enterprise Services						
Staff costs (MNIT or agency)						
Total						
MNIT FTEs						
Agency FTEs						

Results:

Type of Measure	***Name of Measure***	***Future***	***Dates***
Quantity	8 residents per year successfully matched into rural training tracks; FM is a 3-year and Psych a 4-year program (*RTT & rural clinicals*)	2 per program per year;	July 2027 first RTT matriculates into program

Type of Measure	*Name of Measure*	*Future*	*Dates*
Quantity	Increase in number of studies and reports yielding useful analysis of workforce needs and solutions (*Workforce research*)	2 per year	2024
Quality	Increase the number/percent of the rural workforce that come from BIPOC or other diverse groups, thereby improving available culturally competent care (*IMG training*)	5-10 IIMGs in training	2024
Results	Ability to use Minnesota-specific workforce research in developing health care policies that are responsive to state needs. (*Workforce research*)	TBD	2024 and beyond
Results	Improved clinical outcomes and economic health/stability in rural and underserved communities where rural training tracks have resulted in primary care providers familiar with the unique attributes and population issues facing rural community members.	95 new rural-ready providers with rural training experiences	2026 and beyond

Statutory Change(s):
To be determined.

Change Item Title: School Health

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,432	1,932	2,983	2,983
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,432	1,932	2,983	2,983
FTEs	**3.5**	**3.5**	**3.5**	**3.5**

Recommendation:

The Governor recommends a general fund investment to provide competitive grants to expand health education and health services to existing or new school-based health clinics (SBHC) and schools statewide to meet the health needs of students K-12. These grants will support schools in their response to physical, mental, and behavioral health needs of their students. This work would be in collaboration with the Minnesota Department of Education (MDE) to align support for mental and physical health services. Of the total appropriation, $800,000 will be given as grants in fiscal year 2024, $1,300,000 will be given in grants in fiscal year 2025, and $2,000,000 in grants thereafter.

Rationale/Background:

Schools have direct contact with young people aged 5 to 18 years, for about six hours per day and up to 13 critical years of their social, psychological, physical, and intellectual development. Schools play an important role in promoting the health and safety of children and adolescents by helping them to establish lifelong health patterns. Healthy students are better learners and academic achievement bears a lifetime of benefits for health. Schools are an ideal setting to teach and provide students with opportunities to improve their dietary and physical activity behaviors and manage their chronic health conditions (asthma, diabetes, epilepsy, food allergies, and poor oral health). When school health policies and practices are put in place, healthy students grow to be healthy and successful adults. National evidence demonstrates school-based care can address education equity, assist the whole community, support the current mental health crisis, and provide an affordable and sustainable safety net for children.

Children and adolescents benefit from access to high quality medical, mental, and behavioral health services from health care providers who understand child, adolescent and young adult health and development. Young people prefer health services that are youth-friendly, culturally competent, affordable, accessible, convenient, and confidential. COVID-19 and the trauma around the on-going global pandemic has had a tremendous impact on young people's physical health, prevention services, including vaccination rates, social emotional learning, coping skills, and overall mental health.

Currently, there are seven sponsoring agencies, operating 27 school-based health centers (SBHCs) in Minnesota, and these clinics serve approximately 9,000 students with routine check-ups, mental health screening, management of chronic conditions like diabetes, and routine dental services. Most students in Minnesota do not attend school in a district with a school-based health center. There are ten school districts with SBHCs in their district and there are 331 independent school districts in the state. There is strong evidence that SBHCs increase

access to care, improve health outcomes, and increase academic achievement for participating children. Schools that have SBHCs integrated into their community report:

- Increased attendance and student time spent in classroom
- Improved student behavior and decreased disciplinary referrals
- Barrier-free access to mental health treatment
- Lower dropout rates and higher graduation rates
- Improved school climate or learning environment as reported by students, teachers, and parents

Proposal:

This proposal would implement the school health initiative to strengthen and expand the health promotion and health care delivery activities in schools for improving the holistic health of students. Under this proposal, MDH will provide $800,000 in FY2024, $1,300,000 in FY2025, and $2,000,000 in FY2026 and annually thereafter in competitive grants to expand services in existing or new SBHCs statewide to meet the mental and physical health needs of young people. Grants would be used to help SBHCs in their response to the physical and mental health needs of young people in a convenient location. In addition, MDH will provide $300,000 annually to the Minnesota School Based Health Alliance (SBHA) to ensure best practices in school-based care, address sustainability and equity of care delivered in schools, and to expand throughout Minnesota.

The specific services provided by each school and their delivery model may vary based on community needs and resources as determined through collaborations between the community, the school district, health care providers, and local public health. The intention is to support schools on educating students while health care organizations provide whole-child wellness care in the same place. Grants would support SBHCs to:

- Promote teen-centered health care (youth-friendly care)
- Provide accessible health care to all regardless of ability to pay
- Ensure confidentiality in health care for adolescents and young adults
- Enroll children, adolescents, and young adults in health insurance
- Increase focus on mental wellness
- Increase access to mental health services and supports

The proposal includes MDH staff to: 1) plan and coordinate the initiative across the state and local levels, and ensure compliance with terms of the grants detailed above, 2) provide oversight to the school health portfolio to improve the department's collaboration and coordination with MDE, school districts, and school health services, 3) collaborate with school nurses and other school health staff to build effective partnerships with SHBCs, support nurse practice and training with SBHC clinical staff, and strengthen the nurse leadership of the school nurses, and 4) approve invoices and other financial requirements.

Impact on Children and Families:

SBHCs are a transformational and evidence-based approach for delivering health care to children and adolescents. School-based health care means that students K-12 can get a flu shot, have an annual physical, have their teeth examined and their eyes checked, or speak to a mental health counselor in a safe, nurturing place without the

barriers that families too often face. School-based health care is one of the best models for assuring all children and adolescents can enjoy good health and achieve their fullest potential.

This proposal intends to strengthen and expand the health promotion and health care delivery activities in schools using the SBHC model which is an evidence-based approach for delivering health education, care and support to children and adolescents through coordinated and youth-centric environments.

Equity and Inclusion:

The School Health Initiative is an effective framework to address racial, historical, cultural, and economic disparities in educational opportunity. Integrating and coordinating health and education through the SBHCs model efficiently and cost-effectively addresses health inequities like access to mental health support, vaccines, vision care, and other essential medical care for children and youth in Minnesota. Minnesota has a variety of successful working models of SBHCs, which partner health care providers and schools or entire districts that educate children while health care organizations provide whole-child wellness care in the same place. These models are imbedded into the school culture, woven into relationships with parents, teachers, administrators, and allied service providers such as school counselors, social workers, and school nurses.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

None

Results:

Part A: Performance measures

Currently, SBHCs voluntarily report performance measures to the SBHA, including number of students served and limited data on outcomes. Through the SBHA, MDH, SBHCs, and other stakeholders will define a set of priority performance measures building on the national School Health Services National Quality Initiative. Under this grant opportunity, MDH will require a small set of performance measures from each SBHC grantee, and simultaneously, MDH will build the SBHA's capacity to collect, monitor, and communicate performance measures from across all SBHCs in the state.

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quantity	Number of students served by grantee SBHCs	9,000	11,250	FY 2021 FY 2026
Quality	Percentage of students reporting their health needs were met at the clinic (student satisfaction survey)	No baseline	75%	FY 2026
Result	Percentage of students screened with a positive depression screening will decrease	60%	50%	FY 2020 FY 2026

Part B: Evidence-based practices

Evidence-based Practice	**Source of Evidence**
School Based Health Centers	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/school-based-health-centers

Statutory Change(s):

New statute required to establish the program in Minnesota Statues 145.XXX.

Change Item Title: Sentinel Event Reviews for Police-Involved Deadly Encounters

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	561	561	561	561
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	561	561	561	561
FTEs	**3.0**	**3.0**	**3.0**	**3.0**

Recommendation:

The Governor recommends general fund dollars to establish law enforcement-involved deadly force encounter sentinel event review committees. Of the total investment, $50,000 annually is for grants. Multidisciplinary committees will meet no less than once a year to identify opportunities for prevention and make actionable recommendations to state policymakers.

Rationale/Background:

Attorney General Keith Ellison and Department of Public Safety (DPS) Commissioner John Harrington note in the forward in the report of Minnesota's 2019 working group on law enforcement-involved deadly force encounters, that "any encounter between police and community that results in injury or death is not only a tragedy for the person that is injured or killed; it is life-altering for their loved ones and the officers involved, and has a profound impact on the community."

A wave of growing public concern over law enforcement-involved deadly force encounters deaths has arisen in Minnesota and the United States in recent years. Estimates from public health scholars suggest that these incidents occur frequently in the United States. For example, one study in the American Journal of Public Health estimated that between 2012 and 2018, an average of 2.8 people died per day during encounters with law enforcement. A recent MDH investigation identified 176 civilian deaths in Minnesota that resulted from encounters with law enforcement during the years 2016-2021.[1] Deaths that occur during encounters between law enforcement and civilians are tragic but preventable. The public health approach to this issue seeks to recognize patterns between cases and recommend systems-level changes that will prevent future deaths.

Traditional approaches to this issue treat each of these tragic incidents from a primarily reactive and blaming lens. The public has been accustomed to looking back upon each isolated incident to identify which individuals are culpable. However, when we approach these deaths from a public health perspective, it is possible to identify patterns between incidents and recommend forward-looking solutions that could prevent incidents from happening. One especially relevant technique in the public health toolbox is the sentinel event review, which brings people together across disciplines to review critical incidents and propose solutions. Sentinel event reviews have been used for years in public health and adjacent fields to inform prevention efforts for tough topics,

[1] Cory Cole, MPH; Ben Townsend; Anjali Mani; Jon Roesler, MS; Ruth Lynfield, MD. (2022, December 30). Establishing a Baseline Measure for Evaluating Upstream, Primary Prevention Efforts: Quantifying Fatal Events Associated with Law Enforcement Service Calls and Encounters in Minnesota – 2016-2021. https://www.health.state.mn.us/communities/injury/documents/leafe2021.pdf

including maternal mortality, motor vehicle collisions, and drug overdose deaths. Law enforcement-involved deadly force encounters can be preventable and with the right public health tools we can address their impact on Minnesota communities.

Proposal:

This recommendation will establish and convene a statewide sentinel event review multi-disciplinary committee, in collaboration with the Department of Public Safety (DPS), Department of Human Services (DHS), Department of Human Rights (MDHR), and other state agencies and nonprofit organizations, to formally review all law enforcement-involved deaths. The committee will be charged with identifying and analyzing the root causes of the incident. MDH additionally will produce an annual legislative report of aggregate data on cases reviewed with key findings, recommendations, impact, and outcomes from the sentinel event reviews. The sentinel event review committee will engage at the local level to understand community-level context, sharing key findings from the review, and co-creating and implementing recommendations. MDH staff members will establish the review structure and process, collect, and analyze data, engage extra-agency partners, facilitate reviews, and implement action recommendations.

MDH has years of experience conducting similar fatality reviews for the purpose of identifying systems changes capable of preventing adverse health outcomes. Some of these topics include maternal deaths, sudden and unexpected infant deaths, and deaths by suicide among military veterans. Additionally, MDH staff possess expertise in many public health topic areas that are relevant to law enforcement-involved deadly force encounter deaths, including traffic safety, suicide, and the use of alcohol and other drugs. MDH staff have also, in recent years, greatly advanced their methodology for identifying and monitoring law enforcement-involved deadly force encounter cases with respect to timeliness and completeness.

Conducting these reviews at the state level allows incidents from each locality to be afforded the same resources and level of attention. State level public health professionals can provide impartial and balanced facilitation.

The program capacity that this proposal will build adds significant value including:

Leadership

Minnesota will be the first state health department in the country to create a robust infrastructure for addressing law enforcement-involved deadly force encounters as a public health issue. As communities throughout the United States continue to grapple with issues of police violence, mental health crisis response, and racism in the criminal justice system, Minnesota will be a leader.

Accountability and transparency

Preventing deaths and injuries due to law enforcement action is a matter of government accountability. Minnesotans have insisted that the state put structures in place that would allow community members to participate in making decisions about policing that could define how they and their families live in their communities. Instituting a public health approach to evaluating law enforcement-involved deadly force encounters and holding semi-annual review meetings that involve partners from all sectors will bring about new understandings and system-level changes.

Demonstrable action towards anti-racism and health equity

Law enforcement-involved deadly force encounters are a racial equity issue. Black and brown Minnesotans have voiced this for decades and MDH's own investigation into encounters that took place in the state from 2016 – 2021 revealed that Black, African, and African American Minnesotans as well as American Indians and Alaska Natives are over four times as likely to die in an encounter with law enforcement than their white counterparts. Enacting this proposal would demonstrate Minnesota's dedication to closing this gap.

Evidence-based recommendations
This proposal will result in actionable, evidence-based, and forward-looking recommendations that have the potential to prevent people from dying and entire communities from being traumatized repeatedly.

Impact on Children and Families:

While most people killed in law enforcement-involved deadly force encounters are adults, the issue does indirectly and directly affect children. Of the 176 law enforcement-involved deadly force encounter civilian deaths that MDH identified from 2016 to 2021, ten occurred to Minnesotans under the age of 18, the youngest of whom was 13. These tragedies cause untold grief and trauma for the loved ones of the victims and cause others in the community to fear for the safety of their own family. Many of the adults who die in encounters with law enforcement are parents of children or important members of communities where children are raised. Preventing law enforcement-involved deadly force encounters before they happen keeps families together and protects every child's ability to grow up with the continued presence and support of the adults that care about them.

Equity and Inclusion:

There is no way to adequately address law enforcement-involved deadly force encounters in Minnesota without addressing the role of inequity. An MDH investigation into 176 law enforcement-involved deadly force encounters civilian deaths occurring in the state from 2016–2021 found that Black, African, and African American Minnesotans were 4.5 times more likely to die in an encounter with law enforcement than white Minnesotans. American Indians and Alaska Natives were 5.7 times more likely to die of a law enforcement-involved deadly force encounter than white Minnesotans. National data suggests that people with disabilities may also face a disproportionate burden of law enforcement-involved deadly force encounters. A 2016 investigative report published by the Ruderman Family Foundation, an advocacy organization for Americans with disabilities, estimated that between 1 in 3 and 1 in 2 people who died in law enforcement encounters across the United States from 2013 to 2015 had a disability. Reviews of law enforcement-involved deadly force encounters will allow MDH to not only compute and compare rates between white Minnesotans and Minnesotans of color, or between people with and without disabilities; they will allow review participants to identify how these patterns of inequity are introduced and propose changes that will interrupt these processes at the systems level.

Tribal Impact:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes

This proposal will identify and seek to resolve the root causes underlying the inequity. The department will continue to gather input through the Tribal Liaison and community stakeholders as the proposal moves forward.

Tribal Consultation:

Does this proposal involve Tribal Consultation with one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs:

None

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of sentinel event reviews held annually	0	2016-2020	0	2	March and September, yearly beginning 2025 at the latest
Quantity	Number of annual reports presented to legislature and public	0	2016-2020	0	1	August, annually beginning 2025 at the latest
Quality	Percentage of known law enforcement-involved deadly force encounters deaths reviewed within one year of the death post-incident	0%	2016-2020	0%	80%	2024-2027
Results	Quantifiable reduction in yearly incidence rate of law enforcement-involved deadly force encounters in Minnesota	0.48 per 100,000 annually (2016-2020 average crude incidence rate)	2016-2020	0.48 per 100,000 annually (average crude rate)	0.40 per 100,000 annually (average crude rate)	2026-2030

Statutory Change(s):

To be determined

Change Item Title: Strengthening Public Drinking Water Systems' Infrastructure

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	8,155	8,155	3,323	3,323
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	8,155	8,155	3,323	3,323
FTEs	**8.5**	**8.5**	**8.0**	**8.0**

Recommendation:

The Governor recommends a general fund appropriation for drinking water protection activities to increase resiliency and security of public water systems' infrastructure and source water protection areas. Of the total investment, $5,525,000 annually is for grants in the first biennium and $1,975,000 annually for grants in future biennia. These projects will directly impact Minnesota's strategy to protect drinking water and improve the health of Minnesotans throughout the state and move towards the Environmental Protection Agencies (EPA) expectations to proactively address these issues. These proposals are designed to ensure the uninterrupted delivery of safe water through emergency power supplies and back-up wells, backflow prevention, water reuse, increased cybersecurity, floodplain mapping, support for very small water system infrastructure, and piloting solar farms in source water protection areas. These activities will be completed by a combination of staff, grants, and contracts.

Rationale/Background:

The resiliency of a public drinking water system (PWS) is the ability of the system to prevent, recover from, and/or reduce the impacts of a disruptive event while maintaining essential functions. Common disruptive events that are anticipated to increase in Minnesota include heavy precipitation, winds, drought, and loss of power. Climate impacts and environmental changes are affecting our watersheds and water supply systems. To increase resiliency, several preemptive measures can be taken to build infrastructure redundancy, improve water safety, and maintain the ecosystems that serve as sources of our drinking water.

The United States Environmental Protection Agency requires public water systems with a population over 3,300 and recommends for all systems to assess the resiliency of their systems and to develop long term plans to resolve gaps. Needs identified include redundancy to water supplies, such as having more than one source water well; installing backup power sufficient to meet drinking water capacity; and completing assessments of cybersecurity for systems reliant on electronic controls, as directed in the Governor's Executive Order 22-20. Recommended activities related to source water protection include updates to flood plain mapping to improve our understanding of areas currently and newly susceptible to flooding and planning for future improvements to resiliency by exploring the use of solar power and the incorporation of water reuse plans into the designs of drinking water systems. For very small public water supply systems, grants for upgrades, maintenance, and management will enhance their capacity which is currently limited by relatively small customer bases. Many of these systems are privately owned and lack access to low interest loans or grants that larger systems have. Implementation and monitoring of state-wide cross connection control requirements as defined by the Minnesota Plumbing Code and the Safe Drinking Water Act will enhance protection of drinking water by significantly reducing the chance of accidental cross-contamination.

Proposal:

The department requests a series of projects to improve the security and resiliency of public water systems in Minnesota. These new programs will move the state forward in improvement of public health and safety by ensuring a dependable supply of safe drinking water to all consumers. Included in this proposal are emergency generators and well source redundancy, cybersecurity, cross-connection control, very small system infrastructure improvements, flood plain mapping, water reuse, and solar development. Staff will work on project planning, coordination, and communications.

Emergency Power and Well Redundancy

Adequate and reliable emergency and standby power is essential for all drinking water utilities to manage risk and provide resiliency. Provision of power to the primary components of drinking water facilities is key to maintaining effective operation of the system, protecting both public health and the environment. Most systems without emergency power are small or very small systems (serving populations less than 3,300). Effective water system operation includes meeting average daily capacity requirements, preventing pressure losses that allow contaminants to seep into the distribution pipes, and providing adequate volume for fire protection. Approximately 400 community public water supplies do not have emergency power backup systems. Power backup is achieved through emergency generators with a fuel source. Emergency generators begin at $4,000 for a very small capacity system and up to $25,000 for a mid-size system. Electrical connections costs range from $4,000 to $25,000 each. This project creates a grant program to provide 100 public water systems each year in the first biennium and 25 public waters systems each year in future biennia a grant for up to $30,000 each for generators and power source connections.

All community public water supplies (CWS) are recommended to have more than one well for their water source. Redundancy of source water supply provides resiliency to water systems if a well fails or becomes contaminated. There are 140 community public water systems with only one well. These systems are mainly very small with populations of less than 500. This project would create a grant program to provide up 30 systems a year a grant up to $50,000 to install a second well. Staffing for both emergency power program and backup well will create and manage the grant programs, track progress, and provide engineering assistance.

Cybersecurity

Cybersecurity has been identified as a critical component of drinking water systems as reflected in the Executive Order 22-20 directing state agencies to implement cybersecurity measures to protect critical infrastructure in Minnesota. Evaluating and maintaining public water systems' IT capability helps to ensure resistance to and quicker recovery from cyber threats. This proposal is to provide guidance and technical assistance related to cybersecurity. Included in this project is assistance to register with MNFUSION Center, provide information and guidance in the event of a cyber-attack, and produce training and guidance material to conduct cyber self-assessments or procure contractors to provide assessments. MDH would also create a tracking database for public water systems to certify annual cyber assessment.

Staffing includes an engineer and grants specialist to create, manage and track the cyber support program.

Cross Connection Control

Successful implementation of cross connection control requirements in the Minnesota Plumbing Code and under the Safe Drinking Water Act can have a significant impact in protecting drinking water and preventing contamination that results in "Do Not Drink Advisories" for community water systems. Participating systems would be expected to develop and implement programs that are self-sustaining through internal funding mechanisms, typically service fees. Initial funding to individual community water systems to develop and implement programs that would be self-sustaining for a total cost up to $3,600,000. The cost to develop and initiate programs for small systems (those with less than 250 service connections with backflow protection) is $10,000 each, medium-sized systems (up to 1,000 service

connections with backflow protection requirements) is estimated at up to $30,000 each, and large systems (those more than 1,000 service connections each with backflow protection) at an average of $50,000 each. The grant program would allow 30 grants per year in the first biennium and 10 grants per year in future biennia targeting a combination of small, medium, and large size systems. Staff to provide technical assistance including assisting the development and implementation of cross connection control programs are included in the proposal.

Very Small System Infrastructure Maintenance

Very small public water systems have some of the same infrastructure and maintenance needs as larger municipal supplies, including ongoing maintenance and periodic replacement of treatment, water service lines, and sewer systems. The majority of these very small systems are privately owned, and do not have the same access to low interest loans or other public works funding as do the larger systems. Treatment systems for regulated contaminants such as arsenic have a finite lifespan, and replacement costs are considerable. These facilities may be located in regions with limited resources but still provide essential services to the area. Having matching grants available for items including treatment upgrades or replacements, septic or sewer line repair or replacement, backup wells, or flood mitigation can proactively protect safe drinking water for this size of system and allow these systems to be ready for climate change, and new or existing regulatory and health-based requirements. While some funding is currently available for addressing new contaminant exceedances and some infrastructure upgrades, $200,000 in matching grant funding per year will cover a wider range of routine maintenance and management supporting system operations and resiliency to provide safe drinking water. A plan review engineer and grant specialist are needed to implement and manage the project.

Floodplain Mapping

Enhanced floodplain mapping will update statewide data resources to aid in the identification of flood-prone areas where prevention actions should be implemented. Initial steps include convening the multiple partners to agree on the appropriate set of criteria (e.g., hydrologic conditions and storm scenarios) and data (e.g., LiDAR) to use in the effort. Work products include the development of digital maps in prioritized areas of the state. This effort helps Minnesota's clean water (MPCA) and drinking water (MDH) agencies comply with new federal requirements that water and wastewater projects conform to floodplain siting restrictions or design criteria. Resources needed include a floodplain mapping contract to complete the LiDAR survey and process the information into the floodplain mapping. Staff support is needed to provide technical assistance to users of the updated floodplain maps.

Water Reuse

Water Reuse plans for public water systems can play a role to make sure water reuse is considered and/or incorporated in the process of planning and implementing water and wastewater infrastructure projects, reducing the systems' dependency on limited groundwater supplies. This project includes an assessment of water reuse needs/opportunities in the state and a toolkit for water utilities to assess the feasibility (cost/benefit) of implementing water reuse in their communities. Resources needed include a consultant contract to conduct the water reuse assessment and develop a toolkit as well as an engineer.

Solar Energy

This project will advance the development of renewable energy supplies, especially solar, in Drinking Water Supply Management Areas. In this approach to land use, benefits accrue to multiple stakeholders, including private landowners. Pilot scale efforts to date have set the stage for future work. This initiative begins with conducting planning and engineering analyses comparing areas of concern from a drinking water standpoint with available infrastructure on the energy side, including transmission line locations, available capacity on transmission lines, and availability of nearby off-takers. This funding would also support facilitation of meetings with energy wholesalers, regulators, drinking water interests and others to identify policy efficiencies and funding priorities for new federal infrastructure package. Use of solar at public water systems may increase resiliency by providing an additional source of power for emergency use. Resources needed include a contract for engineering

analysis and collaboration with partners. Partners include the Minnesota Department of Commerce and the Great Plains Institute.

Impact on Children and Families:

Children and families rely on the dependable delivery of safe drinking water. Safeguarding our sources and securing resiliency for all water systems is an important foundation for protecting and improving the health of children and families, and for keeping our communities vibrant. Providing emergency power, source redundancy, and system security measures ensures daily water needs may be met. Assistance with maintaining and preventing backflow incidents prevents contamination and negative health effects in the short and long term. Very small systems serve people across the state of Minnesota at rest areas, campgrounds, resorts, schools, and factories. Children are typically more susceptible to drinking water contaminants than adults and providing safe drinking water protects the health and wellbeing of children and families. As climate change affects precipitation patterns and water availability, water reuse can better ensure availability of water supplies for non-potable water uses, such as irrigation, toilet flushing, or vehicle washing. This can in turn better conserve the cleaner drinking water supply for personal needs, particularly ensuring that Minnesota's groundwater is clean and available. Future planning including the use of solar power and flood plain mapping will protect sources and provide renewable energy source to ensure the delivery of safe water to all.

Equity and Inclusion:

MDH DWP strives to improve maintain and protect the health of all Minnesotans. Small systems face the same challenges as larger systems but have fewer available technical and financial resources with which to address them. Many smaller, rural systems that lack large customer bases to share the costs of new infrastructure and adopting current technologies. Matching grants to very small systems help level the economic playing field. Priority points for grants will be awarded in part for disadvantaged communities. Minnesota's population needs safe places to live that are not frequently threatened by flooding. Water reuse helps control the flow of water by directing it to locations where it will not flood residences and using it for beneficial purposes.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

None

Results:

Minnesota will have a more reliable source of safe drinking water as a result of these projects. Results will include fewer drinking water advisories due to loss of water pressure or contamination. Sanitary defects and deficiencies, fewer violations of the Safe Drinking Water Act and the quick return to compliance for those that do have violations, and increased resiliency to climate impacts and other factors affecting sustainability of water systems. MDH will track the impacts of the grants monitoring the number of PWS that now have emergency power and source redundancy, through evaluating compliance rates and reduction of public notices, sanitary defects, and deficiencies. Having a toolkit for utilities to develop and implement water reuse in Minnesota will expedite the health and environmental benefits related to water reuse more quickly and effectively. Updated floodplain mapping will improve preparation for impacts of potential flooding for critical infrastructure.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of CWSs with new backup wells or emergency power supplies	Unknown	9/30/2022	Unknown	130 CWSs	7/1/2027
Quality	Number of cross connection control programs developed and implemented by CWSs	0 (no tracking at the state level)	9/30/2022	0	30 CWSs	7/1/2027
Results	Population served by CWSs that implemented one of the infrastructure projects listed above	0	9/30/2022	0	600,000 people	7/1/2027

Statutory Change(s):

None

Change Item Title: Supporting Long COVID Survivors and Monitoring Impact

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	3,146	3,146	3,146	3,146
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	3,146	3,146	3,146	3,146
FTEs	**6.5**	**6.5**	**6.5**	**6.5**

Recommendation:

The Governor recommends an investment from the general fund to understand the impacts of long COVID in Minnesota and to support those most affected by partnering with long COVID survivors and communities disproportionately harmed by the COVID-19 pandemic. Of the total investment, $900,000 annually is for grants. Of the proposal total, over 64% of funds will return to communities, local and tribal public health, and partners in health care.

Rationale/Background:

Over 20% of Minnesotans infected with COVID-19 do not make a fast or full recovery. A subset of those with ongoing or worsening symptoms experience significant impacts on their ability to complete daily tasks, including those related to work, school, and home life. While some people slowly improve after several months of reduced function and quality of life, thousands of Minnesotans have never recovered from infections as early as March 2020. Vaccines and boosters decrease the risk of long COVID but do not prevent it entirely, as even mild cases can lead to long-term complications. Additionally, repeated reinfections have been shown to demonstrate possible cumulative impacts from the virus. Just as COVID-19 is not going away, long COVID is not going away.

Post-acute SARS-CoV-2, also known as long COVID, is an emerging health crisis in Minnesota and one likely to become endemic as the virus (i.e., COVID-19) and its variants continue to infect and reinfect Minnesotans. Currently, there is no widely accepted clinical definition nor much understanding of its burden among children, adults, individuals with pre-existing conditions, or those already disproportionately impacted by the COVID-19 pandemic. In general, long COVID refers to COVID-19 symptoms that continue or develop four weeks or longer after the initial COVID-19 infection. The World Health Organization suggests symptoms persisting three months or longer should be considered long COVID and, given this, long COVID has the potential to become a chronic condition.

COVID-19 and long COVID are complex. They can affect all systems of the body: neurologic, cardiovascular, pulmonary, endocrine, digestive, mental health, and more. Long COVID can affect healthy children and adults, often with more than one symptom. Common symptoms of long COVID include extreme fatigue, joint pain, muscle pain, breathing problems, chest pain, coughing, headache, loss of taste and/or smell, digestive issues, and cognitive challenges such as memory loss, difficulty concentrating, and “brain fog.” Minnesotans can have one or multiple symptoms. Symptoms can carry over from the initial COVID-19 infection or could arise 4, 6, or 12 weeks later among individuals initially asymptomatic. Mild cases of COVID-19, and thus, even “milder” variants, can result in long COVID.

There is also evidence that COVID-19 infection may contribute to increased risk of diabetes, stroke, kidney and liver disease, dementia, and other conditions. It compounds health issues and associated costs for those already suffering from diabetes, hypertension, heart disease, cancer, asthma, sickle cell disease, obesity, kidney disease, depression, Alzheimer's, HIV, Down syndrome, and various other conditions and disabilities.

Long COVID and post-COVID conditions are impacting the workforce and contributing to labor shortages. Research suggests that as of mid-2022, 16 million working-age Americans may have long COVID. Of those affected, 23-28% experienced job loss, and another 45% had to reduce work hours because of their illness. It is estimated that 15% or more of unfilled jobs are because of long COVID. The Minneapolis branch of Federal Reserve recently found that people with long COVID are 10% less likely to be employed and worked 50% fewer hours than their counterparts without long COVID. Sectors and communities are disproportionately affected as pre-pandemic disparities become worse and frontline workers in health care, schools, and service industries experience higher levels of exposure to the virus.

There is a clear and urgent need to understand how many Minnesotans are affected by long COVID, for how long, and how severely it impacts their daily lives. Prevalence of these symptoms range from around 10-35% in adults and 2-15% in children, depending on the study. A conservative estimate is that 10-20% of all Minnesotans infected with COVID-19 have experienced long COVID symptoms. As some 70% of Minnesotans have been infected by SARS-CoV-2 at least once so far, this suggests hundreds of thousands of Minnesotans have had some form of long COVID, and tens of thousands may have experienced significant impacts on their health, functionality, and quality of life, especially Minnesotans with pre-existing chronic conditions and disabilities who are at greater risk of long COVID and other complications arising from infection with the virus.

Awareness of long COVID remains low among Minnesotans, primary care providers, employers, schools, and local communities. This can lead to misunderstanding, misdiagnosis, and stigma for Minnesotans experiencing long COVID. It can exacerbate existing health inequities. In addition to guidance for health care providers, resources and tools are needed to guide insurers, employers, schools, and other sectors to support and accommodate those affected by long COVID.

Federal efforts around long COVID have been slow and do not provide needed resources to establish action and infrastructure needed to operationalize any forthcoming guidance or resources at the state and community level. In the meantime, there is a need to develop and implement consistent, statewide guidance for diagnosing long COVID, providing treatment and care coordination, and making recommendations for appropriate follow-up and referrals. There is a need to work with long COVID survivors, primary care providers, health systems, health insurers, public health, employers, schools, and other sectors to ensure Minnesotans with long COVID get appropriate diagnoses, care, and accommodations. Importantly, there is a need to ensure health equity among our racial, ethnic, tribal, rural, urban, immigrant, LGBTQIA, low income, and other communities disproportionately impacted by COVID-19.

Proposal:

This proposal addresses essential activities to proactively support COVID survivors whose lives are disrupted by long COVID symptoms and complications. The proposed activities are informed by the current literature on long COVID; meetings with the Centers for Disease Control and Prevention (CDC) long COVID staff; public proposals submitted by the Long COVID Survivors Group, the Minnesota Myalgic Encephalomyelitis and Chronic Fatigue Syndrome Alliance, and Minnesota COVID-19 Longhauler's Public Group; direct feedback from long COVID survivors; community concerns raised to MDH COVID Community Coordinators; and through ongoing meetings with Minnesota physicians who are seeing patients with long COVID symptoms in post-acute COVID clinics at the University of Minnesota/Fairview and the Mayo Clinic.

Through this proposal, the department will raise awareness of long COVID; develop and implement up-to-date statewide consensus guidance for long COVID diagnosis, treatment, and care coordination; co-design tools and resources to support long COVID survivors, their families, primary care providers, public health practitioners, schools, employers, and local communities; contract with local media and communications, community surveyors, health care systems, and data partners to increase awareness and monitor impacts of long COVID; and provide grants to community and nonprofit organizations, long COVID survivor groups, and local and tribal public health to support those most impacted.

For fiscal years 2023 and 2024, MDH long COVID work has focused on understanding the impact of long COVID on Minnesotans through surveys and epidemiologic investigations and engagement with community organizations, health care providers, and other stakeholders from across the state. The health department has also designed broad, initial communications to raise awareness of long COVID in Minnesota, including the MDH webpages for Long COVID: A Post-COVID Condition (www.health.state.mn.us/diseases/longcovid). This work is funded by the CDC and this funding ends on June 30, 2023. In and of itself, this work is not sufficient to understand or address long COVID in Minnesota. MDH proposes to expand and maintain this existing work. Given the complexity of long COVID, a multi-pronged approach is needed. MDH proposes to:

1. **Facilitate development of living, consensus guidance for long COVID screening, diagnosis, treatment, care coordination, and follow-up recommendations, especially for use by primary care providers, and support implementation across points of access to care.** Guidance will evolve as diagnostic testing improves and new treatments emerge. Providers have emphasized the need to have consensus and infrastructure in place to rapidly update and implement long COVID guidance. This work requires input from long COVID survivors, high-risk communities, Minnesota primary care providers, health systems, and other stakeholders (i.e., local public health, etc.) providing care to Minnesotans with long COVID. MDH will convene an expert advisory team and key stakeholders to develop these consensus recommendations for children, adults, and individuals at high risk of severe long COVID outcomes.
2. **Convene and coordinate with Minnesota stakeholders** to co-develop recommendations, resources, and tools that ensure long COVID survivors have appropriate health care coverage and support at work, school, within their communities, and for other activities of daily living.
3. **Co-design and implement ongoing communications to raise awareness of long COVID**, support long COVID survivors, and inform key stakeholder sectors on actions they can take to understand and support Minnesotans with long COVID. This would be done in collaboration with multiple stakeholders.
4. With local public health, tribal and community partners, and long COVID survivors, **address health equity by co-designing and implementing communications, programs, tools, and other resources tailored to their specific communities.** This would include community assessments and surveys about the long COVID experience within these communities to inform needs and priorities.
5. **Collaborate with data partners such as the Minnesota Electronic Health Record Consortium (MEHRC)**, a partnership of over 11 health systems covering all of Minnesota, to establish an ongoing system to examine long COVID symptom clusters and severity, diagnosis rates, treatment and care utilization. Collaborating with data partners will allow us to have a more definitive understanding of long COVID impacts on children, adults with chronic conditions and disabilities, and Minnesotans who are disproportionately affected by long COVID.
6. **Sustain existing long COVID survey, epidemiologic, and communications efforts**. In addition to contracts for tailored communications campaigns, health systems support, and community assessments and surveys, the department will award competitive grants at $900,000 beginning in fiscal year 2024 and each year thereafter for Minnesota long COVID stakeholder organizations, including regional, local, and communities-based entities, to co-design and co-implement all proposed activities. These grants and contracts mean that almost 64% of the requested funds will go back into communities and local and regional efforts.

Impact on Children and Families:

The recent surges of the SARS-CoV-2 omicron variants and relaxing of COVID-19 mitigation efforts has seen increased infection rates across the state, including among children, adolescents, and young adults. COVID-19 vaccinations and boosters, which may lower the chances of developing long-term symptoms, are stalling at low rates for these age groups. Repeated reinfections, now more likely than ever to occur within schools and daycares, may also increase likelihood of long COVID. Lack of clear guidance around long COVID diagnosis and treatment for pediatric patients is leading to misdiagnoses, misunderstanding of long COVID within families and schools, and commensurate confusion, stress, and financial burden for children and their families. To date, the University of Minnesota/Fairview post-acute COVID pediatric clinic has served over 6,000 patients, predominantly from suburban communities. This raises significant concern for children and families living in racially, ethnically, and economically diverse urban and rural communities who may not recognize the symptoms of long COVID and/or have limited resources or access to care services to address long COVID. This proposal will specifically address these issues for children and their families.

Equity and Inclusion:

COVID-19 has disproportionately impacted Black, Indigenous, and other non-white communities and low income, rural, disabled, and elder populations. This includes access to testing, Sars-Cov-2 vaccinations, and access to care for acute COVID symptoms. Data on the impact of long COVID in these communities is sparse in the United States and non-existent in Minnesota. In this proposal, we will conduct epidemiologic surveys and investigations to understand the impact of long COVID in these communities, including working with community organizations and stakeholders to address their emerging concerns. The proposed MDH long COVID activities incorporate co-design and co-implementation to ensure health equity and inclusion are part of Minnesota's long COVID response around surveys, reports, arriving at consensus care recommendations, communications and raising long COVID awareness, designing long COVID resources and tools, and ensuring appropriate health equity policies to support long COVID survivors and their families.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs:

None

Results:

Establishment of a sustainable long COVID program at MDH and with Minnesota stakeholder partners will be evaluated from several perspectives.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of Minnesotans reached with communications & messaging	120,000	FY 2023	120,000	4,000,000	FY 2025
Quantity	Number of resources/tools shared to support long COVID survivors	0	FY 2023	0	30	FY 2025

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quality	Consensus long COVID diagnosis, treatment, and care coordination guidelines	N/A	FY 2023	Guidelines implemented	Guidelines implemented	FY 2025

Statutory Change(s):
New statute (MS 144.xxx)

Change Item Title: Telehealth in Libraries Grant Pilot Program

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	911	911	131	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	911	911	131	0
FTEs	**1**	**1**	**1**	**0**

Recommendation:

The Governor recommends a general fund investment to address health inequities and address the digital/broadband divide that prevents underserved communities from accessing health services. Of the total appropriation in fiscal years 2024 and 2025, $750,000 annually is for grants. MDH's Telehealth in Libraries proposal creates a competitive grant process for six public libraries in medically underserved urban and rural communities to partner with community-based organizations to build enclosed telehealth stations/pods and utilize community health workers to assist individuals with their appointments, care coordination, and access to other resources/services.

Rationale/Background:

The growth of telehealth services in Minnesota since its inception in the mid-1990s has created opportunities to address access issues in both rural and urban settings. Partly a function of technology improvements and partly a function of more equitable reimbursements, because of telehealth, more citizens can access health care where they are. According to the American Medical Association, telehealth use by physicians jumped from 25 percent in 2018 to almost 80 percent in 2020, while almost 85 percent of psychiatrists connected with the patients via video visit or telephone during the height of the pandemic[1]. Telehealth significantly reduces the cost of care and increases cost savings for care seekers and providers[2]. The 2020 Minnesota Department of Human Services report showed that telehealth made it easier to access services and involve other family members in healthcare services and improved equity in access to healthcare for Minnesotans[3]. Yet telehealth services are still unavailable to vulnerable and marginalized people, leaving out many who still don't have reliable broadband access at home. Approximately 19 million Americans—6 percent of the population—still lack access to fixed broadband service at threshold speeds[4]. In rural areas, nearly one-fourth of the population—14.5 million people—lack access to this service. In tribal areas, nearly one-third of the population lacks access.

[1] American Medical Association Physician Practice Benchmark Survey

[2] Snoswell CL, Taylor ML, Comans TA, Smith AC, Gray LC, Caffery LJ. Determining if Telehealth Can Reduce Health System Costs: Scoping Review. J Med Internet Res. 2020 Oct 19;22(10):e17298. doi: 10.2196/17298. PMID: 33074157; PMCID: PMC7605980.

[3] Minnesota DHS Tele Medicine Utilization report. https://mn.gov/dhs/assets/telemedicine-utilization-report-2020_tcm1053-458660.pdf

[4] American Medical Association Physician Practice Benchmark Survey

In Minnesota, 15.2% of households have no broadband internet subscription for their computing needs. This increases to 41.5% among households where the annual income is under $20,000 and 10.6 % of households only have a mobile data plan for internet access. To take advantage of discount Internet programs like the Affordable Connectivity Program (ACP), individuals who are low income need stable housing, an ability to navigate multiple online forms, and often, no current debt with the Internet Service Provider. Many individuals are still left without the essential utility of the internet even with the availability of the ACP. According to the Minnesota Department of Employment and Economic Development (DEED):

- 18.5% of Minnesota households lack a laptop or desktop computer
- 7.1% of Minnesotans have only a smartphone for their computing needs
- 38.5% of households use a non-mobile internet subscription that provides under 25/3 Mbps. This could be by choice (trying to save money by purchasing slower service) or by default (living in an area without high-speed access).

To successfully support this work, libraries need to provide infrastructure, outreach, collaborative support from community-based healthcare workers support successful telehealth access, and they require appropriate space, equipment, and procedures. With adequate support, telehealth services provided by local libraries have the potential to help improve access to health services, reduce health inequities and improve health outcomes for people who are traditionally underserved.

Minnesota's public libraries fill the gap by providing access to technology, spaces, and help – all without a fee. Minnesota's public libraries are free, accessible, and welcoming to community members and library staff around the state are regularly assisting patrons with their social, health, and well-being needs. Minnesota currently has 137 public library systems representing a total of 382 libraries, more than adequate to be available to community members in geographic locations close to their homes and residences. Hennepin County system alone has 40 locations, while Ramsey County has a total of 23 public library locations.

At a public library, community members can use public computers and Chromebooks, Wi-Fi, check out Wi-Fi hotspots, and even use maker technology such as 3D printers. Library staff provide drop-in and appointment-based technology help and formal technology classes. Libraries can offer technology, space, staff help, and access to telehealth so Minnesotans who live in rural areas, are older, who are lower income and lack internet access can participate too.

Examples of other programs that have been utilized to meet health and related needs:

- MyChart/Patient Portal training sessions at libraries so patrons can learn about the telehealth platform in the area
- Libraries offering free COVID-19 tests in partnership with county health departments
- Libraries as free walk-in sites for MNsure training and guidance
- Social workers employed at libraries to provide variety of health needs, including immediate resources and referrals to healthcare providers
- Library pods onsite designed to provide a private space for clients to meet virtually with healthcare providers
- Technology provided to patrons for telehealth support, including laptops/Chromebooks, hotspots, tablets, webcams, scanners and headphones
- Community-based organization drop-in services at the library, including connections to housing, shelter access, medical benefits, health care, identification, chemical dependency, nutrition, and more
- Library programming focusing on health and wellness and calming spaces designed for individuals who need a comforting space to regulate

Proposal:

MDH's Telehealth in Libraries program will award up to six 2-year annual grants of $125,000 per year in FY2024 and FY2025 to libraries to establish and manage telehealth locations to improve access to health care for individuals who currently lack access to health services and do not have adequate technology resources in their homes to access health care or mental health services from their home or lack technology literacy/familiarity. This proposal leverages already-existing public and community resources to serve as community hubs to provide critical health and mental health services to communities and individuals with minimal investment to six Minnesota libraries in rural or underserved urban communities.

Grant funding will support construction of telehealth pods or kiosks, development of and collaboration with health care and community-based organizations to provide and supervise community health worker/health navigator staff and associated administrative costs. To ensure that grant funding impacts communities most in need of accessing telehealth services and represents diverse needs, the Commissioner would limit available funding to libraries in rural and medically underserved urban communities.

Grant funds would be used by grantees to:

- Construct pods, kiosks, or spaces within the library with appropriate privacy and sound considerations, estimated at $20,000.
- Through collaboration with existing local community-based service organizations to obtain the services 1 FTE Community Health Worker(s) (CHW), who would be present to assist telehealth users with setting up the session with their health care providers and act as a health navigator as needed, at an estimated cost of $55,000 per year, to include salary and fringe.
- Provide administrative support for a community-based organization to supervise the CHW, develop operating protocols and procedures, purchase computers and cell phones for the CHW, estimated at $30,000 per year.
- Provide administrative support for the library to assist and support their library's program collaboration with the community-based organization and the CHW, manage grant funding, and fulfill reporting requirements as developed by MDH, estimated at $10,000 per year.
- Provide transportation support to telehealth users, $5,000.

A 1.0 FTE grants administrator will 1) conduct initial and ongoing collaboration with Minnesota's public library community to develop and establish program guidelines, grant reporting requirements, performance measures, 2) provide policy and program technical assistance and input to libraries, and 3) conduct program evaluation in Years 2 and 3 to assess program effectiveness and alignment with Minnesota's broader telehealth environment and resources and to make recommendations for modification or extension of the program.

Impact on Children and Families:

This proposal would ensure that children and families with limited access to or familiarity with technology that supports telehealth visits can access health care and mental health services in their local community, leveraging a trusted public source of information and support.

Equity and Inclusion:

This proposal leads with equity and inclusion in mind. It is specifically intended to level the playing field by providing safe and accessible options to people in communities that lack access to services, transportation or technology.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Results:
Part A: Performance measures

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of library telehealth visits	0	2022	0	300	2025
Quantity	Number of people accessing telehealth in libraries	0	2022	0	150	2025
Quantity	Number of people reported the telehealth met their needs	0	2022	0	100	2025
Quantity	Number providers who reported the telehealth improved their ability to effectively provide clinical services to patients who experience access barriers	0	2022	0	20	2025
Results	% Of people accessing telehealth in libraries who reported improved outcome	0	2022	0	50	2025

Part B: Evidence-based practices

Evidence-based Practice	**Source of Evidence**
Telemedicine, sometimes called telehealth, uses telecommunications technology to deliver consultative, diagnostic, and health care treatment services.	What Works for Health, https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/telemedicine)

Statutory Change(s):
None

Change Item Title: Telehealth Study Budget Change

Fiscal Impact ($000s)	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
General Fund					
Expenditures	(1,200)	1,200	0	0	0
Revenues	0	0	0	0	0
Other Funds					
Expenditures	0	0	0	0	0
Revenues	0	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(1,200)	1,200	0	0	0
FTEs	**0**	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends reallocating $1,200,000 from fiscal year 2023 to fiscal year 2024 for the statewide study of the impact of telehealth expansion and payment parity under the Minnesota Telehealth Act on the following: 1) access to health care services; 2) quality of care; 3) value-based payments; 4) innovation in care delivery; and 5) health care disparities and equitable access for underserved communities.

Rationale/Background:

Following the health care industry's shift to using telehealth to deliver services during the COVID-19 pandemic, the Legislature in 2021 asked MDH to study the impacts of telehealth on healthcare access, quality, patient satisfaction, health outcomes, and health equity for people accessing care through commercial health insurance for future policy considerations. Given the complex multi-method approach, MDH has executed a study planning process to engage input from stakeholders and other state agencies to inform the study design to best frame research questions and capture related data. This planning process has taken most of the past year and was slower than expected due to staff remaining reassigned to COVID-19 response duties. With a solid plan in place, MDH is now ready to implement the data collection and analysis phase and to procure services through the state's procurement system, which is estimated to take an additional three months to execute contracts. However, because the original appropriation for research activities began in fiscal year 2023, the end of the biennium, the funding will not be available for the research activities to continue into fiscal year 2024.

The intended result of this proposal is to reallocate a portion of the budget from fiscal year 2023 to fiscal year 2024 to complete the telehealth study to meet the statutory reporting deadline.

Proposal:

This proposal recommends shifting a portion of the funding allocated to the telehealth study from fiscal year 2023 to fiscal year 2024 to make possible the completion of the telehealth study. Specifically, this shift in funding will enable the Minnesota Electronic Health Record (EHR) Consortium to undertake and complete its work of evaluating the quality of health care provided through the telehealth mode of delivery. The EHR Consortium will assess quality of care by comparing health outcomes for telehealth visits versus in-person visits and by analyzing data to address questions of whether the impact of telehealth is to substitute for in-person care *versus* just adding to the amount of care received. Moving funding to fiscal year 2024 will also allow for the completion of claims data analysis to supplement the data provided and analyzed by the EHR Consortium. This claims data analysis will use data from the Minnesota All Payer Claims Database (MN APCD) to measure health care utilization patterns over time.

Impact on Children and Families:
Results from this study will be used to inform telehealth policies in Minnesota, including those that improve access to health care via telehealth that will positively impact the health and well-being of children and families.

Equity and Inclusion:
It is important that telehealth is available to all Minnesotans in a way that is equitable. Telehealth policies that improve access to health care via telehealth can help reduce barriers to care, including mental health care and specialty care, particularly those barriers experienced by BIPOC Minnesotans and rural Minnesota residents.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs:
n/a

Results:
Results from this study will be used to inform telehealth policies in Minnesota, including those that improve access to health care via telehealth that will positively impact the health and well-being of children and families. Telehealth policies that improve access to health care via telehealth can help reduce barriers to care, including mental health care and specialty care, particularly those barriers experienced by BIPOC Minnesotans and rural Minnesota residents.

Statutory Change(s):
n/a

Change Item Title: Trauma System Fee Adjustment

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	83	83	83	83
Revenues	(354)	(354)	(354)	(354)
State Government Special Revenue Fund				
Expenditures	668	668	668	668
Revenues	668	668	668	668
Net Fiscal Impact = (Expenditures – Revenues)	437	437	437	437
FTEs	**3.5**	**3.5**	**3.5**	**3.5**

Recommendation:

As required by Minnesota Statute, section 16A.1283, governing legislative approval required for fees, the Governor recommends amending statute to include the fee structure to support the statewide designation of trauma hospitals.

In addition, the Governor recommends an increase to hospital license fees and aligning appropriations from the general fund and the state government special revenue fund to provide additional funding for the work of designating trauma hospitals and ensuring an effective statewide trauma system. The proposal supports the staff and technical resources needed to maintain the current program, which designates trauma designations according to industry standards. The proposal will ensure the department is able to continue to designate trauma hospitals at the required frequency in statute and following industry standards, thereby ensuring a coordinated healthcare infrastructure that is able to support Minnesota's communities by providing 24/7 emergency trauma/disaster care locally, regionally, and statewide.

Rationale/Background:

Currently, 99.6% of Minnesotans live within 60 minutes of a state-designated trauma hospital. Minnesota's trauma system is a coordinated network of over 120 hospitals and approximately 300 ambulance services working collaboratively to optimize the care provided to seriously injured people. This organized system best ensures that seriously injured people are promptly transported and cared for at a hospital with resources that match their needs.

In 2005, the statewide trauma system was enacted in Minnesota Statutes, sections 144.602 – 144.608. The department is responsible for oversight of the state's trauma system, including measuring and assuring quality of care and appropriate use of limited resources such as surgical interventions, diagnostic testing, and transfers. When the trauma system began in 2005, Minnesota had no state designated trauma hospitals. The fees were an estimate of an amount sufficient to establish the new system, but the fees have never been increased in the intervening 16 years. In addition, the number of institutions seeking this designation has grown beyond original projections. Increasing program costs over time, and a larger set of hospitals to designate, requires additional funding to maintain.

As of 2021, almost all of the 137 eligible hospitals in the state seek designation, greatly outpacing the estimated uptake of the program and resulting in 126 designated trauma hospitals across all regions of the state. A portion of hospital license fees is deposited to the general fund as non-dedicated revenue. Actual costs to administer the trauma system program are greater than revenue. Information technology, personnel, and other costs have increased over the past two decades.

Proposal:

This proposal is for an appropriation in the state government special revenue fund to support the statewide trauma system. Institutions are currently charged a $1,000 base fee and an additional $12-per-bed fee to pay for trauma designation. This proposal modifies the charge to a $1,826 base fee and an additional $23- per-bed fee. The state government special revenue fund appropriation will be used to support clinical and professional staff and the infrastructure necessary to contract with site reviewers, provide ongoing technical assistance across 126 hospitals, and to cover vendor costs for the trauma registry and electronic application tools. A new application system used by hospitals, professional site reviewers, members of the State Trauma Advisory Council, and staff, would replace the outdated electronic interface. This will reduce the burden on hospitals and streamline all electronic phases related to the review and designation of trauma hospitals.

In addition, the proposal includes a general fund appropriation per year to support staff and the State Trauma Advisory Council to conduct analysis necessary to ensure the program criteria for designation are effective, designed to optimize clinical care (such as general surgery and emergency medical services), modify system requirements based on outcomes, meet all reporting requirements, and measure performance and monitor trends over time (see performance measure section below), ultimately reducing healthcare costs (e.g., eliminate multiple, unnecessary and/or delayed transfers, and repeat diagnostic testing). Analysis of the data would assist MDH in its work with other state and industry partners to address longstanding structural concerns with, and access to, rural emergency medical services, and facilitate the development of injury prevention and rehabilitation programs.

Impact on Children and Families:

Trauma (i.e., injury) is a tremendous burden on families and their communities. For the severely injured person, the time between sustaining an injury and receiving critical care is the most important predictor of survival – the "golden hour." The chance of survival diminishes with time despite the availability of resources and modern technology; therefore, a well-coordinated and executed trauma system enhances the chance of survival regardless of proximity to an urban trauma center. Maintaining and improving Minnesota's Statewide Trauma System is an important means to ensure children, families, and all Minnesotans have the best chance to survive and rehabilitate from sudden trauma.

Equity and Inclusion:

Minnesota has one of the most broadly inclusive trauma designation systems in the country. Six designation levels exist (two are pediatric-specific). Any hospital can participate at a level appropriate to their resources. Remarkably, nearly all Minnesota hospitals voluntarily participate in the system, ensuring a coordinated network of care across all levels and areas of the state. This is especially important for rural Minnesota, where resources are most scarce.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts	50	50	50	50	50	
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)						
Total						
MNIT FTEs						
Agency FTEs						

Results:

The proposal aligns funding to recognize the increased effort involved in maintaining and expanding on 16 years of improvements and continuing to develop appropriate standards and conduct reviews to ensure the critical care healthcare infrastructure is maintained.

As of 2021, Minnesota is remarkably covered with coordinated life-saving injury care resources:

- 99.6 percent of Minnesotans live within 60 minutes of a trauma hospital.
- 82 percent of Minnesotans live within 60 minutes of a Level 1 or 2 trauma hospital.
- 72 percent of Minnesota children live within 60 minutes of a pediatric trauma hospital.
- All Minnesotans benefit from this standardized surgical and emergency medicine foundation for local, regional, and statewide disaster responses.

The proposal will advance these results and provide for dedicated analysis of its data to focus on optimizing clinical care and reducing healthcare costs (e.g., eliminate multiple unnecessary and/or delayed transfers, eliminate repeat diagnostic testing), manage limited statewide resources such as general surgery and emergency medical services, and facilitate the ongoing development of injury prevention and rehabilitation programs.

Performance measures

Over the years the State Trauma Advisory Council has formulated clinical and system performance measures, but without adequate analytical support (see second paragraph under Proposal above), it has not been possible to implement these measures. A sampling of the desired measures include:

- EMS compliance with major trauma triage and transport requirements
- Emergency Department lengths of stay stratified by designation level and Injury Severity Score (ISS)
- Delays in transfers
- Trauma admits that subsequently required transfer
- Over and under triage stratified by level of designation
- Deaths stratified by ISS and age
- Various clinical measures associated with emergent recognition and treatment of life-threatening injuries

- Overuse of diagnostic tests

These and similar measures are essential to better evaluate and improve outcomes for critically injured Minnesotans.

Statutory Change(s):
Minnesota Statutes, sections 144A and 144.602 to 144.608

Change Item Title: Vital Record Surcharge Remittance and Reporting

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Recommendation:
The Governor recommends this housekeeping/technical change to clarify remittance of vital record surcharges collected by local issuance offices. This budget-neutral recommendation fixes a defect in current law. The proposal will specify and direct the frequency at which local offices are required to remit surcharges to Minnesota Management and Budget. This proposal will amend M.S. 144.226 which describes and directs vital records fees and surcharges, but there is no fiscal impact.

Most local vital records issuance offices remit surcharges each month and report the amount to the Minnesota Department of Health, the month following. The Minnesota Department of Health, Office of Vital Records monitors vital record surcharge remittance to assure that program expenditures do not exceed fee revenue in the SFY and to assure that surcharges are identified correctly and deposited to the appropriate fund.

Rationale/Background:
The Minnesota Department of Health, Office of Vital Records budget is based, in part, on vital records surcharges. The law is silent on how frequently they must remit fees collected to Management and Budget. While the majority of counties promptly remit the surcharges, some lag significantly, making MDH budgeting, as well as quality assurance and accounting tracking to actual fee revenue challenging.

Proposal:
This proposal amends M.S. 144.226 to require local issuance offices to remit vital records surcharges to Management and Budget on a monthly basis establishing a routine remittance cycle to better budget and account for fee revenue.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs
None

Results:

This proposal amends the statute to require local issuance offices to remit the vital record surcharges they collect on a monthly basis. The proposal establishes a reliable remittance cycle and regular frequency.

The Minnesota Department of Health, Office of Vital Records performs quality assurance and tracking activities for budgetary purposes. The department:

- Reviews remittance reports provided by Management and Budget to assure that vital record surcharges are identified appropriately for deposit into the correct fund.
- Checks issuance activity in the vital records system and compares the activity to the surcharge calculations and remittance reports.
- Requests that local issuance offices remit surcharges each month to Management and Budget.
- Requests that local issuance offices report their remittance payments for budgetary purposes online at County Office Surcharge Reporting.
- Tracks the vital records surcharge deposits to maintain a balanced budget during the SFY.
- Follows up with local issuance offices when their remittance appears to be miscalculated or identified incorrectly.

Statutory Change(s):

This proposal will amend M.S. 144.226 subdivision 3 and 4 to require the State Registrar and local issuance offices to forward the surcharges they collect on a monthly basis.

Change Item Title: Equitable Health Care Task Force

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	779	749	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	779	749	0	0
FTEs	**3.2**	**3.2**	**0**	**0**

Recommendation:

The Governor recommends establishing and funding a task force to examine inequities in how people experience health care based on race, religion, culture, sexual orientation, gender identity, or disability and identify strategies for ensuring that all Minnesotans can receive care and coverage that is respectful and ensures optimal health outcomes.

Rationale/Background:

Minnesota has a strong system for ensuring access to health insurance, one of the lowest uninsurance rates in the nation, and a national reputation for delivering high-quality care. Most Minnesotans report a very high level of trust in their providers and a high level of satisfaction with their care.

And yet, not everyone has the same type of experience when they seek care or try to navigate their insurance coverage. We know that:

- 35.5% of Black Minnesotans reported that they perceived discrimination in the care they received, compared to 6.6% of all Minnesotans.
- More than 20% of Black, Hispanic/Latino, and American Indian Minnesotans reported that they had experienced discrimination based on their insurance status or lack of insurance, compared with roughly 5% of White Minnesotans.
- 58.9 % of LGBTQ+ Minnesotans reported receiving unfair treatment from health care providers based on their gender, sexual orientation or gender identity, compared to 6% of all Minnesotans.
- 30.1%% of LGBTQ+ Minnesotans reported having low confidence in their ability to receive care and 57.1% reported forgoing care due to costs, compared with 26.2% of all Minnesotans.
- In a 2021 survey[1] of 714 practicing U.S. physicians nationwide, only 56.5 percent strongly agreed that they welcomed patients with disability into their practices, and 18.1 percent strongly agreed that the health care system often treats these patients unfairly.

These disparities can and do impact health outcomes and trust in the health care system overall. When people do not feel that they will be respected and receive the care they need within the system, they may delay seeking care, or may not seek care at all. Physicians, other health care providers, and insurers need to be confident that they are employing best practices and strategies to ensure that all of their patients and families are receiving optimal care and are regarded and treated equally.

[1] Pubmed.gov/National Library of Medicine

Proposal:

MDH would establish an **Equitable Health Care Task Force** to 1) examine the prevalence and types of inequitable experiences of care that occur in Minnesota based on race, ethnicity, preferred language, religion, sexual orientation, gender identity, disability status, age or culture, and 2) develop recommendations for actions that health care provider systems, insurers, and state agencies can take to improve the experience of care and trust in the health care system by individuals in these groups. Over the course of two years, the task force would:

- Conduct a literature and data review to understand the frequency and types of inequitable care or treatment received by individuals in the target communities in Minnesota and nationally;
- Use community forums and other strategies, including an online portal or web-based tool, to gather stories about inequitable treatment or care in Minnesota that originates from or can be attributed to race, religion, sexual orientation or gender identity, disability status, or cultural practices and that can contribute to diminished standards of care, foregone care, or disparate health outcomes;
- Gather examples of successful models or promising practices to address inequities in treatment or care delivery in order to inform potential solutions to employ in Minnesota; and
- Produce a final report and set of recommendations for changes in health care provider or system practices and health insurance regulations that would address identified issues

The task force would include 12 to 20 representative members to include patient or family members of Black, Hispanic/Latino, American Indian, Asian/Pacific Islander, LGBTQ+ and disability communities; health care providers in primary and specialty care; health systems and/or insurers. Meetings would be held six times per year for the duration of the task force.

Task force appointments, coordination, activities and communications, and vendor contract management will be conducted by a 1.0 planner. Meeting facilitation, community outreach, community forums, and development of final report and recommendations will be conducted by a contracted consultant at $200,000 annually. IT development of an online portal is estimated at $25,000 in fiscal year 2024. Oversight of online portal development, supporting community forums, gathering community inputs, conducting grey literature review (government and health care reports on inequitable care, etc.) will be conducted by a 1.0 Research Scientist 2. Data analysis and research to support task force policy goals and solutions and conduct evaluation studies will be conducted by 1.0 Research Scientist 3. Supervision of agency staff supporting the task force, and overall leadership for the initiative, will be conducted by a 0.2 FTE Health Program Manager Senior. Travel and space rental costs would be required to support task force activities over two years, projected at $15,000, and supports for community participation in task force meetings and community forums are estimated at $12,880 per year for two years.

Impact on Children and Families:

This proposal is targeted at improving the health of all children and families, with a focus on those from communities of color, LGBTQ+ communities, and those living with disabilities. Reducing inequitable health care experiences would result in positive impacts on children's health, including but not limited to developmental monitoring and screenings, preventive well-baby pediatric visits, childhood immunizations, insurance coverage, home visiting services, and mental health support.

Equity and Inclusion:

At this proposal's core is a commitment to identifying barriers and solutions to ensure equity and inclusion in Minnesota's health care and health insurance systems for all Minnesotans, regardless of race, religion, sexual orientation or gender identity, or disability status.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Results:

Type of Measure	Name of Measure	Current Value	Date	Projected Value	Date
Quantity	Number of community forums conducted	0	07/01/2023	6	06/30/2025
Quantity	Report, strategic plan and legislative recommendations developed	0	07/01/2023	1	06/30/2025

Statutory Change(s):
None

Change Item Title: Fetal and Infant Mortality Review

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	749	960	960	960
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	749	960	960	960
FTEs	**3.50**	**3.50**	**3.50**	**3.50**

Recommendation:

The Governor recommends an appropriation from the general fund to design and implement Fetal and Infant Mortality studies. Through this proposal, the Department of Health will re-establish the Fetal and Infant Mortality Case Review Committee, which will conduct fetal and infant death study reviews, make recommendations, and publicly share summary information in accord with Minnesota's Data Protection Act. The committee will examine and report particularly on disparities in fetal and infant deaths among racial and ethnic populations and provide recommendations on strategies to help decrease the rates of fetal and infant deaths.

Rationale/Background:

In 2001, Minnesota Statutes, section 145.90, sunset the commissioner of health's duty to establish fetal, infant, and maternal mortality death studies. Later, maternal mortality death studies were reinstated; however, Fetal and Infant Mortality Reviews (FIMR) were not.

Annually, approximately 650 stillbirths and infant deaths occur in Minnesota, and deep disparities among racial and ethnic groups have persisted over the past 20 years. From 2017-2021, the infant mortality rate for American Indians is 9.6 per 1,000 live births and 8.3 for Black infants while the infant mortality rate for non-Hispanic Whites is 3.6 per 1,000. American Indians and Black infants are respectively 2.7 and 2.3 times more likely to die in infancy than non-Hispanic whites. While each of these deaths represents a painful loss for a family, the state has minimal information about circumstances contributing to these deaths and how to prevent future deaths. The FIMR process is a well-established continuous quality improvement methodology that reviews these cases and conducts root cause analyses to identify risk factors, protective factors, and systems gaps. Conducted in collaboration with medical professionals, community members, social-service providers, policymakers, advocates, and other stakeholders, the FIMR process results in action-oriented policy, system, and community-level recommendations to reduce preventable fetal and infant deaths.

The FIMR process was developed jointly by the National Fetal and Infant Mortality Review (NFIMR), the American College of Obstetrics and Gynecologists (ACOG) and the Maternal and Child Health Bureau (MCHB). FIMR is endorsed by the American Academy of Pediatrics, the March of Dimes Birth Defects Foundation, and the United States Department of Health and Human Services.

Without access to comprehensive FIMR information, the Minnesota Department of Health's understanding of and ability to work toward reduction in rates of fetal and infant deaths, including a reduction of the disparities among American Indian and African American, is diminished due to lack of sufficient, actionable data.

Proposal:

The recommendation will re-establish a Fetal and Infant Mortality Review process is to better understand the causes of significant disparities in Minnesota's fetal and infant mortality rates. This proposal will define fetal deaths as those that occur after 20 weeks gestation excluding abortions, and infant deaths are those of a live-born infant up to age one year.

Under the FIMR process, MDH will have authority to access relevant records (medical records, birth and death records, social service records), medical examiners' and coroners' reports, and contact information for the family, to better understand the factors that influenced an infant or fetal death and in accord with relevant Minnesota data privacy laws. In addition to records, the department will work with trauma-informed interviewers to complete voluntary family interviews to bring their voice into the process. A sample of cases will be abstracted and reviewed by the Case Review Committee, which is a multidisciplinary team including medical examiners, representative from health care institutions, obstetric and pediatric practitioners, Medicaid representatives, and individuals from the communities most impacted. The Case Review Committee releases summary data and creates policy, system, and community-level recommendations to prevent future fetal and infant deaths and reduce disparities.

The department, with the support of a contracted agency, will convene Community Action Teams, which are comprised of community decisionmakers and are charged with implementing community improvements based on the findings and recommendations of the Case Review Committee. These teams will develop creative solutions to improve services and resources for families, and they work alongside stakeholders to implement these interventions. The department will offer voluntary grief support and connection to local resources to all families who experience a stillbirth or infant death through a grant to statewide organization, and this grant would receive partial support from birth defects prevention program.

This proposal requests a general fund investment to implement the FIMR process and support community-led committees to generate action. Funds will support 3.5 FTE staff which will be used for public health advisors, research specialists, and other staff to abstract cases, provide oversight, coordinate the project, and support the Case Review Committees. The department will work with community-focused organizations to implement the Community Action Teams. The department will contract with trauma-informed interviewers to complete voluntary parent and family interviews. Financial support will be given to those who participate in an interview, including for time spent, travel costs, and childcare.

Impact on Children and Families:

Understanding factors that contribute to fetal and infant deaths provides the department with data needed to inform policy and systems changes to improve fetal and infant health. This data is particularly important to understand how to decrease the rates of fetal and infant deaths among populations that experience disparate rates of such deaths, including the Black and American Indian communities in Minnesota.

Confidentiality is assured for both families and providers, and Minnesota's Data Privacy laws apply. Policy, system, and community issues are identified and recommendations for system and service improvement are developed and implemented. A voluntary family interview also provides significant input into the process and provides an opportunity to assess family needs for services such as grief counseling and treatment for maternal depression.

Equity and Inclusion:

All children and families will be impacted by this proposal. Without access to comprehensive information on fetal and infant deaths, the department's understanding, and ability to work toward reducing the significant disparities in American Indian and African American infant deaths is diminished. The information gathered from Minnesota's FIMR will provide insight into the causes and circumstance surrounding the deaths, enable summary level data sharing, and advance policy and systems' changes recommendations that improve disparities in fetal/infant

mortality. The FIMR process is built to meaningfully engage community stakeholders to create and implement their own solutions to improve outcomes.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

American Indian communities experience the highest rates of stillbirth and infant deaths of any racial/ethnic group in the state. The last FIMR conducted in Minnesota was done by the Ojibwe tribes, excluding Red Lake. Reviewing deaths has the potential to impact all tribes in the state, and the recommendations could inform Tribal/Urban Indian health service provision and engagement of pregnant and parenting people. Tribes and Urban Indian Health Directors have not been consulted prior to this proposal, but they have indicated that this a priority previously.

Results:
Part A: Performance measures
The FIMR process will publish summary data from the case reviews of stillbirths and infant deaths at regular intervals, including by race, ethnicity, and geographic area when possible. In addition to measuring overall rates, the department will closely monitor the reduction of disparities for American Indian and Black communities.

In addition to the results data, the department will measure the performance of the components of the FIMR process, including the Case Review Committee meetings, alongside other metrics like established governance protocols and seats appointed on the Committees. For quality, the department will assess the functioning of the Community Action Teams, as measure of community engagement with the recommendations and data produced by the process.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Case Review Team meetings held	0	2023	0	8	2024
Quality	Community Action Teams operational	0	2023	0	3	2025
Results	Stillbirth rate	5.0 fetal deaths per 1,000 live births and fetal deaths	2021	5.1	4.7	2024
Results	Infant mortality rate disparity ratio – Black compared to non-Hispanic white infant deaths	2.3	2017-2021	2.3	1.6	2021-2025
Results	Infant mortality rate disparity ratio - American Indian	2.7	2017-2021	2.7	2.0	2021-2025

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
	compared to non-Hispanic white infant deaths					

Part B: Evidence-based practices

FIMR has strong evidence to support its use to improve quality of clinical care in high-incomes settings where stillbirths and infant deaths are comparatively low. The World Health Organization recommends that perinatal death reviews should be completed in every hospital as part of larger surveillance and quality improvement process. However, death reviews alone are insufficient to reduce stillbirth and infant deaths, and death reviews must inform systemic improvements at the policy, clinical, family supports, and community levels.

Evidence-based Practice	**Source of Evidence**
Perinatal Death Reviews/Audits	https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012982.pub2/full

Statutory Change(s):

New statute required

Change Item Title: HIV Prevention Health Equity Programming – Ryan White HIV Funding

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	2,267	2,267	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	2,267	2,267	0	0
FTEs	**2.5**	**2.5**	**0**	**0**

Recommendation:

The Governor recommends an ongoing general fund investment to support HIV prevention programs that directly address the health inequities of communities experiencing the greatest rates of HIV. The request includes $1,264,100 annually in grants to community organizations working with people affected by the HIV outbreaks and other individuals at risk across the state to prevent and control the transmission of HIV.

Rationale/Background:

Even though statewide HIV case numbers overall have remained relatively stable over time, Minnesota is experiencing three ongoing HIV outbreaks. Because there are medications to treat people with HIV and prevent people who are negative from becoming infected, we would expect to see the overall number of new cases decreasing. People who identify as American Indian/Alaskan Native (AI/AN), Black, and Latino/Latinx are disproportionally impacted by HIV due to a combination of historical, current, and intergenerational trauma; structural and individual racism; and discrimination that all influence the social determinants of health.

MDH declared Minnesota's first ever HIV outbreak in February 2020. The outbreak, centered in Hennepin and Ramsey counties, was split into two outbreaks in September 2022. One is related to homeless encampments and the other involves people whose risk behavior includes injection drug use (IDU) or a combination of male-to-male sex and injection drug use (MSM/IDU). In March 2021, MDH declared another outbreak in the Duluth area. All three outbreaks continue to grow. As of February 7, 2023, 71 cases are linked to the encampment-related outbreak, 95 cases are linked to the MSM/IDU or IDU outbreak, and 35 are linked to the outbreak in the Duluth area.

People who receive appropriate HIV treatment and maintain viral suppression can stay healthy for many years and not spread it to others sexually. Viral suppression means that a person has a very low or undetectable amount of HIV in the body. People who are not virally suppressed can have weak immune systems; this leaves them susceptible to many serious diseases. In addition, they can spread HIV to their partners who can then further spread the disease, perpetuating the chain of infection. As of February 13, 2023, 38% of the encampment-related outbreak cases, 33% of the MSM/IDU outbreak cases, and 29% of the Duluth outbreak cases were not virally suppressed, highlighting the urgent need to address the outbreaks.

In 2017, the Minnesota legislature mandated that the Minnesota Department of Human Services (DHS) and MDH work together to develop a strategy to end HIV in Minnesota (Minnesota Session Laws 2017, Chapter 75, section 1). There was no additional funding provided for the development of the strategy or implementation of its recommendations. The strategy was developed in collaboration with, and using input from, many community

members including those living with and at risk of getting HIV, health care providers, HIV service providers, community-based organizations, and local public health (LPH). DHS and MDH presented the strategy, called END HIV MN, to the legislature in January 2019. The law also mandated specific outcomes that are listed in the table below.

Comparing the mandated outcomes with 2021 data (see Table 1), Minnesota is doing well in relation to outcomes 1 and 3 but still has a long way to go in terms of retaining people with HIV in HIV medical care and decreasing the annual number of new diagnoses, both of which are critical to ending HIV in Minnesota.

Table 1: Comparison of Legislative Mandates and Minnesota's Progress

Outcome	Legislative Outcome for 2025	2021 Minnesota Data
1. Increase percentage of individuals living with HIV who know their serostatus to at least:	90%	89%
2. Increase percentage of individuals diagnosed with HIV who are retained in care to at least:	90%	71%
3. Increase percentage of individuals diagnosed with HIV who are virally suppressed to at least:	90%	91%
4. Reduce annual number of new HIV diagnoses by at least	25% (75% by 2035)	1.1% increase from 2017 to 2018 3.5% decrease from 2018 to 2019 4.0% decrease from 2019 to 2020/2021*

* The number of new infections diagnosed in 2020 is not representative of a normal year in Minnesota due to COVID-19. As a result, the average annual number of new infections from 2020 and 2021 combined was compared to the number of new infections from 2019.

A fundamental part of HIV prevention is reducing missed opportunities to identify and treat people living with HIV. In Minnesota in 2020, 22% of new cases were late testers, meaning they were diagnosed with AIDS disease within one year of their initial HIV diagnosis (HIV is the virus that causes AIDS). These cases represent missed opportunities for earlier diagnosis and treatment.

An estimated 1,100 people living in Minnesota are unaware of their HIV infection. Additionally, 29% of people who are aware of their infection (nearly 2,800 additional people) are not in care. CDC estimated in 2019 that these two populations, those who are unaware of their HIV infection and those who are aware but not in care, are responsible for 80% of new infections.

MDH currently receives both state and federal funding for HIV programmatic activities and external grants. Since 2002, MDH has also received HIV rebate revenue generated through the federal 340B rebate program via an interagency agreement with DHS. However, MDH learned in October 2022 that the amount of rebate revenue we will receive from DHS would decrease by nearly 60% beginning January 1, 2023, which subsequently results in a decrease of grants being awarded to community-based organizations and clinics to implement HIV prevention interventions. In addition, five staff positions were moved to short-term funding that ends in 2025 and 2.50 vacant FTE staff are not currently being filled.

Even before the loss of rebate funds, the level of state and federal funding has been insufficient to support the staff and interventions required to end the current outbreaks, prevent future outbreaks, address ongoing HIV health inequities, and achieve and maintain the legislatively mandated outcomes. This request replaces the lost rebate revenue.

Proposal:

This proposal will allow MDH to continue its critical work in addressing the health inequities of communities experiencing the greatest rates of HIV through programing and ensure that the END HIV MN objectives are met

through the end of FY 2025. The recommendation amount is the average amount per year that MDH would have received from DHS. It will fund the following:

- $1,264,100 per year in grants to fund HIV testing, pre-exposure prophylaxis, and harm reduction[1] programs at community organizations and clinics at the amount originally planned prior to the reduction in rebate revenue. These grants will reach persons disproportionately impacted by HIV as described above.
- FTE staff to manage the additional grant agreements.
- FTE staff to focus on implementing harm reduction interventions and policies through coordination with community partners and people who use or inject drugs.
- 0.50 FTE student worker to assist with coordinating and delivering HIV testing trainings to HIV testing grantees. Student worker will also assist with organizing and implementing HIV testing events.
- Purchase of supplies needed by MDH funded organizations funded for HIV prevention services.
- One media campaign to reach populations at highest risk. The campaign would target a new population each fiscal year.

Impact on Children and Families:

The encampment-related outbreak includes pregnant persons who are living with HIV and did not receive adequate prenatal care; were coinfected with syphilis, gonorrhea, hepatitis C, or hepatitis B; engaged in substance use; and/or experienced mental health issues. Forty percent (40%) of these cases are women of child-bearing age. There have been several high-risk pregnancies, births, and miscarriages during the outbreak in the encampments. None of the births resulted in HIV transmission to the infants; however, they were near misses and the infants required intensive care due to prematurity, neonatal abstinence syndrome, and respiratory distress, as well as intensive follow-up treatment care to ensure they did not get HIV. It is crucial that HIV positive pregnant people receive care and treatment during their pregnancy to ensure their babies are born health and do not have HIV.

Equity and Inclusion:

People who identify as AI/AN, Black/African American, or Latine/Latinx, along with those in the LGBTQ+ community and other marginalized groups and individuals, are disproportionally impacted by the HIV outbreaks and by HIV in Minnesota generally.

People who identify as AI/AN make up 51% and 34% of the HIV outbreaks cases (encampment and Duluth outbreaks respectively) and 3% of new diagnoses in 2021 yet account for only 1% of the population in Minnesota. Those who identify as Black/African American make up 17% of the HIV outbreak cases and 41% of new diagnoses in 2021 but only 7% of the population in Minnesota. People who identify as Latine/Latinx (any race) make up 7% of outbreak cases and 14% of new diagnoses in 2021 but represent only 6% of the population in Minnesota.

HIV testing, linkage to care for those newly infected with HIV, and prevention services for those at greatest risk are key interventions to adequately address the ongoing HIV outbreaks in Minnesota and to achieve the mandated END HIV MN outcomes. Supporting community-based organizations and clinics and providing culturally and linguistically appropriate services for those disproportionately impacted by HIV is crucial.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

[1] The Substance Abuse and Mental Health Services Administration defines harm reduction as “an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission; improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services.

Tribes that have been impacted by the HIV outbreaks would be eligible for the community grants. Some of the tribes are highly impacted by the syphilis outbreak and we have been working with them, so we think they will be supportive. MDH consulted with our tribal liaison who is supportive of this proposal and will assist us in reaching out to the tribes.

IT Costs: None

Results:

The short-term goal is to provide grants to community organizations working in outbreak and other geographic areas to prevent and control the transmission of HIV. The long-term goal is to reduce HIV transmission in Minnesota.

MDH will continue to monitor the four legislatively mandated outcomes, focusing efforts on retaining people with HIV in medical care, and decreasing the annual number of new HIV infections. See Table 1 (above) for the legislatively mandated outcomes.

Statutory Change(s):

Minnesota Statutes, section 145.924 (AIDS Prevention Grants).

Change Item Title: Information and Telecommunications Account Extension

Fiscal Impact ($000s)	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
General Fund					
Expenditures	(292)	292	0	0	0
Revenues	0	0	0	0	0
Other Funds					
Expenditures	0	0	0	0	0
Revenues	0	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(292)	292	0	0	0
FTEs	**0**	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends reallocating $292,000 from fiscal year 2023 to fiscal year 2024 for the purpose of completing two Information and Telecommunications Account (ITA) projects. The projects include modernization activities related to the department's external website and developing electronic workflow solutions for critical business operations. There is no fiscal impact.

Rationale/Background:

Due to delays caused by the three years the Minnesota Department of Health (MDH) was responding the COVID-19 pandemic, two important ITA projects experienced delays in completion of planned goals. First, while MDH has one of the largest websites among state agencies, the site has been historically under-resourced and it is showing its age. To ensure our ongoing ability to provide vital information to Minnesotans online, we have an urgent need to improve the accessibility, functionality, and user experience of our site. We also need to improve website navigation and introduce a content management system to allow greater centralized control and curation. We have already made significant progress toward a new site, completing extensive research, design and planning related to user experience, and restructuring the existing site's content to better reflect the way users understand and look for MDH information. The final phase of this project, migrating the site into a content management system and updating the design, is needed to ensure the site has all elements in place to maintain a clean, customer-friendly site in the future.

Additionally, MDH is in the process of automating manual and paper-based processes for critical business operations including financial management, human resources, facilities management, and other centrally shared services. MNIT resources are needed to carefully gather business requirements and design a plan and approach to identify, procure, pilot and implement technology solutions. These solutions will strengthen internal controls, improve productivity, reduce manual handoffs, improve workflow and tracking, increase process transparency, create ability to track and report performance metrics, and strengthen records retention compliance for services used by all divisions across the department.

Proposal:

This proposal recommends shifting a portion of the funding allocated from FY 2023 to FY 2024 to two ITA projects to complete activities delayed by reallocation of personnel resources to the COVID-19 pandemic response. The amount to be shifted include $192,000 for the external website modernization project and $60,000 for the business process modernization project. These projects require a final year to accomplish intended activities.

The completed external website project will include a content management system and other components to ensure that the site can be maintained at a level of quality to help our stakeholders find what they need when they need it – regardless of what device they are using. The completed business system automation will automate administrative processes, increase workflow transparency, and enable more useful performance metrics through data analytics.

Impact on Children and Families:

Results of these project will ensure that public health information is available to all Minnesotans and that resources are used and tracked in a manner that demonstrates responsible stewardship.

Equity and Inclusion:

This proposal allows for the completion of a project intended to increase availability of public health information to the public. The improvements to MDH's external facing website will ensure access for persons regardless of the type of device used for accessing content.

IT Costs

Please complete the table below to indicate costs for FY 2024-29. Specify the purposes of the funding proposal, such as infrastructure, hardware, software, or training. If staff are associated with this request, specify the number of FTEs that are MNIT employees (i.e., MNIT@agency) and agency employees. For proposals with significant IT investment, please also complete the IT addendum below.

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll	0					
Professional/Technical Contracts	292					
Infrastructure	0					
Hardware	0					
Software	0					
Training	0					
Enterprise Services	0					
Staff costs (MNIT or agency)	0					
Total	**292**					
MNIT FTEs	0					
Agency FTEs	0					

Results:

Project	What are the project's success metrics?	How Measured?
External Website Redesign	Website content is accessible for those using assistive technologies and responsive for those using mobile devices	No critical/major issues identified when using accessibility and responsiveness testing tools

External Website Redesign	MDH website content is migrated to the new web content management server.	No static content still exists on the current web server.
Business Process Automation	Reduce turn around for transactions by 20%	Compare baseline turn around for transactions to post implementation
Business Process Automation	Reduce costs for paper storage and filing by 20%	Compare cost post implementation for storage services and staff time spent filing to baseline
Business Process Automation	Improve customer satisfaction for process transparency	Establish survey for stakeholders to measure pre and post implementation

Statutory Change(s):
N/A

Change Item Title: Lead Service Line Replacement

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	120,000	120,000	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	120,000	120,000	0	0
FTEs	**0**	**0**	**0**	**0**

Recommendation:
The Governor recommends an appropriation of $120,000,000 in FY 2024 and $120,000,000 in FY 2025 from the General Fund to the Public Facilities Authority for grants to replace lead service lines.

Rationale/Background:
These state appropriations would supplement federal funds from the Infrastructure Investment and Jobs Act (IIJA) dedicated to replacing lead service lines. Forty-nine percent of the federal money must be used for grants to local government, up to sixteen percent is available for set-aside activities, the remainder must be used for loans to local government.

The Public Facilities Authority's costs for administration of lead service line replacement activities will come from federal IIJA money. Up to four percent of the federal grants may be used for admin (this is part of the up to sixteen percent available for set-asides).

Up to 10% of the appropriation will be transferred to the Department of Health for grants to municipalities for mapping lead service lines. Transfers will be through interagency agreements between the authority and the department. The agreements may allow for a portion of the amount transferred to be used by the department for administrative costs related to lead service line replacement.

Proposal:
This is a new initiative.

The state appropriations would be used, together with the federal money, to:

- Make grants to local government to map inventories of lead service lines;
- Make grants to local governments for the safe removal, replacement, and disposal of, lead service lines;
- Pay for a portion of the department of health’s related administrative costs.

Equity and Inclusion:
All residents currently having lead service lines in their water supply will benefit from the safe removal and replacement of those lines.

IT Costs
N/A

Results:
The intended result of this proposal is to protect public health by replacing drinking water lead service lines in municipal water systems.

Statutory Change(s):
None.

Change Item Title: MN Uninsured and Underinsured Adult Vaccine (UUAV) Program

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,470	1,470	1,470	1,470
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,470	1,470	1,470	1,470
FTEs	**1.0**	**1.0**	**1.0**	**1.0**

Recommendation:

The Governor recommends an ongoing general fund investment to support the Uninsured and Underinsured Adult Vaccine (UUAV) program that will address health inequities for those Minnesotans least likely to seek preventative care. Supplementing insufficient federal funding, MDH will purchase 32,000 doses of routine immunizations, at a reduced price, for 173 provider sites throughout the state serving uninsured and underinsured adults aged 19 years and older. Of the total appropriation, $1,330,000 annually is to purchase vaccines.

Rationale/Background:

Vaccination is one of the most successful public health interventions in reducing disease spread, preventing hospitalizations and long-term complications, and deaths from vaccine preventable diseases.

Vaccines are also among the most effective and cost-effective preventive health interventions available. For every $1 invested in childhood vaccines, there is an estimated $16-44 saved (Ozawa et al. 2016).

Despite the demonstrated benefits of vaccines, most adults are missing one or more vaccines recommended by CDC's Advisory Committee on Immunization Practices (ACIP). The most recent published data on all routinely recommended vaccines from the 2018 National Health Interview Survey found that at least three out of every four adults are missing one or more of four routinely recommended vaccines. Moreover, because of the COVID pandemic, racial disparities in vaccine coverage in adults worsened.

Both access to vaccine and cost are commonly noted as barriers to improving adult immunization rates.

The UUAV program is an existing program at the Minnesota Department of Health currently funded by the Centers for Disease Control and Prevention (CDC). UUAV offers free or low-cost vaccine for eligible adults age 19 years and older who do not have insurance or whose insurance does not cover vaccines. Vaccine is purchased at a reduced-price using a contract negotiated by the CDC with manufacturers and utilizes the shipping and distribution infrastructure that CDC built for the Vaccines for Children (VFC) program. Most clinics enrolled in the UUAV program offer all routinely recommended vaccines for adults.

This limited CDC discretionary grant funding has not been able to keep up with demand due to new, more expensive vaccines coming to market for adults as well as increased interest in adult vaccines due to the COVID-19 pandemic. Due to these constraints, the UUAV program has had to reduce the number of providers that are in the

program and limit the routine vaccines it can offer. For example, Shingrix, the vaccine to prevent shingles in adults has been removed from the program due to the cost per dose.

Without additional funding, we are facing additional cuts to the program either through eliminating additional routine vaccines from the program or reducing the number of providers who can participate. Because the expansion of Medicaid due to the COVID-19 pandemic is ending, we are expecting an increase in uninsured adults in Minnesota, so additional cuts to the program will leave more Minnesotans vulnerable to vaccine preventable diseases. With increased, stable state funding for vaccine, we hope to maintain our network of UUAV safety net providers and ensure they can get adequate supply of vaccine to serve the uninsured and underinsured population in the state.

The CDC offers states the ability to purchase vaccines at a discounted price from the contracts they negotiate with manufacturers. However, in the last four years prices on that contract have risen 23% due to new, more expensive vaccines being added to the adult immunization schedule. This increase, along with an increased demand for adult vaccines due to the COVID-19 pandemic, has caused the expenses of the program to outpace the federal dollars we are appropriated to support it. We estimate we will need a 50% increase in the current level we have to maintain the program as is.

Proposal:

This proposal addresses the increasing shortfall of the current federal funding to ensure that uninsured and underinsured adult Minnesotans, who are disproportionally people of color, have access to the routine immunizations on CDC's recommended adult schedule. Recommended adult vaccines include those for flu, tetanus, shingles, pneumonia, meningitis, and hepatitis (https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html).

The proposal will specifically fund the following:

- $1,330,000 per year to purchase approximately 32,000 doses of vaccine for 173 provider sites throughout the state for uninsured and underinsured adults, aged 19 years and older
- 1 FTE staff to coordinate the MDH UUAV program. Responsibilities include managing vaccine ordering, enrolling and providing assistance to UUAV providers, and ensuring annual reporting is completed.

Impact on Children and Families:

Keeping adults and caregivers healthy and out of the hospital due to vaccine preventable diseases is fundamental to the health, safety and wellbeing of children and families. Immunizations are an effective measure to keep adults out of the hospitals due to preventable disease. Vaccinating the adults in the household also prevents spread of disease to vulnerable family members, including children. The UUAV program eliminates the cost barrier to offer vaccines to patients without insurance or with insurance that doesn't cover vaccines.

Equity and Inclusion:

While Minnesota's uninsured rate fell to its lowest-ever measured level (4%) because of federal and state policies and funding through the COVID-19 pandemic racial disparities in coverage worsened. The uninsured rate among Minnesotans of color and American Indians rose from 7.6% in 2019 to 10.2% in 2021. In contrast, the uninsured rate dropped among non-Hispanic Whites from 3.7% in 2019 to 2.4% in 2021. Source: MDH Health Economic Program and University of MN School of Public Health. MN Health Access Survey

Funding this proposal will reduce disparities that adult people of color disproportionately have in accessing immunizations that reduce morbidity and mortality related to vaccine preventable diseases.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

While there is no substantial direct effect on Minnesota Tribal governments, there are tribal clinics that are enrolled in the UUAV program. Without additional funding, these clinics could see a reduction in the vaccines available to them through this program. MDH will consult with Tribal governments and our tribal liaison as needed.

IT Costs
None

Results:
Part A: Performance measures

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of Doses Distributed (shipped to providers)	33,260	Federal Fiscal Year 2022	24,460	58,527	Federal Fiscal Year 2024
Quality	Number of provider sites enrolled in the program	173	Federal Fiscal Year 2022	100	173	Federal Fiscal Year 2024
Results	Number of underinsured and uninsured people vaccinated	29,450	Calendar Year 2022	21,524	51,503	Federal Fiscal Year 2024

Part B: Evidence-based practices (optional)

Evidence-based Practice	**Source of Evidence**
Ensuring access to adult vaccines is a cost-effective practice	https://www.sciencedirect.com/science/article/abs/pii/S0091743519301963?via%3Dihub
Reducing out-of-pocket costs as an intervention to improve coverage of vaccines recommended for routine use among children, adolescents, and adults.	https://www.thecommunityguide.org/media/pdf/Vaccination-Provider-Assessment-and-Feedback.pdf

Statutory Change(s):
None.

Change Item Title: Preserving Funding for Medical Education and Research Costs

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,482	1,482	1,482	1,482
Revenues	149	149	149	149
MERC Fund				
Expenditures	(7,725)	(7,725)	(7,725)	(7,725)
Revenues	(7,725)	(7,725)	(7,725)	(7,725)
Other Funds (Dedicated Account)				
Expenditures	7,576	7,576	7,576	7,576
Revenues	7,576	7,576	7,576	7,576
Net Fiscal Impact = (Expenditures – Revenues)	1,333	1,333	1,333	1,333
FTEs	**1.10**	**1.10**	**1.10**	**1.10**

Recommendation:

The Governor recommends a general fund investment to transition funding for the Medical Education and Research Cost (MERC) program out of the MERC fund. This includes an annual general fund appropriation of $1,182,000 beginning in fiscal year 2024 for the clinical dental education innovations grant program to increase dental access for underserved populations and promote innovative clinical training of dental professionals, and an annual general fund appropriation of $300,000 beginning in fiscal year 2024 for administration of the MERC grant program to replace the current $149,000 in administration funding that was previously appropriated from the MERC fund in Minnesota Statutes 62J.692, subdivision 4 (g) and adding $151,000 in general funds. Additionally, a dedicated MERC account would be established in the special revenue fund for deposit of the existing cigarette tax revenue per Minnesota Statutes, section 297F.10, subd. 1(2). This is a joint proposal with the Minnesota Department of Human Services (DHS).

Rationale/Background:

The Medical Education and Research Cost (MERC) grant was established in 1996 to provide support for medical education activities in Minnesota that were historically supported in significant part by patient care revenues. The grant recognizes Medicaid's share of the costs of training new medical professionals. The Centers for Medicare and Medicaid Services (CMS) released a rule that the current payment methodology was no longer permissible. In order to have medical education costs recognized, the federal agency required that DHS reconfigure payment mechanisms. DHS has requested to shift the funds that were previously carved out of the Medicaid rates and distributed through MERC payments to a methodology that will distribute the medical education component through fee-for-service rates to comply with CMS guidance. This necessitates a number of updates to the statutes that govern the MERC program.

Proposal:

The proposal eliminates the Medical Education and Research Cost (MERC) fund in the state treasury. DHS payments for the MERC formula grants will instead be from the general fund, rather than being passed through MDH. MERC payments by DHS will be maintained at $49,552,000 per year, the same amount in fiscal year 2022. MDH will continue to gather the information from hospitals and clinic sites and perform the calculations that determine the amounts that will be paid out through the rates.

A dedicated MERC account in the special revenue fund would be established by MDH for the receipt of the existing $3,788,000 in cigarette tax revenue per Minnesota Statutes, section 297F.10, subdivision 1(2), and for the DHS federal match, for the continued annual total of $7,576,000. Administration of the MERC is not eligible for federal match, so the proposal would directly appropriate $300,000 annually from the general fund beginning in fiscal year 2024 to MDH for administration of the MERC account and formula, an increase of $151,000 over prior levels to allow for the addition of 0.7 full-time equivalent staff (FTE) and for information technology costs.

The proposal maintains the clinical dental education innovations grants previously authorized by Minnesota Statutes, section 62J.692 subdivision 7(4), by placing the authorization in section 144, with an annual general fund appropriation of $1,122,000 per year beginning in fiscal year 2024 for grants, plus 0.4 FTE for administration each year. These grants were previously appropriated in the MERC fund.

The proposal directs amounts appropriated for MERC distribution in prior session law to support providers who are unaffiliated with a hospital as required by the new DHS funding. A total of $1,000,000 in the annual Health Improvement general fund base previously appropriated by the Laws of 2015, chapter 71, article 14, section 3, subdivision 2, and a total of $1,000,000 in the annual Health Improvement health care access fund base previously appropriated by the Laws of 2016, chapter 189, article 23, section 3, subdivision 2, are proposed for distribution according to the revised Minnesota Statutes, section 62J.692, subdivision 4(b).

Impact on Children and Families:

This proposal will continue a program that is designed to provide critical funding for training providers who treat Minnesotans, including children and families who have low incomes and are eligible for Medical Assistance and Prepaid Medical Assistance.

Equity and Inclusion:

The MERC formula is designed to give weight to facilities that train providers working with and providing services to people who have low incomes and are receiving support through Medical Assistance and Prepaid Medical Assistance.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

The proposal includes $26,000 for improvements and maintenance of information technology systems to manage the MERC formula application portal and distribution processing, which has greatly eased the application process for stakeholders.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of dental innovation grants	$1.122 million	FY 2023	$0	$1.122 million	FY 2024

Statutory Change(s):

Minnesota Statutes, section 62J.692; 144.1913; 297F.10; 256B.69; 256B.969, subd. 2b (k); 256B.75(b)

Change Item Title: Clean Water Legacy—Drinking Water Contaminants of Emerging Concern

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Clean Water Fund				
Expenditures	4,746	5,354	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	4,746	5,354	0	0
FTEs	**17.36**	**25.46**	**0**	**0**

Recommendation:

The Governor recommends a clean water fund investment to support the department's capacity to respond to new Environmental Protection Agency (EPA) regulations and information related to the health effects of per- and polyfluoroalkyl substances (PFAS). This funding will support expert toxicologists, epidemiologists and risk assessors working to develop health-based water guidance values used to provide health risk context for PFAS currently detected in Minnesota's waters.

Additionally, the proposal will support the department's Public Health Laboratory in expanding its PFAS testing capacity for the increased number of drinking water and environmental samples that will need to be tested as well as for developing new capabilities to look for currently unidentified PFAS chemicals through non-target analysis and total fluorine analysis.

This funding will also support the Minnesota Environmental Laboratory Accreditation Program (MNELAP), which will work to accredit the many private laboratories that will be bringing on PFAS testing methods in response to new EPA regulations scheduled to go into effect in 2023.

Rationale/Background:

PFAS were first detected in Minnesota's water in 2002. Subsequent work by MDH and the Minnesota Pollution Control Agency (MPCA) identified a large PFAS groundwater plume in the East Metro. Since that time, it has become apparent that PFAS are ubiquitous in the environment, in consumer goods, medical equipment, and in industrial processes throughout the world. States have had to do their own investigations of the scope of the environmental contamination and human exposures. PFAS were once characterized as a handful of related chemicals, but currently they are numbered in the thousands. Virtually all Minnesotans have measurable PFAS in their blood and the health risks associated with this are only now beginning to be understood.

Most PFAS have little to no toxicological information available. To protect public health, MDH needs expertise to incorporate new toxicological methods and data streams into Minnesota's current risk assessment methods. Currently, the federal government does not have any regulatory standards for PFAS in drinking water, but there are two under development, with an expected release date in 2023. Since 2002, MDH has been able to derive health-based water guidance values for six PFAS. Recent monitoring by MDH has shown that Minnesotans are currently being exposed to 13 or more PFAS that have no MDH (or federal) water guidance values. Deriving guidance for these 13 PFAS, with more expected to be added to the list as sampling continues, drives the need for additional toxicologists, risk assessors, and epidemiologists to move quickly and provide much needed health risk

context for environmental and drinking water detections. Minnesota does not receive federal resources to support risk assessment work needed to protect public health in relation to this evolving problem.

The department's Public Health Laboratory (PHL) has been testing for PFAS for the past 20 years and was one of the first labs in the country to develop a test for PFAS in drinking water. The PHL has also led in developing biomonitoring methods for PFAS in serum, and testing of dust, soil and produce. New methods, such as non-targeted analysis, and Total Oxidizable and Organic Fluorine must be developed to understand the full impact of PFAS on Minnesota waters. These analyses require specialized training and equipment. The volume of samples has also been steadily increasing over time as more partners are sampling in more places to describe the scope of PFAS contamination in Minnesota. This volume is expected to further increase as the EPA releases new regulations. For example, when the federal government releases new drinking water regulations, regular sampling by all public water supplies (900+ in Minnesota) is required. The demand from our key stakeholders for environmental laboratory analytical expertise in this arena has significantly outpaced our current laboratory capacity of staffing and equipment and the PHL is currently unequipped to deal with the expected needs for PFAS testing in the coming years.

Having a robust environmental lab accreditation program will ensure that public and private labs conducting testing on the waters of the state are providing reliable and reproduceable PFAS results. The department requires accredited environmental laboratories to meet the national standards in staffing, data collection, and rigor so that laboratories generate defensible and accurate data for various federal and state environmental programs and clients. The department's laboratory accreditation program was established through EPA primacy to ensure safe drinking water for all Minnesota residents, by supporting a robust system of laboratories that can reliably test water quality across the state and disseminate the results. PFAS substances present regulatory challenges in that there are no federal or state promulgated methods. The lack of promulgated methods has led to variations in how laboratories analyze these complex chemical substances to meet the increasingly lower regulatory detection limits. These PFAS methods require specialized expertise to process and identify the chemical substances to ensure the results meet the data accuracy and defensibility requirements.

Proposal:

This proposal will allow for both new PFAS work and existing programmatic work to continue at MDH. Since 2002, MDH and its partners have worked to characterize and evaluate the environmental and public health impacts of PFAS in Minnesota. The scope of the problem has become so large that new approaches and additional staffing are now needed. This is particularly true because these chemicals are highly persistent both in the environment and in the human body, making this a long-term problem. It is also an area of active research as new understandings of the dangers of exposure to PFAS are continually being made.

Core toxicology and risk assessment staffing levels at MDH have not changed much over the past twenty years, yet the problem has grown in both size and complexity. This proposal adds FTE staff to the department's risk assessment program. Added staff will allow for the incorporation of human health data (epidemiology studies) into PFAS risk assessments, which improves their quality and accuracy. It will also allow for the development of new methods to review PFAS more quickly and with newer types of toxicological information, so it doesn't take months to derive water guidance for a single contaminant. This is particularly important as many PFAS have little to no human health data. As stated above, recent sampling by MDH of public water supplies revealed 13 PFAS present in finished drinking water with no water guidance, federal or state. Being able to respond to these kinds of environmental detections with new cutting-edge methods and epidemiological approaches is critical to protecting the health of Minnesotans who are already being exposed. There currently is no capacity for this type of work.

New health advisory limits suggest PFAS are toxic in drinking water at exceptionally low concentrations (in the parts per quadrillion) and therefore, highly sensitive instruments are needed to detect these compounds. This funding investment will purchase a new LC-MS/MS instrument and extraction equipment that is needed for low

concentration PFAS detection. This equipment would cost approximately $700,000 the first year. Additional equipment will also need to be purchased to meet the estimated increased volume of samples expected in response to the release of the new EPA regulations.

In addition, to fully understand the extent of PFAS contamination in Minnesota, new methods that allow the identification of larger numbers of PFAS must be developed. Non-target analysis allows the identification of thousands of PFAS not routinely tested for and requires the use of a High-Resolution Mass Spectrometer (HRMS) that is capable of quantifying concentrations of contaminants and identifying thousands of compounds in one analysis. These are incredibly useful tools for tracking contamination sources and this proposal will lease this instrument beginning in fiscal year 2025 for approximately $200,000.

Finally, the PHL would like to bring on Total Oxidizable Precursors (TOPs) and Total Organic Fluorine (TOF) tests. It is known that thousands of PFAS compounds exist in the environment. Our current understanding of the distribution of PFAS in MN beyond the roughly two dozen that are currently looked for is poor. The TOP and TOF tests provide information on the contribution of the rest of the PFAS compounds. The TOP test uses oxidation to mimic what would happen to these other PFAS compounds in the environment if they were to degrade to become a stable end-product. This method can be analyzed on an LC-MS/MS so no additional instrumentation would be needed. Supplies to bring this method on would cost approximately $50,000. The TOF test measures the total amount of organic fluorine in the sample using Combustion Ion Chromatography. This measure of total organic fluorine is compared to the targeted test results to determine the extent of the unknown compounds not currently identified. A Combustion Ion Chromatograph costs approximately $150,000. These three new tests; non-target, TOP and TOF are critical to fully understand the extent of the PFAS problem in Minnesota.

Increasing the testing capacity of the PHL and developing these new tests will require an increase in staffing. The PHL plans to establish an analytical unit dedicated to PFAS testing. The unit would consist of a unit supervisor and seven chemists tasked with developing new methods and analyzing samples. The increase in samples will also require additional administrative employees. The PHL is also asking for a sample receiving staff member and two data review employees.

This proposal also funds three FTE staff to ensure that private accredited environmental laboratories can perform and report PFAS analytical results that align with the PFAS Blueprint for preventing, managing, and cleaning up PFAS contaminated areas. This will be accomplished through increased assessor oversight and evaluation of accredited labs, proficiency testing evaluation, data review, complaint and enforcement follow-up on accredited labs, and ensuring labs are in compliance with updated state and federal regulations. The proposal also includes database updates and other IT enhancements to accommodate credentialing and laboratory data review.

There is an interrelated web of work being completed on the PFAS problem in Minnesota. It relies on staff from the Minnesota Department of Agriculture, MPCA, MDH, DNR and MDH to identify and manage PFAS impacts. Toxicological reviews play a large role because health-based guidance values developed by MDH are used by MDA, DNR and MPCA to understand if environmental detections present a human health risk. Without the sampling and analyses provided by MPCA, MDA, DNR and MDH, Minnesotans wouldn’t know they are being exposed, and therefore wouldn’t know to make different choices to protect their health. Additionally, coordinated response programs would not happen, such as public meetings where toxicological and exposure information is shared with affected community members.

The enhanced database and FTEs will implement and automate tools to document ongoing quality-related or operational activities, compliance reporting, enforcement, and PFAS data and records management. The department will ensure that public and private environmental laboratories are held accountable to standards that support defensible and accurate data from which decisions are made regarding the environmental conditions in Minnesota. The assessments, collection and analysis data, issuance of enforcement reports, assessment oversight

will be performed according to the environmental laboratory accreditation requirements under Minnesota Statutes, section 144.98.

Impact on Children and Families:

Research has shown that the smallest among us, infants and children, are usually the most heavily exposed to chemicals in drinking water. In the case of PFAS, breastfed infants have the highest exposure because it passes through the breast milk of the mother. To reduce and prevent these exposures, prevention needs to occur years before a woman becomes pregnant and breastfeeds because PFAS builds up in the body over a long period of time, and it also takes a long time for levels in the body to decline. Research by the MDH has shown that reducing exposures through water (where they occur) is the most effective strategy for lowering how much PFAS is in peoples' blood. But in order to reduce water exposures, the type and concentration of PFAS in drinking water sources must be characterized and risk assessments to describe the toxicity of those PFAS must be completed.

Based on the current science, it is highly likely that exposure to PFAS in infancy and childhood results in a lowered immune response to vaccination. This may result in infants and children being more susceptible to the illnesses that they are vaccinated against. Additionally, this reduced response to vaccination indicates a potential disruption in how their immune system is working. This is an area that is currently under investigation, but its implications for the wellbeing of children are concerning. A healthy immune system is critical for health.

PFAS have been detected in public drinking water and private wells in Minnesota. The testing of PFAS can be expensive and are performed by a small number of accredited environmental laboratories. This proposal will ensure the laboratories using the specialized equipment and quality control procedures meet the method detection limits for private and public drinking water supplies for families to take action to remediate sources and reduce exposures.

The EPA does not regulate private wells and private well owners are responsible for the safety of their own water. This proposal provides the staffing and MNIT infrastructure necessary to support current and additional PFAS laboratories that are analyzing and reporting data for private and public water supplies.

Equity and Inclusion:

The development of water guidance values includes an exposure review to identify how people are being exposed and to what concentrations. Part of this funding request would go to enlarging the exposure review to identify specific communities and populations that may be more highly exposed or more sensitive to PFAS. Current methods do not specifically call out processes to look at historically underserved populations and communities. Enhancing our processes to capture available data in this area would help us make sure we are addressing health equity and environmental justice concerns for all Minnesotans. Information about the toxicity of PFAS found in Minnesota's waters related to sensitive populations and communities would be shared with risk managers in other programs at MDH and at our sister agencies for consideration during regulatory activities.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

The tribal nations in MN have not been consulted about this issue as they relate directly to US EPA for their community systems. Likewise, they are not required to respond to our state guidance values. However, given the ubiquitous nature of PFASs, we expect that their groundwater sources of drinking water are potentially affected as well. Data, information, and health risk guidance that we gain from this initiative may be helpful to tribal nations as well.

IT Costs

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll	0	0				
Professional/Technical Contracts	0	0				
Infrastructure	0	0				
Hardware	0	0				
Software	30,000	30,000				
Training	0	0				
Enterprise Services	0	0				
Staff costs (MNIT or agency)	370,386	113,496				
Total	**400,386**	**143,496**				
MNIT FTEs						
Agency FTEs						

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Annual laboratory capacity for testing drinking water samples for PFAS compounds	5,000	9/8/22	5,000	15,000	5/1/24
Quantity	Annual laboratory capacity for testing fish for PFAS compounds	0	9/8/22	300	1,000	5/1/24
Quantity	Annual laboratory capacity to conduct non-target analysis of samples for expanded list of PFAS compounds	0	9/8/22	10	200	5/1/24
Quantity	Annual laboratory capacity for testing samples for Total Oxidizable Flourine and Total Organic Fluorine	0	9/8/22	0	500+	5/1/24
Quantity	Annual laboratory capacity for testing human serum samples for PFAS compounds	1,000	9/8/22	1,000	3,500	5/1/24
Quantity	New health-based water guidance values for PFAS	6	9/14/22	8	15	6/30/24
Quantity	Reevaluation of existing PFAS water guidance values	0	9/14/22	2	6	6/30/24

Statutory Change(s):

None

Change Item Title: Clean Water Legacy—Future of Drinking Water

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Clean Water Fund				
Expenditures	250	250	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	250	250	0	0
FTEs	**0.69**	**0.69**	**0**	**0**

Recommendation:

The Governor recommends a clean water fund investment in strategic planning and policy development that will protect Minnesota's drinking water from new threats and challenges and address inequities in access to safe drinking water. The activities proposed include public engagement and review of the draft statewide, multi-agency Protecting Minnesota's Drinking Water Plan, policy development focused on risk management of emerging threats, and follow up on select recommendations from the University of Minnesota's Future of Drinking Water (PDF) report.

There is no ongoing base in the clean water fund and amounts must be appropriated each budget cycle. The recommended level is the same as the amount appropriated in the 2022-2023 biennium for this activity.

Rationale/Background:

Minnesotans expect to be able to go anywhere in the state and be confident that the water they drink is safe. Safe, sufficient, and affordable drinking water is an essential contribution to the department's mission. People who drink from private wells do not have the same protections as those who drink from more highly regulated public water supplies. Yet even for public water systems, new threats that are not addressed by the federal Safe Drinking Water Act are increasing in recent years. New contaminants, expanded knowledge about health effects, aging infrastructure, and workforce shortages all threaten the safety of Minnesota's drinking water. This initiative engages the water agencies, state and national experts, and local partners to complete an action plan and develop policies that go beyond current regulatory requirements to address emerging threats and ensure long-term, safe, and sufficient drinking water in Minnesota.

Proposal:

Current federal and state regulations no longer provide adequate health protection for customers of public water systems and users of private wells. The Future of Minnesota's Drinking Water initiative will engage the public as we complete an actionable state drinking water plan to protect against new threats that endanger safe drinking water in Minnesota. In response to mounting threats, this initiative will develop specific activities and policies that address technological, behavioral, economic, and social factors that either protect or threaten drinking water.

Additionally, this initiative will focus on implementation of select recommendations from the University of Minnesota's (UMN) Future of Drinking Water report that will prepare both public and private well supplies to adapt to an uncertain future. A multi-agency team comprised of the water agencies in the executive branch along with the Metropolitan Council will complete the plan, including incorporation of diverse stakeholder voices. As recommended by the UMN report, the team will use a modified Governance Assessment Framework to

systematically evaluate the integration of drinking water protection actions across agencies and partnerships against twelve specific criteria of good water governance. These criteria are grouped into three broad areas: 1) effectiveness of governance and management, 2) efficiency of implementation and delivery, and 3) trust in the system as well as inclusion of diverse interests. The department will design a structured approach to ensure periodic review and assessment of plan progress with defined actions, timelines, measures, and milestones, as well as explore ways to be more transparent including engaging a broader, more diverse audience in decision-making and communication.

The proposal will continue to fund two partial FTEs in the Water Policy Center. A contract will provide applied economic expertise in the areas of cost/benefit analysis and comparative risk assessment of multiple contaminants, both of which are in the UMN report recommendations. The proposal also includes funding for a contract to conduct public engagement with water resource professionals, public water system customers, and private well users. Last biennium's funding supported initial development of the draft plan, an external review of the Community Public Water Supply unit organization and functions considering new federal regulations and policies to support risk management for unregulated contaminants, and external review of the Public Water Supply section's response to threats from repercussions from the COVID-19 pandemic.

Impact on Children and Families:

Access to a plentiful supply of safe and affordable drinking water is an essential condition for healthy children, families, and a healthy economy. Water contaminants such as nitrate and manganese, are especially risky for fetuses and infants with health effects that can affect their development or can lead to death. A recent assessment of county and city regulations found little regulation of the water quality in wells that serve rental properties that are not large enough to be covered by the Safe Drinking Water Act. Any actions depend on the initiative of the property owner and there is no data on water quality, frequency of testing, or actions taken to ensure the drinking water is safe for the renter.

Equity and Inclusion:

Health equity will be woven into the public engagement and policy options for ensuring equitable access to safe drinking water through public and private water supplies. Initial concerns include: many smaller, rural systems lack large customer bases to share the costs of new infrastructure; private well owners are responsible for testing and treating for contaminants in their well, but often lack technical understanding or financial resources for testing and treatment; and both public water systems and private well owners bear the cost of treating for contamination from sources outside of their control.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs:

None

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of public engagement opportunities to review the draft plan	0	NA	0	5 residents and 5 water resource professionals or local public health (or 10 academic experts)	Summer 2023
Quality	Recommendations from the University of Minnesota report that are incorporated into programmatic work	0	FY 2021-2022	0	2	FY 2024-2025
Results	Emerging threats that are proactively addressed through policy and planning.	2	FY22-23	0	2	FY 2024-2025

Statutory Change(s):
None

Change Item Title: Clean Water Legacy—Groundwater Restoration and Protection Strategies

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
Clean Water Fund				
Expenditures	750	750	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	750	750	0	0
FTEs	**3**	**3**	**0**	**0**

Recommendation:

The Governor recommends a clean water fund investment for groundwater protection activities. Of the annual appropriation, $217,000 is for grants. There is no ongoing base appropriation in the clean water fund and amounts must be appropriated each budget cycle. The recommended level is a 29.76% increase from the $1,156,000 appropriated in the 2022-2023 biennium for this activity.

This proposal supports the development of Groundwater Restoration and Protection Strategies (GRAPS) for watersheds that are engaged in developing a local comprehensive water plan, referred to as the "One Watershed One Plan." The increased budget will bring needed support to the GRAPS program resulting in the capacity required to deliver core services and technical support to local governments for groundwater protection.

This increase will add capacity to produce and improve groundwater data delivery and technical support for local government partners engaged in comprehensive watershed planning and implementation activities through the Groundwater Restoration and Protection Strategies (GRAPS) initiative. Specifically, the increased funding will support two new FTEs engaged in the GRAPS and local county Soil and Water Conservation Districts.

Rationale/Background:

GRAPS is an interagency effort to coordinate the delivery of state agency groundwater data, information, and implementation strategies for use at the local level. The aim is to facilitate local efforts to benefit groundwater resource restoration and protection. Key efforts include 1) migrating data and information to online tools; 2) coordinating GRAPS work with local comprehensive watershed planning so that local partners have the resources they need in a timely manner; and 3) building local capacity through education, outreach, and financial assistance.

As the GRAPS program continues to grow it has become clear that it lacks the capacity required to meet the needs of local government partners. The first generation GRAPS reports were developed at the same time as the comprehensive watershed planning efforts of the One Watershed One Plan (1W1P). This has proven to be a significant barrier because the pace of 1W1P program efforts have been exceeding the capacity of the GRAPS program.

Proposal:

This proposal will build on existing efforts supported by the clean water fund to develop GRAPS for every watershed in Minnesota. The GRAPS process and associated deliverables will provide clear and concise information and strategies to local water managers (i.e., counties, soil and water conservation districts, and watershed districts). A key objective of this work is to provide information and recommend appropriate,

actionable strategies for groundwater protection to local partners. These strategies will align with state and local priorities to justify their incorporation into local comprehensive watershed plans. In fiscal years 2024 and 2025, proposed funding will continue to support facilitation of interagency collaboration on GRAPS, provide grants to local partners to help pilot state/local collaboration on GRAPS, and develop technological tools to provide information electronically statewide. The intent is to provide a GRAPS report for each of the 'One Watershed One Plans' developed through the Minnesota Board of Water and Soil Resources. This is estimated to be 7 to 9 reports per year.

This recommendation increases programmatic capacity, doubling the current staff dedicated to the GRAPS process. This is a critical need to help keep pace with the number of 1W1P planning grants awarded, plus support the ancillary activities requested by our partners to engage in groundwater protection.

In addition to the FTEs, programmatic capacity will be enhanced by supporting a groundwater specialist to be housed in the Soil and Water Conservation Districts Technical Service Areas (TSA) that will provide regional groundwater expertise that is currently lacking at the local level. The pilot position will target areas of the state at greatest risk to groundwater contamination.

In addition to the increase in programmatic capacity, the GRAPS initiative will continue to: 1) tailor existing data to local partner needs, 2) increase local staff capacity, training and education, and strategy development, and 3) provide grant funding to support sustained groundwater protection.

Impact on Children and Families:

A plentiful and affordable supply of safe drinking water is essential for healthy children, families, and a robust economy. As three out of four Minnesotans rely on groundwater as their source of drinking water, the GRAPS initiative plays a key role in protecting and restoring this resource into the future.

Equity and Inclusion:

Currently, water rates in Greater Minnesota consume a larger percentage of monthly income than in metropolitan areas. Disparities exist between large, well-funded public water systems and smaller systems that lack sufficient customer bases to fund operations and infrastructure. The GRAPS initiative supports protection of groundwater resources that if contaminated would result in increased treatment costs and more technically qualified personnel.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

None

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	GRAPS reports generated to inform and guide groundwater and drinking water protection in the 1W1P	5	FY 22-23	5	7-9	FY24-25
Quantity	Number of trainings targeting local government partners engaged in the 1W1P	2	FY 22-23	2	6	FY24-25
Quantity	Development of online groundwater modules to increase capacity of both resource professionals and elected leaders	1	FY 22-23	1	2	FY24-25
Quantity	Capacity building grants to local government partners that will result in targeted, on-the-ground water resource and public health protection	6	FY 22-23	6	6	FY24-25
Quantity	Partnering with Minnesota Geological Survey to create 3D images of underlying geology to help make the invisible visible, defining the extent of regional aquifers that will lead to targeted protection on a watershed scale	5 watersheds	FY 22-23	4	4	FY24-25

Statutory Change(s):
None

Change Item Title: Clean Water Legacy—Private Well Initiative

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Clean Water Fund				
Expenditures	1,500	1,500	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,500	1,500	0	0
FTEs	**5.39**	**5.39**	**0**	**0**

Recommendation:

The Governor recommends a clean water fund investment in fiscal years 2024-2025 to reduce health risks for the 1.2 million people in Minnesota who get their drinking water from a private well (private well users). Funding will be used to better understand and explain the occurrence and distribution of contaminants in Minnesota private well water, expand education and outreach to private well users about private well testing and mitigation, and build capacity of partners through grants and educational opportunities to help provide low-cost or free well testing and financial assistance to address water quality issues. These strategies will help inform the development of a 10-year plan that ensures the opportunity for all private well users to get their well water tested and for eligible households to receive financial assistance to address water quality issues.

There is no ongoing base appropriation in the Clean Water Fund, and amounts must be re-appropriated each budget cycle. There was no funding directly allocated to the Private Well Initiative in fiscal years 2022-2023.

Rationale/Background:

About 1.2 million Minnesotans rely on private wells for their drinking water (private well users). MDH estimates that nearly half of private wells may have at least one of five common contaminants in Minnesota well water (coliform bacteria, nitrate, arsenic, manganese, or lead) at a level that could present a health risk if not mitigated through water treatment or well repairs. Unlike people who get their drinking water from public water system, private well users are largely on their own for ensuring that water from their well is safe for everyone in their household. The Minnesota Well Code provides some protection from contamination through regulation of location and construction requirements. This initiative supplements the protections of the Minnesota Well Code through learning more about contaminants that could be in well water, expanding outreach and education about well testing and treatment, and engaging partners and building their capacity to support private well users in their community.

Testing is the only way to know if a contaminant is present in well water. While public water systems routinely test and treat for over 100 contaminants, private wells are only required to be tested when they are first constructed. All testing beyond the initial test for arsenic, coliform bacteria, and nitrate is the responsibility of the private well owner. Over the lifespan of a well, MDH recommends private well owners test for coliform bacteria every year (estimated to be in about 27% of wells), nitrate every other year (in some townships it is found at unsafe levels in over 40% of wells), at least once for arsenic (detected in about 40% of wells) and lead, and test for manganese before a baby drinks the water (about 50% of wells are projected to have a concentration above what is considered safe for a baby). Each private well owner has the responsibility of deciding whether they will continue testing their well water or take protective action to reduce their household's exposure to a contaminant.

A 2016 survey of 798 households with wells known to have elevated arsenic found that 34% did not take action to reduce arsenic in their drinking water and less than 20% had tested their well water within the last two years. This initiative aims to ensure every private well owner knows how to test their well water, has the opportunity to do so, and has financial assistance available to address water quality issues if needed.

This initiative is supported by the Clean Water Council's goal that private well users have safe drinking water through related strategies that support widespread and routine testing and that help private well owners achieve safe water at the tap.

Proposal:

The goal of this proposal is to ensure that Minnesotans who get their drinking water from a private well have safe water at the tap. This initiative has been an ongoing initiative since 2016 but did not receive funding in the previous biennium.

This funding will help drive planning for a statewide well testing and mitigation program. Funding will increase our efforts to build local capacity for private well protection by building on lessons learned from two pilot grants in the last biennium. Two Phase 2 grants at $100,000 each will be made available in fiscal year 2024 targeting local government partners that participated in the Phase 1 pilot grants last biennium. The purpose of these Phase 2 grants is to increase testing and provide modest financial support for mitigation, if needed, in these already established grant areas. We will also provide six new Phase 1 grants at $100,000 each to local governments through a competitive process. The purpose of these Phase 1 grants is to fund grantee efforts to establish and communicate a new private well testing program in their communities. Two of these Phase 1 grants will be available in fiscal year 2024; four Phase 1 grants will be available in fiscal year 2025.

As part of our commitment to equity, we are increasing outreach and education, technical support, and financial assistance for private well users so they can be confident in the safety and quality of their drinking water. The department will:

- Study the occurrence and magnitude of additional contaminants and develop appropriate actions that reduce private well users' exposure to these contaminants.
- Share this information with over 500 well contractors who construct about 5,500 wells each year so that the wells are less likely to have contamination and they can provide reliable information to homeowners.
- Based on social science evidence, develop new outreach and education content, materials, and delivery methods and improving existing materials. This will include translating materials into non-English languages.
- Increase local government capacity to protect groundwater quality and those who drink from private wells through education, technical assistance, and grants.
- Develop partnerships for expanding outreach to households with young children, households with limited English proficiency, and households with high socioeconomic vulnerability.
- Provide well testing kits through grant partners.

The proposal will fund staff that will focus on strategic planning, project design and implementation, health communications and outreach, partnership engagement, and grant management. Staff will also provide technical expertise, research, and assist with grant management and provide initiative oversight and direction.

Impact on Children and Families:

The developing baby, infants, and children are especially vulnerable to health effects from contaminants in drinking water such Blue Baby Syndrome, gastrointestinal illnesses, and other waterborne diseases. Babies drink more water per pound of body weight than older children and adults; as such, they are at higher risk of being affected by contaminants in private well water. In addition to acute health issues, contaminants such as arsenic, manganese, and lead in drinking water can have long-term effects on children and their development; they can

reduce intelligence in children; cause problems with memory, attention, and motor skills; damage the brain, kidney, and nervous system; slow development; and lead to problems with behavior and hearing.

This funding allows us to provide technical assistance to private well users and local units of government on addressing water contaminants and provide grant funding to local governments to establish local well testing programs and financial assistance to address water quality issues in private wells. Current grantees are leveraging program such as WIC, family home visiting, and other programs that have direct interaction with children and families to promote private well testing and prioritizing households with small children for testing and financial assistance for addressing water contaminants. We will encourage future grantees to do the same in their communities.

Private well testing and mitigation of drinking water quality issues in households with children will help ensure that children are consuming water that is safe for them to drink and will not negatively affect their health or development in the short-term or long-term.

Equity and Inclusion:

This proposal focuses on health equity for people who get their drinking water from a private well. Private well users are in every county, come from a variety of socio-economic and ethnic backgrounds and include people of color, Native Americans, people with disabilities, people in the LGBTQ community, other protected classes, or Veterans. Private well users are not afforded the same water quality safeguards as people who get their drinking water from public water systems. This proposal aims to reduce the disparities between public water system users and private well users, and it also aims to understand and identify how to address the disparities among private well users by combining sociodemographic data with private well data to guide program development and decision-making.

In the grants provided to local government for well testing and mitigation assistance, RFP applications score higher that clearly articulate how they will prioritize outreach, well testing, and mitigation for private well users who are people of color, Native Americans, people with disabilities and Veterans. The current grantees have had the most success reaching these groups through partnership with organizations that work directly with the focus groups; this is a model we would promote going forward, as it helps ensure that focus groups' interests are incorporated into program planning.

This proposal will also facilitate translating educational materials into appropriate languages to ensure all Minnesotans on private wells have access to information in their preferred language about how they can protect their private well water.

IT Costs

None

Results:

The table below shows the key measures the Private Well Initiative currently tracks. Below the table is a chart that shows the number of private well educational material orders and number of brochures ordered each year since 2018.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Total number of educational materials ordered by partners	58,163	September 2022	60,000	100,000	June 30, 2025
Quantity	Number of well testing and mitigation grants to local government	2	September 2022	2	6	June 30, 2025
Quality	Percent of 8 key outreach materials available in more than English	25%	September 2022	25%	100%	June 30, 2025
Quality	New strategies developed through partner grants	1	September 2022	1	5	June 30, 2025
Results	Number of households that have tested their well water due to local grant funding	278	September 2022	300	1200	June 30, 2025
Results	Number of households that have a water quality issue mitigated due to grant funding	29	September 2022	35	200	June 30, 2025

Statutory Change(s):
None

Change Item Title: Clean Water Legacy—Recreational Water Quality Online Portal

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Clean Water Fund				
Expenditures	300	300	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	300	300	0	0
FTEs	**1.48**	**1.48**	**0**	**0**

Recommendation:

The Governor recommends an investment from the Clean Water Fund in fiscal years 2024-2025 to create a statewide beach portal.

The only funding the Minnesota Department of Health receives regarding beach monitoring is $203,000 annually from the United States Environmental Protection Agency to conduct beach monitoring on the shore of Lake Superior.

Rationale/Background:

The goal of beach monitoring is to determine if the beach water is safe for recreational activities and to minimize the risk of recreational water illnesses. Beach testing is conducted at the discretion of the entity responsible for the beach (e.g., local public health agency, park district, county). This includes the frequency of monitoring and criteria used for issuing an advisory. Currently there is no centralized source for statewide beach monitoring results and no data on beach monitoring trends.

This proposal would result in a statewide beach portal where Minnesotans and tourists can find all beach alerts for anywhere in the state, including beach monitoring results. Decision making regarding whether a beach is monitored would remain a local decision.

This proposal is aligned with the vision of the strategic plan of the Clean Water Council that Minnesota will have fishable and swimmable waters throughout the state. Furthermore, it makes Minnesotans aware of crucial issues impacting water quality.

Proposal:

This new initiative is for creation of a statewide beach portal that would allow Minnesotans and visitors to go to one online location to access information on any recreational water testing conducted or beach closures currently in place. Additionally, the portal would allow for users to be made aware of any alerts currently in place at the beach of interest, such as the appearance of harmful algal blooms or major pollution events. Furthermore, the portal would serve as a tool to provide education to Minnesotans on preventing waterborne illness and recreational water stewardship. The public will also be able to use the portal to report waterborne illnesses and water hazards such as algal blooms and pollution events.

This proposal complements the beach monitoring that is being conducted by many local public health agencies, counties, and park boards. Additionally, it pairs well with the work being done by partner agencies, particularly the Minnesota Pollution Control Agency, on harmful algal blooms or other potential health alerts at beaches, on being able to notify the public.

The beach portal is anticipated to be available for use in the summer of 2024.

Impact on Children and Families:

Maintaining access to swimmable waters is important for healthy children and families in all of our communities.

Equity and Inclusion:

The statewide beach portal affects all Minnesotans who depend on swimmable waters and provides low barrier access to potential health alerts at any beach.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Development of a statewide beach portal	0	FY23	0	1	FY24
Quantity	New education and outreach materials developed	0	FY23	0	2	FY24/25
Quantity	Percent of local jurisdictions conducting beach monitoring submitting results	0	FY23	0	80	FY24/25

Statutory Change(s):

None

Change Item Title: Clean Water Legacy – Source Water Protection

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Clean Water Fund				
Expenditures	3,750	3,750	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	3,750	3,750	0	0
FTEs	**15.13**	**15.13**	**0**	**0**

Recommendation:

The Governor recommends a clean water fund investment in fiscal years 2024-2025 for source water protection activities. Of the total investment, $745,000 annually is for grants, an increase of about $125,000 because of ongoing unmet demand. The proposal maintains wellhead protection plan development and implementation efforts, increases funds available to grants to public water systems, accelerates protection efforts for public water supplies that use surface waters as sources, increases integration of drinking water protection into Minnesota's new "One Watershed One Plan" local water planning approach, and provides for development of a drinking water ambient monitoring program.

There is no ongoing base appropriation in the clean water fund and amounts must be requested each budget cycle. The recommended level is a 4.8% decrease from the $7,884,000 appropriated for this activity in the 2022-22 biennium.

Rationale/Background:

Protecting our sources (groundwater, rivers, and lakes) is the most equitable and cost-effective approach to safeguarding our drinking water now and for future generations. This funding facilitates planning and implementation specific to local needs for protecting drinking water sources. Additionally, program resources are being directed towards 1) enhancing the characterization of water quality conditions using rigorous screening, monitoring, and analysis and 2) fulfilling the Clean Water Council and department strategic objectives of securing long term protection for the most vulnerable lands in drinking water supply management areas (DWSMAs) statewide. Characterization of water quality conditions are done in partnership with the Public Health laboratory which provides water analysis capacity.

Proposal:

The proposal maintains existing capacity to deliver source water protection planning and implementation assistance to approximately 960 community water systems statewide. Formal source water protection plans developed through these efforts are increasingly important to local units of government because they unlock state and federal resources for implementation available through program partners (e.g., grant and cost share dollars from the Minnesota Board of Water and Soil Resources, U.S. Department of Agriculture, and Environmental Protection Agency). This proposal also supports implementation efforts directly by delivering $745,000 in grants to about 125 public water systems annually. These planning and implementation activities bear directly on three objectives of the Clean Water Council's strategic plan.

This proposal will also allow the program to accelerate work for systems that rely on surface water sources of drinking water supply. Such systems serve the largest populations, are among the most vulnerable to

contamination in the state and, for related reasons, are significantly more complicated to prepare and coordinate than are source water protection plans for groundwater systems. Currently 1 full-time equivalent staff are dedicated to surface water work. Increased funding will allow us to direct more staff resources to this area. Progress in this area would help advance two key objectives of the Clean Water Council's strategic plan.

The department will also build on existing projects to advance the water quality characterization of drinking water sources. Multiple drivers are prompting us to formalize these projects into routine program operations. Much of the impetus comes from increasing interest and evolving concerns about chemicals in water supplies, especially those that are not regulated by the Safe Drinking Water Act. Examples include per- and polyfluoroalkyl substances (PFAS), pharmaceuticals, and other related compounds. The work funded by this proposal will help to set priorities for future characterization efforts, establish possible management options, and inform the development of health-based guidance. The overall aim is to reduce uncertainties about water quality of resources used for drinking water supply, improve public health outcomes, and increase trust in public water systems.

Impact on Children and Families:

Safeguarding our water sources for drinking water is an important foundation for protecting and improving the health of children and families, and for keeping our communities vibrant. While this program primarily works with public water systems, it coordinates its efforts with other programs such as Groundwater Restoration and Protection Strategies (GRAPs) and Private Well Initiative (PWI) to develop data, tools, and information of value to multiple constituencies. These help to leverage our impact to provide better outcomes for children and families.

Equity and Inclusion:

MDH has added and we intend to maintain staff and program resources to address the needs of small public water systems. These systems often face the same challenges as larger systems but have fewer available technical and financial resources with which to address them. Additionally, the source water protection grants program provides priority scoring points for public water systems operating in areas that are disadvantaged by income.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

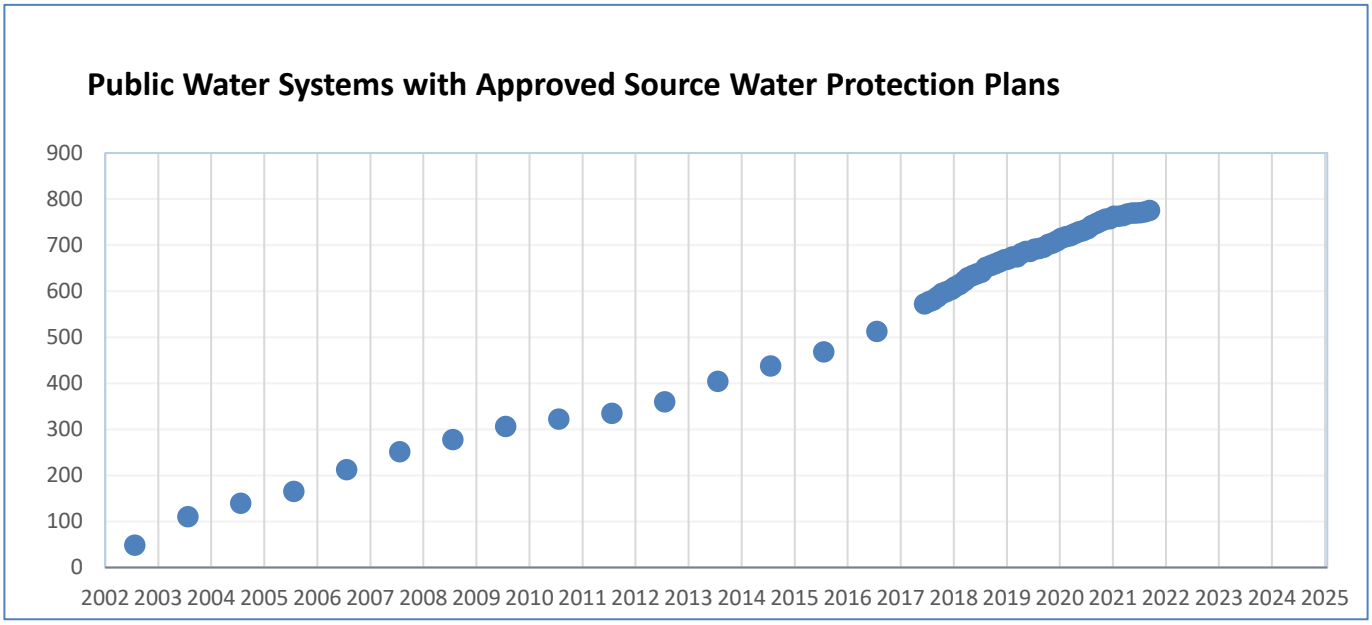
Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll	0	0				
Professional/Technical Contracts	0	0				
Infrastructure	0	0				
Hardware	0	0				
Software	130,893	130,893				
Training	0	0				
Enterprise Services	0	0				
Staff costs (MNIT or agency)						
Total	130,893	130,893				

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
MNIT FTEs						
Agency FTEs						

The project will result in replacement and to the SWP Grants Data System to a software platform that is supported by MNIT. We will conduct an RFP process to select a third-party provider to meet these needs and initial MNIT estimates are above.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Public water systems completing objective, science-based planning process to protect their drinking water sources. See graphic below for progress to date – note COVID affected program output.	28	FY 22-23	40	40	FY 24-25
Quantity	Drinking water ambient monitoring (participating systems)	0	FY 22-23	0	50	FY 24-25
Quality	Source water protection grants for implementation activities	125-150	FY 22-23	125	150	FY 24-25
Quality	Source water protection measures implemented (Measuring tools currently lacking)	unknown	FY 22-23	NA	70% by system	FY 24-25



Statutory Change(s):
None

Program: Health Improvement

AT A GLANCE

Budget activities:

- Child and Family Health
- Community Health
- Health Equity
- Health Policy
- Health Promotion and Chronic Disease
- Office of Medical Cannabis

PURPOSE AND CONTEXT

As Benjamin Franklin is often quoted, “an ounce of prevention is worth a pound of cure.” This insight captures the importance of this budget program and the power of prevention strategies. Prevention is a powerful and cost-effective component of the overall effort to improve the health of Minnesotans. The Health Improvement budget program contains a cohesive set of activities designed to maintain and improve the health of all Minnesotans via prevention. The budget program also supports the health care delivery and payment systems by ensuring they are efficient, effective, equitable, and affordable for Minnesotans. Activities are built on the values of collaboration and accountability.

The purpose, services, results, and authorizing statutes of each budget activity are described in the following pages. The fiscal page for Health Improvement reflects a summation of activities under this budget program area.

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	90,674	93,313	112,413	137,932	122,144	117,403	271,517	261,388
1100 - Medical Education & Research	79,306	78,934	78,984	68,568	7,725	7,725	0	0
1200 - State Government Special Rev	8,352	7,600	10,424	12,847	11,305	11,305	8,968	9,258
1250 - Health Care Response	40,253	94,014						
1251 - COVID-19 Minnesota	139,034	64,293						
2000 - Restrict Misc Special Revenue	3,025	2,315	2,221	7,229	1,278	1,278	8,854	18,679
2001 - Other Misc Special Revenue	51,658	746	822	4,500	632	632	632	632
2360 - Health Care Access	35,180	34,864	34,645	43,561	38,385	40,644	52,207	56,921
2403 - Gift	4	1	0	79				
2800 - Environmental	310	752						
3000 - Federal	169,065	308,686	521,784	321,356	286,007	252,287	286,007	252,287
3001 - Federal TANF	10,503	11,530	11,579	11,713	11,713	11,713	11,713	11,713
3010 - Coronavirus Relief	24,112	202,902	40,066					
3015 - ARP-State Fiscal Recovery			(2,786)					
Total	**651,476**	**899,950**	**810,151**	**607,785**	**479,189**	**442,987**	**639,898**	**610,878**
Biennial Change				(133,491)		(495,760)		(167,160)
Biennial % Change				(9)		(35)		(12)
Governor's Change from Base								328,600
Governor's % Change from Base								36
Expenditures by Activity								
Child and Family Health	165,690	163,074	168,442	222,782	221,793	217,394	261,838	258,635
Health Promotion and Chronic Disease	43,448	37,902	41,571	59,273	70,632	65,119	119,112	117,434
Community Health	232,165	485,518	458,597	168,188	108,033	94,162	142,657	128,789
Statewide Health Improvement				125	188	188	188	188
Health Policy	207,824	211,439	137,728	151,526	66,886	54,467	88,955	78,591
Office of Medical Cannabis	2,350	2,017	3,812	5,891	4,205	4,205	0	0
Health Equity					7,452	7,452	27,148	27,241
Total	**651,476**	**899,950**	**810,151**	**607,785**	**479,189**	**442,987**	**639,898**	**610,878**
Expenditures by Category								
Compensation	56,262	76,454	52,905	74,282	78,798	73,856	102,507	99,758

(Dollars in Thousands)

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY20	FY21	FY22	FY23	FY24	FY25	FY24	FY25
Operating Expenses	188,333	397,182	356,941	111,478	66,300	50,090	93,650	76,510
Grants, Aids and Subsidies	406,867	425,724	400,195	422,022	334,088	319,038	443,738	434,607
Capital Outlay-Real Property	12	541	8					
Other Financial Transaction	3	49	102	3	3	3	3	3
Total	**651,476**	**899,950**	**810,151**	**607,785**	**479,189**	**442,987**	**639,898**	**610,878**
Total Agency Expenditures	651,476	899,950	810,151	607,785	479,189	442,987	639,898	610,878
Internal Billing Expenditures	11,634	12,370	18,361	17,484	19,748	16,508	28,730	25,818
Expenditures Less Internal Billing	**639,842**	**887,580**	**791,790**	**590,301**	**459,441**	**426,479**	**611,168**	**585,060**
Full-Time Equivalents	**485.50**	**654.92**	**493.79**	**558.94**	**594.16**	**538.51**	**778.52**	**730.22**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In	77	5,841	223	12,993				
Direct Appropriation	96,268	95,462	126,251	125,737	122,144	117,403	271,517	261,388
Transfers In	355	245	265					
Transfers Out	391	2,694	786	798				
Cancellations	27	5,318	548					
Balance Forward Out	5,608	223	12,993					
Expenditures	**90,674**	**93,313**	**112,413**	**137,932**	**122,144**	**117,403**	**271,517**	**261,388**
Biennial Change in Expenditures				66,357		(10,798)		282,560
Biennial % Change in Expenditures				36		(4)		113
Governor's Change from Base								293,358
Governor's % Change from Base								122
Full-Time Equivalents	77.28	72.44	76.17	75.36	69.43	67.71	247.94	249.12
1100 - Medical Education & Research								
Balance Forward In	529	215	427	433				
Receipts	78,991	78,991	78,991	68,135	7,725	7,725	0	0
Transfers In	150	150	150	150	150	150	0	0
Transfers Out	150	150	150	150	150	150	0	0
Balance Forward Out	213	271	433					
Expenditures	**79,306**	**78,934**	**78,984**	**68,568**	**7,725**	**7,725**	**0**	**0**
Biennial Change in Expenditures				(10,688)		(132,102)		(147,552)
Biennial % Change in Expenditures				(7)		(90)		(100)
Governor's Change from Base								(15,450)
Governor's % Change from Base								(100)
Full-Time Equivalents	2.03	1.22	1.06	1.06	1.06	1.06	0.00	0.00
1200 - State Government Special Rev								
Balance Forward In		696		1,542				
Direct Appropriation	7,614	6,924	11,967	11,305	11,305	11,305	8,968	9,258
Transfers In	1,449	1,449						
Transfers Out	77	691						
Cancellations		778						
Balance Forward Out	634		1,543					

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures	**8,352**	**7,600**	**10,424**	**12,847**	**11,305**	**11,305**	**8,968**	**9,258**
Biennial Change in Expenditures				7,320		(661)		(5,045)
Biennial % Change in Expenditures				46		(3)		(22)
Governor's Change from Base								(4,384)
Governor's % Change from Base								(19)
Full-Time Equivalents	53.76	47.51	56.13	56.28	56.28	56.28	48.52	48.52

1250 - Health Care Response

Balance Forward In		89,954						
Direct Appropriation	132,526	10,339						
Cancellations		6,279						
Balance Forward Out	92,273							
Expenditures	**40,253**	**94,014**						
Biennial Change in Expenditures				(134,267)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents		3.36						

1251 - COVID-19 Minnesota

Balance Forward In		19,688						
Direct Appropriation	144,924	87,830						
Cancellations		43,225						
Balance Forward Out	5,890							
Expenditures	**139,034**	**64,293**						
Biennial Change in Expenditures				(203,327)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents		116.35						

2000 - Restrict Misc Special Revenue

Balance Forward In	5,653	5,630	5,956	5,950				4,913

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Receipts	1,374	1,261	1,035	199	198	198	12,687	17,599
Transfers In	1,021	1,003	1,046	1,080	1,080	1,080	1,080	1,080
Net Loan Activity	271	242	136					
Balance Forward Out	5,294	5,820	5,952				4,913	4,913
Expenditures	**3,025**	**2,315**	**2,221**	**7,229**	**1,278**	**1,278**	**8,854**	**18,679**
Biennial Change in Expenditures				4,110		(6,894)		18,083
Biennial % Change in Expenditures				77		(73)		191
Governor's Change from Base								24,977
Governor's % Change from Base								977
Full-Time Equivalents	6.71	4.03	4.03	2.29	1.84	1.84	1.84	6.34

2001 - Other Misc Special Revenue

Balance Forward In	2,311	2,857	4,031	3,868				
Receipts	728	771	661	632	632	632	632	632
Transfers In	50,800							
Transfers Out	24	68						
Balance Forward Out	2,157	2,814	3,870					
Expenditures	**51,658**	**746**	**822**	**4,500**	**632**	**632**	**632**	**632**
Biennial Change in Expenditures				(47,081)		(4,058)		(4,058)
Biennial % Change in Expenditures				(90)		(76)		(76)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	10.41	4.78	1.94	0.94	0.94	0.94	0.94	0.94

2360 - Health Care Access

Balance Forward In	3,799	6,425	4,214	6,729				
Direct Appropriation	37,285	36,968	37,512	36,832	38,385	40,644	52,207	56,921
Transfers In	182							
Transfers Out	182	634						
Cancellations	39	4,051	351					
Balance Forward Out	5,865	3,844	6,730					
Expenditures	**35,180**	**34,864**	**34,645**	**43,561**	**38,385**	**40,644**	**52,207**	**56,921**
Biennial Change in Expenditures				8,161		823		30,922

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial % Change in Expenditures				12		1		40
Governor's Change from Base								30,099
Governor's % Change from Base								38
Full-Time Equivalents	65.21	47.52	58.89	58.89	55.34	53.86	70.01	68.48

2403 - Gift

Balance Forward In	41	44	47	79				
Receipts	6	3	32					
Balance Forward Out	44	47	79					
Expenditures	**4**	**1**	**0**	**79**				
Biennial Change in Expenditures				75		(79)		(79)
Biennial % Change in Expenditures				1,703		(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								

2800 - Environmental

Balance Forward In		296						
Transfers In	512	512						
Cancellations		56						
Balance Forward Out	202							
Expenditures	**310**	**752**						
Biennial Change in Expenditures				(1,062)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents	1.32	0.58						

3000 - Federal

Balance Forward In	360	408	12,585	168				
Receipts	170,908	309,963	509,366	321,188	286,007	252,287	286,007	252,287
Balance Forward Out	2,203	1,685	168					
Expenditures	**169,065**	**308,686**	**521,784**	**321,356**	**286,007**	**252,287**	**286,007**	**252,287**
Biennial Change in Expenditures				365,389		(304,846)		(304,846)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial % Change in Expenditures				76		(36)		(36)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	266.36	250.13	285.85	362.06	407.21	354.76	407.21	354.76

3001 - Federal TANF

Balance Forward In	0							
Receipts	10,503	11,530	11,579	11,713	11,713	11,713	11,713	11,713
Expenditures	**10,503**	**11,530**	**11,579**	**11,713**	**11,713**	**11,713**	**11,713**	**11,713**
Biennial Change in Expenditures				1,258		134		134
Biennial % Change in Expenditures				6		1		1
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	2.32	0.99	2.06	2.06	2.06	2.06	2.06	2.06

3010 - Coronavirus Relief

Balance Forward In		53,512	62,831					
Direct Appropriation	75,195	202,256	20,737					
Transfers Out		740						
Cancellations	944	48,212	43,503					
Balance Forward Out	50,138	3,913						
Expenditures	**24,112**	**202,902**	**40,066**					
Biennial Change in Expenditures				(186,949)		(40,066)		(40,066)
Biennial % Change in Expenditures				(82)				
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents	0.10	106.01	7.66					

3015 - ARP-State Fiscal Recovery

Cancellations			2,786					
Expenditures			**(2,786)**					
Biennial Change in Expenditures				(2,786)		2,786		2,786
Biennial % Change in Expenditures								

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Governor's Change from Base								0
Governor's % Change from Base								

6000 - Miscellaneous Agency

Balance Forward In	15	0	8	54				
Receipts	76	71	71	72	72	72	72	72
Transfers Out	91	64	25	126	72	72	72	72
Balance Forward Out		8	54					

Program: Health Improvement
Activity: Child and Family Health

https://www.health.state.mn.us/about/org/cfh/h

AT A GLANCE

- Nutrition services for over 153,000 pregnant women, infants, and young children.
- Breastfeeding peer counseling services for over 7,000 women.
- Family planning counseling services for more than 45,000 low-income or high-risk individuals.
- 23,000 early childhood screenings and referral for assessment and services to families.
- Provides home visiting services for more than 6,600 families.
- Bereavement support and referral services for over 600 families experiencing a fetal or infant death.
- Help Me Connect online resource navigator accessed by over 77,500 families to find early childhood and family support resources in their community.
- Provides evidence-based curriculum for teen pregnancy prevention for over 4,700 high-risk teens and 1,600 parents.

PURPOSE AND CONTEXT

Health outcomes for people are greatly influenced by early-life experiences. Our activities improve long-term health outcomes by supporting Minnesota's children and families. Services focus on populations experiencing the greatest disparities in health outcomes, including families living in poverty, families of color, American Indian families, and children and adolescents with special health care needs.

In our work, we advance factors that predict a child's lifelong success:

- Healthy births.
- Safe, stable, and nurturing environments for families.
- Access to adequate nutrition.
- Early identification of health, developmental, or social-emotional issues and provision of appropriate interventions.
- Prevention of unintended pregnancy.
- Abstaining from substance use.

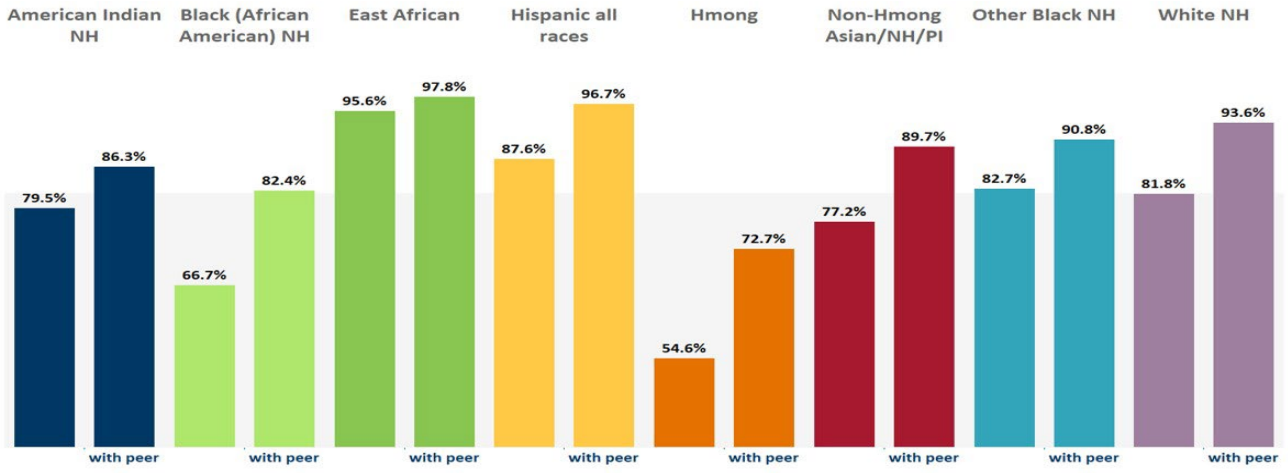
SERVICES PROVIDED

- **Improve the health of women so babies are born healthy and address racial, ethnic, and socioeconomic disparities in maternal and infant health**. The Maternal and Child Health program encourages early access to prenatal care, provides support services to high-risk pregnant women, and encourages preventive care and healthy behaviors prior to and during pregnancy to reduce risk of birth defects and other adverse pregnancy outcomes. We address issues that impact birth outcomes such as substance use disorders, midwifery and doula care, and infant safe sleep activities. The program also identifies and reports issues that underlie maternal deaths. The Women Infant Children (WIC) Supplemental Nutrition program serves nearly 40% of all infants born in Minnesota, improving the nutrition of pregnant and postpartum women, infants, and young children through nutrition education, breastfeeding resources, and targeted supplemental foods.
- **Increase the proportion of planned pregnancies so families are better prepared to raise a child.** The Maternal and Child Health program provides pre-pregnancy family planning grants to reproductive health providers and local public health to ensure that family planning services are accessible to low-income and high-risk individuals.

- **Improve equitable access and outcomes for early identification and services, which address both developmental and behavioral health, as well as social determinants of health**. Help Me Connect, an online resource navigator, helps families and referring providers find prenatal and early childhood services that support healthy child development and family well-being, including basic needs. Help Me Connect is available in all 87 counties, 11 Tribal Nations, and multiple languages.
- **Assure early childhood screening so that children receive services and support for school readiness and success.** The Children and Youth with Special Health Needs (CYSHN) program provides trainings and grants to local public health agencies so that infants and children receive early and ongoing screening, intervention, and follow-up services. Our Maternal and Child Health program develops and trains health care providers and school nurses on screening protocols.
- **Help children and youth with special health care needs reach their full potential.** The CYSHN program addresses inequities experienced by families in accessing and paying for quality services and supports to care for their children by improving care coordination, transition from pediatric to adult health care, and ensuring families are connected early to local public health, primary and specialty care, and community resources.
- **Family Home Visiting.** We help connect families and pregnant women with prenatal care, educate about healthy child development in utero through early childhood, and promote responsive parent-child relationships. Home visiting ensures families with young children access to one-on-one support and community resources. The program also screens and refers children to appropriate early childhood services. We train home visiting staff, building local capacity to deliver strong programs to meet community needs.
- **Support teens and their families so teens are successful in school, avoid unintended pregnancies, and become healthy, self-reliant adults.** We provide teen pregnancy prevention and healthy youth development grants to local public health departments, schools, and non-profits. Additionally, we provide grants to school-based health centers delivering mental health support and clinical services for students and train pediatric providers, school nurses, and other youth providers in best practices in adolescent health.

RESULTS

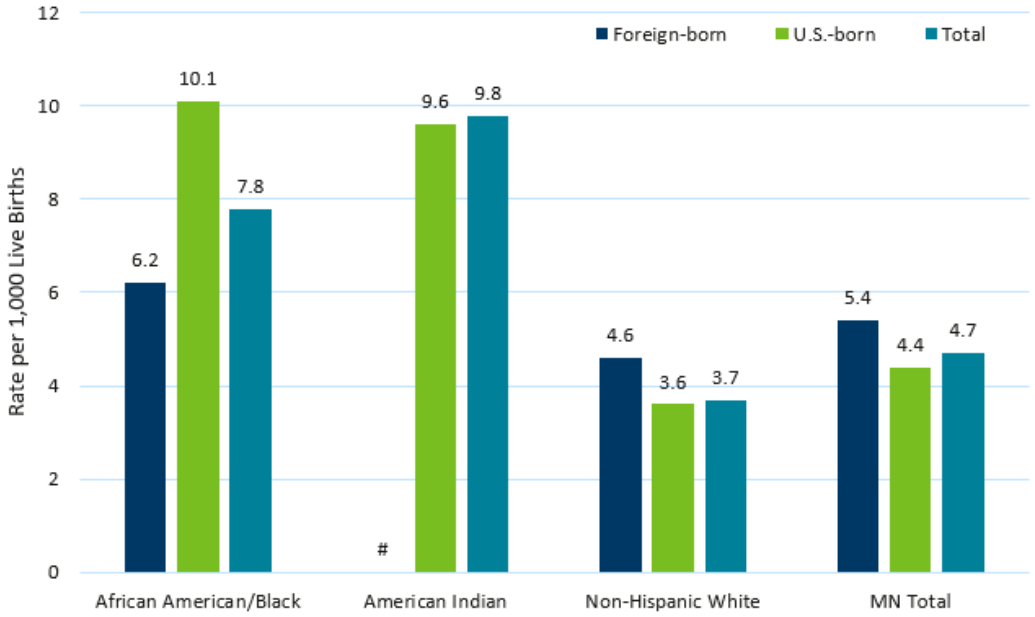
WIC peer breastfeeding support program by race/ethnicity, 2020



Black (A-A) includes mothers born in the U.S. who do not identify with another culture | East African includes Somali, Ethiopian, Kenyan, Sudanese, and Oromo | NH: Non-Hispanic

Breastfed babies are less likely to suffer from serious illnesses and are less likely to die in the first year of life. The WIC Peer Breastfeeding Support program funds counselors that are trained in management of normal breastfeeding, striving to help each parent reach their personal infant feeding goals. A result of the program is an increase in the number of women who started breastfeeding across all ethnicities and race.

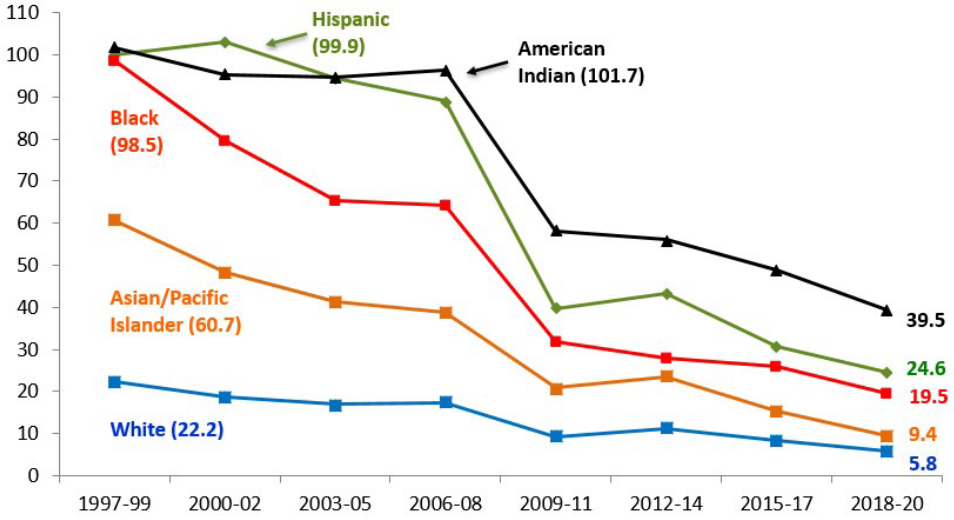
Minnesota infant mortality rates by selected maternal race/ethnicity & nativity, 2016-2020



Data are not shown when there are fewer than 10 deaths

Minnesota's infant mortality rate has declined by 42.5% since 1990, from a high of 7.3 deaths per 1,000 live births to 4.2 in 2020. Despite Minnesota's favorable infant mortality rate and ranking, substantial variation by race and ethnicity remains due to systemic racism and the impact of social determinants of health. Infants born to U.S.-born Black and American Indian women have the highest rates of mortality (10.1 and 9.6 respectively) compared to other racial and ethnic populations in the state.

Minnesota teen birth rate per 1,000 by race/ethnicity, 1997 – 2020

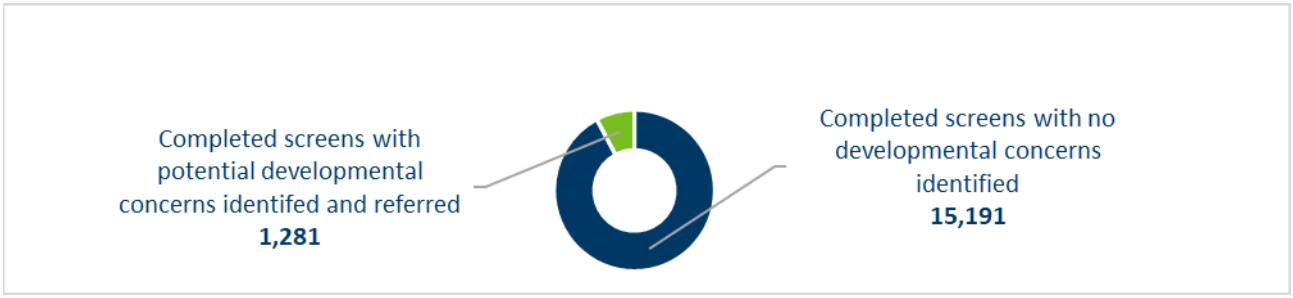


Source: Minnesota 2022 Adolescent Sexual Health Report - Pregnancy & Birth

Teen birth rates in Minnesota dropped 77% in the last 30 years, but significant disparities persist, particularly when teen birth rates are examined by poverty, race and ethnicity, and geography. For example, the birth rate for all other races was 2 to 7 times higher than white teens in 2020.

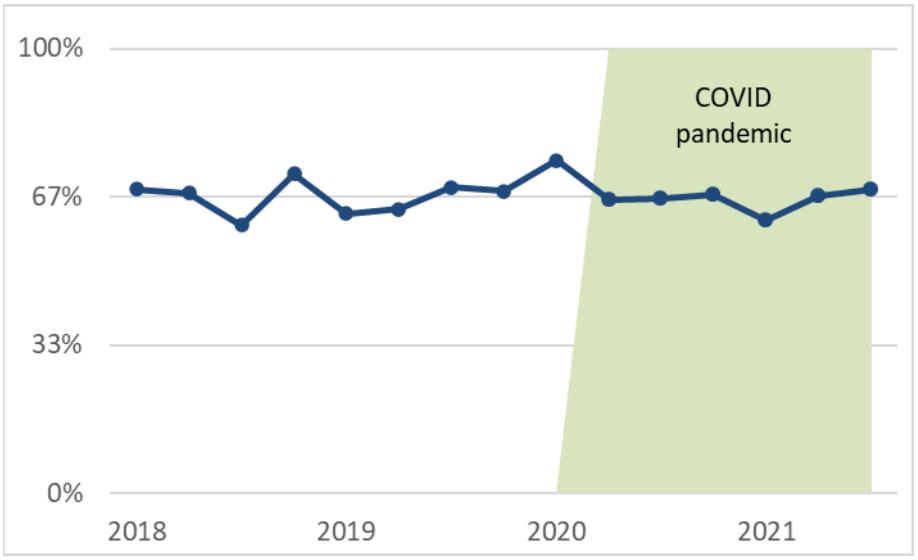
Early Identification for Physical and Social-Emotional Delays in Children 0-36 months

Developmental Concerns Identified through the Follow Along Program - 2021



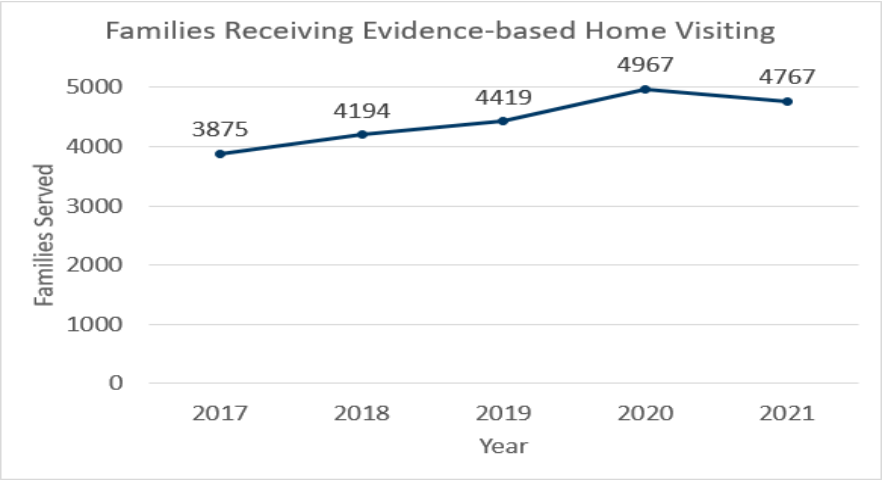
The Follow Along Program provides grant funding to local public health departments to assure that all families who have a child 0-36 months of age are offered physical and social-emotional developmental screening and referral to early intervention services as needed.

Percent of Children and Youth with Special Health Needs families referred to local public health agencies who received an assessment, 2018-2021



In 2021, the Children and Youth with Special Health Needs Section referred 1,245 Minnesota infants with a special health need to local public health agencies. Over 800 of those infants' families (67%) received an assessment that may cover income, infant growth and development, connection to community resources, caretaking and parenting, or health care supervision. The average assessment rate was consistent even during COVID response. Of the families who received an assessment, 82% received at least one intervention, such as general counseling or referrals related to educational and developmental resources, health insurance or public assistance.

Families receiving evidence-based home visiting, 2017-2021



Access to high quality, evidence-based home visiting has dramatically increased across the state as the program has supported local communities in implementing proven models that support pregnant women and families with young children. In 2012, only 47 counties (54%) were implementing an evidence-based model. Due to increased state investments, 85 counties (97%), 19 non-profits, and eight tribal nations were implementing the model by 2021.

Part B: Evidence of Effectiveness

Evidence-based Practice	Source of Evidence	FY 22-23 Expenditures
Family Home Visiting Models: Family Connects, Early Head Start, Family Spirit, Healthy Families America, Maternal Early Childhood Sustained Home Visiting, Nurse Family Partnership, Parents as Teachers	Department of Health and Human Services Home Visiting Evidence of Effectiveness, https://homvee.acf.hhs.gov/	Approximately $23.5 million/year (grants to local communities including counties, tribal nations, and non-profits.)

STATUTES

M.S. 144.064 The Vivian Act, Cytomegalovirus (https://www.revisor.mn.gov/statutes/cite/144.064)
M.S. 144.125-144.128 Tests of Infants for Heritable and Congenital Disorders (https://www.revisor.mn.gov/statutes/cite/144.125)
M.S. 144.1251 Newborn Screening for Critical Congenital Heart Disease (CCHD) (https://www.revisor.mn.gov/statutes/cite/144.1251)
M.S. 144.1461 Dignity in Pregnancy and Childbirth (https://www.revisor.mn.gov/statutes/cite/144.1461)
M.S. 144.2215 Minnesota Birth Defects Information System (https://www.revisor.mn.gov/statutes/?id=144.2215)
M.S. 144.574 Dangers of Shaking Infants and Young Children (https://www.revisor.mn.gov/statutes/?id=144.574)
M.S. 144.966 Early Hearing Detection and Intervention Program (https://www.revisor.mn.gov/statutes/?id=144.966)
M.S. 145.4235 Positive Abortion Alternatives Program (https://www.revisor.leg.state.mn.us/statutes/?id=145.4235)
M.S. 145.4243 Woman's Right to Know Printed Information (https://www.revisor.mn.gov/statutes/?id=145.4243)

M.S. 145.88 Maternal and Child Health (https://www.revisor.mn.gov/statutes/?id=145.88)
M.S. 145.891 Maternal and Child Health Nutrition Act of 1975 (https://www.revisor.mn.gov/statutes/?id=145.891)
M.S. 145.898 Sudden Infant Death (https://www.revisor.mn.gov/statutes/?id=145.898))
M.S. 145.899 WIC Vouchers for Organics (https://www.revisor.mn.gov/statutes/?id=145.899)
M.S. 145.901 Maternal Death Studies (https://www.revisor.mn.gov/statutes/?id=145.901)
M.S. 145.905 Location for Breast-Feeding (https://www.revisor.mn.gov/statutes/?id=145.905)
M.S. 145.906 Postpartum Depression Education and Information (https://www.revisor.mn.gov/statutes/?id=145.906)
M.S. 145.925 Family Planning Grants (https://www.revisor.mn.gov/statutes/?id=145.925)
M.S. 145.9255 Minnesota Education Now and Babies Later (https://www.revisor.mn.gov/statutes/?id=145.9255)
M.S. 145.9261 Abstinence Education Grant Program (https://www.revisor.mn.gov/statutes/?id=145.9261)
M.S. 145.9265 Fetal Alcohol Syndrome Effects; Drug Exposed Infant (https://www.revisor.mn.gov/statutes/?id=145.9265)
M.S. 145A.17 Family Home Visiting Program (https://www.revisor.mn.gov/statutes/?id=145A.17)
M.S. 145A.145 Nurse Family Partnership Programs (https://www.revisor.mn.gov/statutes/2021/cite/145A.145)
M.S. 145.87 Home Visiting for Pregnant Women and Families with Young Children (https://www.revisor.mn.gov/statutes/cite/145.87)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	32,588	32,273	34,334	38,368	36,565	35,084	76,542	76,210
1200 - State Government Special Rev	1,058	1,046	1,467	2,157	2,140	2,140	2,208	2,255
2000 - Restrict Misc Special Revenue	6	5	4	16	8	8	8	8
2001 - Other Misc Special Revenue	56	4	4	22	1	1	1	1
2403 - Gift				1				
3000 - Federal	123,160	120,189	123,047	172,505	173,366	170,448	173,366	170,448
3001 - Federal TANF	8,823	9,557	9,586	9,713	9,713	9,713	9,713	9,713
Total	**165,690**	**163,074**	**168,442**	**222,782**	**221,793**	**217,394**	**261,838**	**258,635**
Biennial Change				62,461		47,963		129,249
Biennial % Change				19		12		33
Governor's Change from Base								81,286
Governor's % Change from Base								19
Expenditures by Category								
Compensation	10,957	9,594	11,495	17,263	18,234	17,255	22,866	22,360
Operating Expenses	9,572	8,419	10,934	15,646	14,003	13,096	21,035	20,351
Grants, Aids and Subsidies	145,159	145,060	146,013	189,871	189,554	187,041	217,935	215,922
Other Financial Transaction	2		1	2	2	2	2	2
Total	**165,690**	**163,074**	**168,442**	**222,782**	**221,793**	**217,394**	**261,838**	**258,635**
Total Agency Expenditures	165,690	163,074	168,442	222,782	221,793	217,394	261,838	258,635
Internal Billing Expenditures	3,260	2,485	4,114	4,583	4,365	4,253	7,000	6,928
Expenditures Less Internal Billing	**162,429**	**160,589**	**164,329**	**218,199**	**217,428**	**213,141**	**254,838**	**251,707**
Full-Time Equivalents	**105.37**	**88.56**	**102.10**	**129.85**	**124.61**	**114.42**	**162.01**	**153.82**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		1,170		1,982				
Direct Appropriation	33,599	33,649	36,445	36,515	36,565	35,084	76,542	76,210
Transfers In	110							
Transfers Out		669	129	129				
Cancellations	15	1,877						
Balance Forward Out	1,106		1,982					
Expenditures	**32,588**	**32,273**	**34,334**	**38,368**	**36,565**	**35,084**	**76,542**	**76,210**
Biennial Change in Expenditures				7,842		(1,053)		80,050
Biennial % Change in Expenditures				12		(1)		110
Governor's Change from Base								81,103
Governor's % Change from Base								113
Full-Time Equivalents	22.66	18.48	20.63	20.63	19.40	18.93	56.23	57.76
1200 - State Government Special Rev								
Balance Forward In		134		17				
Direct Appropriation	1,159	1,068	1,484	2,140	2,140	2,140	2,208	2,255
Cancellations		156						
Balance Forward Out	101		17					
Expenditures	**1,058**	**1,046**	**1,467**	**2,157**	**2,140**	**2,140**	**2,208**	**2,255**
Biennial Change in Expenditures				1,520		656		839
Biennial % Change in Expenditures				72		18		23
Governor's Change from Base								183
Governor's % Change from Base								4
Full-Time Equivalents	5.28	3.55	6.82	6.82	6.82	6.82	7.39	7.39
2000 - Restrict Misc Special Revenue								
Balance Forward In	6		6	8				
Receipts		11	6	8	8	8	8	8
Balance Forward Out		6	8					
Expenditures	**6**	**5**	**4**	**16**	**8**	**8**	**8**	**8**
Biennial Change in Expenditures				9		(4)		(4)
Biennial % Change in Expenditures				83		(21)		(21)
Governor's Change from Base								0

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Governor's % Change from Base								0

2001 - Other Misc Special Revenue

Balance Forward In	27	25	7	21				
Receipts	50	0	18	1	1	1	1	1
Transfers Out		13						
Balance Forward Out	21	7	21					
Expenditures	**56**	**4**	**4**	**22**	**1**	**1**	**1**	**1**
Biennial Change in Expenditures				(35)		(24)		(24)
Biennial % Change in Expenditures				(58)		(92)		(92)
Governor's Change from Base								0
Governor's % Change from Base								0

2403 - Gift

Balance Forward In	1	1	1	1				
Balance Forward Out	1	1	1					
Expenditures				**1**				
Biennial Change in Expenditures				1		(1)		(1)
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

3000 - Federal

Balance Forward In	265	261	174	13				
Receipts	123,153	120,189	122,886	172,492	173,366	170,448	173,366	170,448
Balance Forward Out	259	261	13					
Expenditures	**123,160**	**120,189**	**123,047**	**172,505**	**173,366**	**170,448**	**173,366**	**170,448**
Biennial Change in Expenditures				52,203		48,262		48,262
Biennial % Change in Expenditures				21		16		16
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	75.11	65.54	72.59	100.34	96.33	86.61	96.33	86.61

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
3001 - Federal TANF								
Balance Forward In	0							
Receipts	8,823	9,557	9,586	9,713	9,713	9,713	9,713	9,713
Expenditures	**8,823**	**9,557**	**9,586**	**9,713**	**9,713**	**9,713**	**9,713**	**9,713**
Biennial Change in Expenditures				920		127		127
Biennial % Change in Expenditures				5		1		1
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	2.32	0.99	2.06	2.06	2.06	2.06	2.06	2.06

Program: Health Improvement
Activity: Health Promotion and Chronic Disease

https://www.health.state.mn.us/about/org/hpcd/

AT A GLANCE

- Maintains the statewide cancer reporting system and registered over 35,000 new cancer cases.
- Supports a total of 30,137 Minnesotans who enrolled in a diabetes prevention program proven to reduce the risk of developing diabetes by 58%.
- Manages 44,319 calls through the state's poison control system from residents who were poisoned or in danger of being poisoned.
- Provides grants to support National Suicide Prevention Lifeline Centers that handled 33,887 calls from Minnesota.
- Provides services for 9,782 Minnesotans with a traumatic brain or spinal cord injury.

PURPOSE AND CONTEXT

Health Promotion and Chronic Disease (HPCD) provides leadership in the prevention and management of chronic diseases and injuries, including efforts to eliminate health disparities. Chronic diseases are ongoing, generally incurable illnesses or conditions, such as heart disease, asthma, Alzheimer's and related dementias, cancer, arthritis, diabetes, and dental disease. Chronic diseases and injuries (e.g., suicides and substance abuse) negatively impact the health of the population by contributing to long-term disabilities, diminished quality of life, and high health care costs. These diseases are often preventable and frequently manageable through early detection, treatment, regular care, and lifestyle changes, such as diet or exercise.

We partner with community-based and other statewide organizations to:

- Monitor chronic diseases and injuries to report statewide trends, geographic patterns, and risk factors.
- Provide data, grants, and technical assistance to local governments, community-based organizations, and health systems to address disparities, support community resiliency, and eliminate health disparities.
- Improve clinical services to prevent and manage chronic diseases, injuries, and related complications and to ensure proper referral for treatment and support programs.
- Increase availability, access, participation, and sustainability of evidence-based programs that prevent and manage chronic conditions.
- Provide information to the public about how to prevent and/or manage chronic disease and injury.

SERVICES PROVIDED

Partner with health systems to implement changes to deliver high-quality care for all patients, especially those most likely to become disabled or die from chronic diseases and injuries.

- Promote collaboration among health care providers to improve cancer screening and other preventive services.
- Develop and promote services designed to heal the trauma experienced by sexually exploited youth through the Safe Harbor Program.
- Help health systems implement care practices that prioritize early detection and management of chronic disease risk factors and healthy aging.
- Provide funding for health care improvement programs such as dental sealants, cancer screening, and health coaching for people living with diabetes and hypertension.
- Pay health care providers to offer free breast, cervical, and other health screening along with follow-up services and counseling to eligible low-income, uninsured, and underinsured Minnesotans.

- Maintain a statewide system to help local professionals track and manage Naloxone to prevent drug overdose deaths.
- Collaborate with other agencies to promote healthy home and work environments.

Build relationships between clinics and community groups to improve management of chronic conditions.

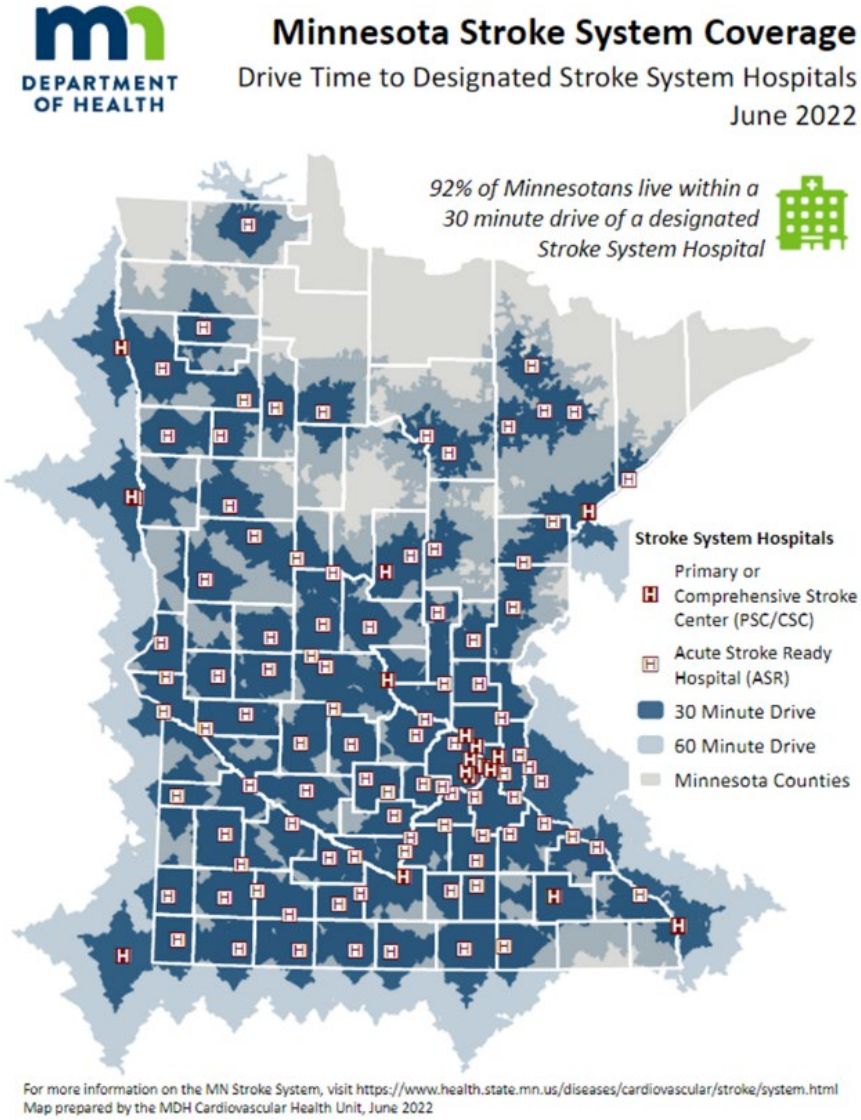
- Provide tools, training, support, and peer learning opportunities for providers and evidence-based programs.
- Sustain programming to support self-management for people with chronic conditions and injuries.
- Develop materials and train community health workers to better work with underserved and at-risk populations.
- Support community and medical partners in implementing statewide plans for chronic disease, injury, and violence prevention.
- Provide grants for Minnesotans with a traumatic brain or spinal cord injury to receive medical follow-up, employment, education, and family counseling sessions.

Develop, collect, and share data to inform chronic disease and injury prevention and management initiatives.

- Maintain a statewide registry of cancer cases.
- Analyze and report on the prevalence, disparities, and trends in deaths and disabilities from specific chronic diseases, injury, and violence.
- Collect, analyze, and report on rates and trends of workplace hazards, illnesses, and injuries.
- Provide funding to the four in-state National Suicide Prevention Lifeline (Lifeline) Centers that provide localized support to people who are in a mental health crisis or experiencing thoughts of suicide.
- Use data to identify possible connections between chronic diseases and environmental exposures.
- Provide funding to the Minnesota Poison Control System to assist parents, families, and others regarding poisoning incidents with 90% of calls where a person was exposed to a poison at their residence being able to manage the incident at home, preventing unnecessary health care utilization, avoiding potential medical costs, and reducing crowding in the emergency department.

RESULTS

Expanding access to designated stroke centers

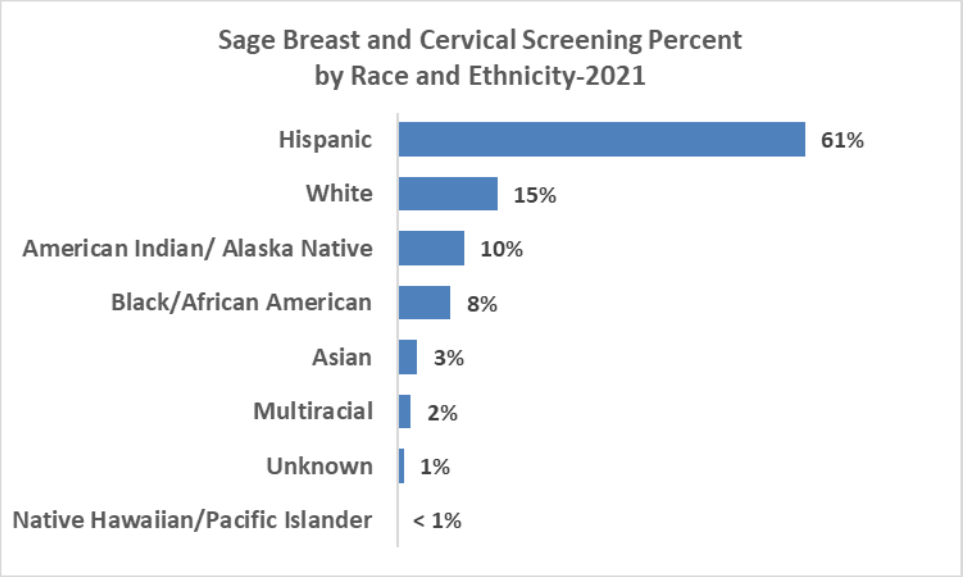


% Minnesotans Living Within a 30 Minute Drive of a Stroke Center	
2012	**2022**
60%	92%

In 2012, only 60% of Minnesota's population lived within 30 minutes of a designated stroke center. Since then, the Minnesota Stroke Program has worked with hospitals across the state to build additional capacity to treat stroke and encourage them to take steps to meet official stroke designation standards.

In 2022, there are 116 designated stroke hospitals in the state, thereby lowering the disparity to 92% now living within a 30-minute drive of a designated Stroke System Hospital. Over the last 10 years, 1.8 million more Minnesota residents gained access to a designated stroke center, significantly improving the quality of health care and outcomes.

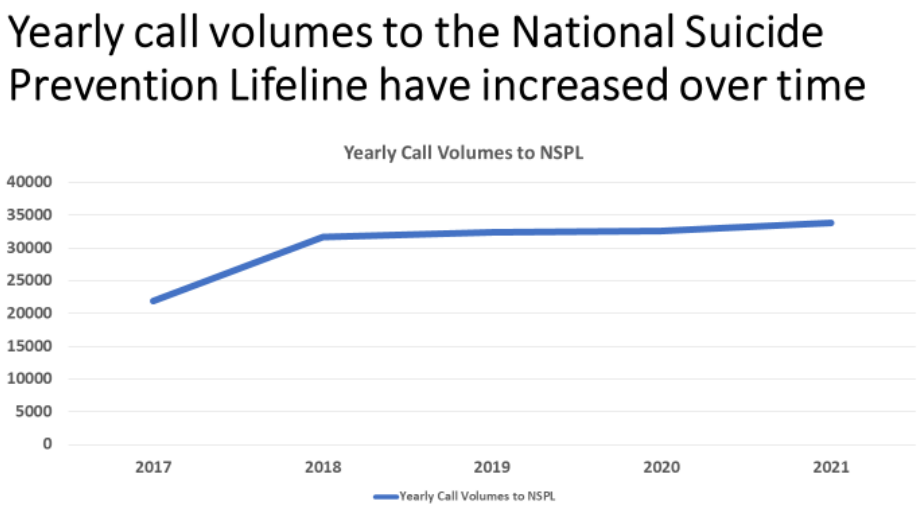
Serving diverse populations through cancer screening



The MDH Sage Program partners with 480 clinics in the state to screen about 10,000 uninsured and underinsured women for breast and cervical cancer and cardiovascular health every year.

Sage continues to increase reach into diverse and underserved communities. In 2013, people of color and American Indians comprised 46% of Sage breast and cervical patients. By 2021, this percentage increased to 85%. Sage additionally supports cancer screening by working with clinics to improve their health systems and by providing patient navigation services in multiple languages to about 3,000 Minnesotans annually, regardless of their insurance or income status. These services include helping to find a screening clinic, setting up appointments, coordinating follow-up visits, and health coaching.

Increasing access to suicide prevention services by adding four in-state National Suicide Prevention Lifeline Centers



From 2017 to 2021, calls to the Lifeline increased by 54% from nearly 22,000 in 2017 to almost 34,000 in 2021. Suicide, or death by intentional self-harm, is the eighth leading cause of death in Minnesota. For the past 20

years, the number of suicides in Minnesota has steadily increased, mirroring patterns across the United States and contributing to a decline in average life expectancy. With the recent transition to the national three-digit dialing code, 988, calls to the Lifeline are expected to continue to increase.

STATUTES

M.S. 144.05 subd. 5 Firearms Data (https://www.revisor.mn.gov/statutes/?id=144.05)
M.S. 144.497 ST Elevation Myocardial Infarction (https://www.revisor.mn.gov/statutes/?id=144.497)
M.S. 144.6586 Notice of Rights to Sexual Assault Victim (https://www.revisor.mn.gov/statutes/?id=144.6586)
M.S. 144.661 - 144.665 Traumatic Brain and Spinal Cord Injuries (https://www.revisor.mn.gov/statutes/?id=144.661)
M.S. 144.671 - 144.69 Cancer Reporting System (https://www.revisor.mn.gov/statutes/?id=144.671)
M.S. 144.492 Stroke Centers and Stroke Hospitals (https://www.revisor.mn.gov/statutes/?id=144.492)
M.S. 145.4711 - 145.4713 Sexual Assault Victims (https://www.revisor.mn.gov/statutes/?id=145.4711)
M.S. 145.4715 Reporting Prevalence of Sexual Violence (https://www.revisor.mn.gov/statutes/?id=145.4715)
M.S. 145.4716 - 145.4718 Safe Harbor for Sexually Exploited Youth (https://www.revisor.mn.gov/statutes/?id=145.4716)
M.S. 145.56 Suicide Prevention (https://www.revisor.mn.gov/statutes/?id=145.56)
M.S. 145.867 Persons Requiring Special Diets (https://www.revisor.mn.gov/statutes/?id=145.867)
M.S. 145.93 Poison Control System (https://www.revisor.mn.gov/statutes/?id=145.93)
M.S. 145.958 Youth Violence Prevention (https://www.revisor.mn.gov/statutes/?id=145.958)M.S. 157.177 Sex Trafficking Prevention Training (https://www.revisor.mn.gov/laws/2018/0/Session+Law/Chapter/179/)
M.S. 256B.057 subd. 10 Certain Persons Needed Treatment for Breast or Cervical Cancer (https://www.revisor.mn.gov/statutes/?id=256B.057)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	14,979	13,889	14,109	16,074	14,839	14,839	63,319	57,329
2000 - Restrict Misc Special Revenue	1,633	1,378	1,294	1,609	1,082	1,082	1,082	10,907
2001 - Other Misc Special Revenue	57	198	108	24	14	14	14	14
2403 - Gift	2	0	0	31				
2800 - Environmental	310	752						
3000 - Federal	26,467	21,685	26,059	41,535	54,697	49,184	54,697	49,184
Total	**43,448**	**37,902**	**41,571**	**59,273**	**70,632**	**65,119**	**119,112**	**117,434**
Biennial Change				19,494		34,907		135,702
Biennial % Change				24		35		135
Governor's Change from Base								100,795
Governor's % Change from Base								74
Expenditures by Category								
Compensation	13,055	14,193	14,685	23,458	26,724	23,715	32,982	30,247
Operating Expenses	7,827	8,246	8,123	12,470	14,088	12,833	22,255	20,882
Grants, Aids and Subsidies	22,554	15,074	18,763	23,345	29,820	28,571	63,875	66,305
Capital Outlay-Real Property	12	387						
Other Financial Transaction		1						
Total	**43,448**	**37,902**	**41,571**	**59,273**	**70,632**	**65,119**	**119,112**	**117,434**
Total Agency Expenditures	43,448	37,902	41,571	59,273	70,632	65,119	119,112	117,434
Internal Billing Expenditures	2,705	3,180	3,151	3,851	4,943	4,162	7,557	6,756
Expenditures Less Internal Billing	**40,743**	**34,722**	**38,420**	**55,422**	**65,689**	**60,957**	**111,555**	**110,678**
Full-Time Equivalents	**133.75**	**134.97**	**139.07**	**179.10**	**229.60**	**183.51**	**279.94**	**233.85**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In	0	561		1,235				
Direct Appropriation	15,500	14,280	15,403	14,839	14,839	14,839	63,319	57,329
Transfers In	245	245	265					
Transfers Out	245	519						
Cancellations	8	678	324					
Balance Forward Out	513		1,235					
Expenditures	**14,979**	**13,889**	**14,109**	**16,074**	**14,839**	**14,839**	**63,319**	**57,329**
Biennial Change in Expenditures				1,315		(505)		90,465
Biennial % Change in Expenditures				5		(2)		300
Governor's Change from Base								90,970
Governor's % Change from Base								307
Full-Time Equivalents	33.88	32.87	32.16	31.60	29.69	28.95	80.03	74.79
2000 - Restrict Misc Special Revenue								
Balance Forward In	634	440	598	526				4,913
Receipts	339	525	177	3	2	2	4,915	9,827
Transfers In	1,021	1,003	1,046	1,080	1,080	1,080	1,080	1,080
Balance Forward Out	361	591	527				4,913	4,913
Expenditures	**1,633**	**1,378**	**1,294**	**1,609**	**1,082**	**1,082**	**1,082**	**10,907**
Biennial Change in Expenditures				(107)		(739)		9,086
Biennial % Change in Expenditures				(4)		(25)		313
Governor's Change from Base								9,825
Governor's % Change from Base								454
Full-Time Equivalents	1.56	0.98	0.92	0.73	0.53	0.53	0.53	5.03
2001 - Other Misc Special Revenue								
Balance Forward In	73	69	108	10				
Receipts	26	206	10	14	14	14	14	14
Transfers Out	23	10						
Balance Forward Out	19	67	10					
Expenditures	**57**	**198**	**108**	**24**	**14**	**14**	**14**	**14**
Biennial Change in Expenditures				(123)		(104)		(104)
Biennial % Change in Expenditures				(48)		(79)		(79)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents		0.30	0.94	0.94	0.94	0.94	0.94	0.94

2403 - Gift

Balance Forward In	21	22	25	31				
Receipts	3	3	6					
Balance Forward Out	22	25	31					
Expenditures	**2**	**0**	**0**	**31**				
Biennial Change in Expenditures				29		(31)		(31)
Biennial % Change in Expenditures				1,357		(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								

2800 - Environmental

Balance Forward In		296						
Transfers In	512	512						
Cancellations		56						
Balance Forward Out	202							
Expenditures	**310**	**752**						
Biennial Change in Expenditures				(1,062)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents	1.32	0.58						

3000 - Federal

Balance Forward In	6	41	31					
Receipts	26,467	21,690	26,028	41,535	54,697	49,184	54,697	49,184
Balance Forward Out	6	46						
Expenditures	**26,467**	**21,685**	**26,059**	**41,535**	**54,697**	**49,184**	**54,697**	**49,184**
Biennial Change in Expenditures				19,442		36,287		36,287
Biennial % Change in Expenditures				40		54		54

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	96.99	100.24	105.05	145.83	198.44	153.09	198.44	153.09

Program: Health Improvement
Activity: Community Health

https://www.health.state.mn.us/about/org/ch/index.html

AT A GLANCE

- Provide support, training, and technical assistance to Minnesota's community health boards, tribal nations, community organizations, and health care systems.
- Distribute funds to 51 community health boards, 10 tribal nations, and eight regional health care coalitions, to support local community health and emergency preparedness activities.
- Implement the State Health Improvement Partnership program in all 87 counties and with 10 tribal nations, including collaboration with over 6,400 partners such as schools and worksites.
- Coordinate the emergency response activities for MDH, in partnership with community health boards, tribal governments, and eight regional health care preparedness coalitions during the occurrence of a disaster.
- Conduct health surveys, including the Minnesota Student Survey (every 3 years), the Behavioral Risk Factor Surveillance System (annually), Youth Tobacco Survey (every 3 years), and School Health Profiles (every 2 years), which provides crucial data on the health behaviors and trends in Minnesota.
- Help Minnesotans quit using commercial tobacco products through Quitline programs; over 13,000 Minnesotans have been enrolled since April 2020.

PURPOSE AND CONTEXT

State, local, and tribal public health departments in Minnesota have a unique responsibility to detect, prevent, and respond to public health challenges. Health departments need skills and capabilities to support community health and wellbeing programs and coordinate across sectors when emergencies occur. Minnesota's public health system is undergoing a significant transformation to address gaps highlighted during the COVID-19 response. This transformation will strengthen Minnesota's governmental public health system so every community can expect a basic level of public health protections. The three centers within this budget activity work across the Department of Health (MDH), with local and tribal health departments, and with multiple community partners to build foundational capabilities and advance health equity through the provision of funding, guidance, technical assistance, and training. Each center has a specific area of focus and provides a particular set of services.

SERVICES PROVIDED

Emergency Preparedness and Response

- Lead MDH response to and recovery from disasters and public health emergencies in coordination with state and local partners.
- Provide training and exercises to build response capacity within MDH and support our local public health and tribal health partners in becoming response ready.
- Maintain the MDH Business Continuity Plan to ensure the agency can deliver priority services when directly impacted by a disaster or emergency.
- Support local public health, tribes, health care systems, health care coalitions, and response partners during an emergency.
- Support MDH COVID-19 response and develop a transition plan to integrate COVID-19 activities into the agency.
- Administer an alert network to rapidly notify health care, public health, and community partners about emerging disease threats or other health hazards such as contaminated medications or food.

- Prepare for the need to rapidly receive, stage, store, and distribute vaccines, medication, and other critical supplies to protect people and communities during an emergency.
- Ensure a cohort of trained staff (strike team members) who can quickly and effectively stand up and maintain a response structure in the event of a public health emergencies.

Public Health Practice

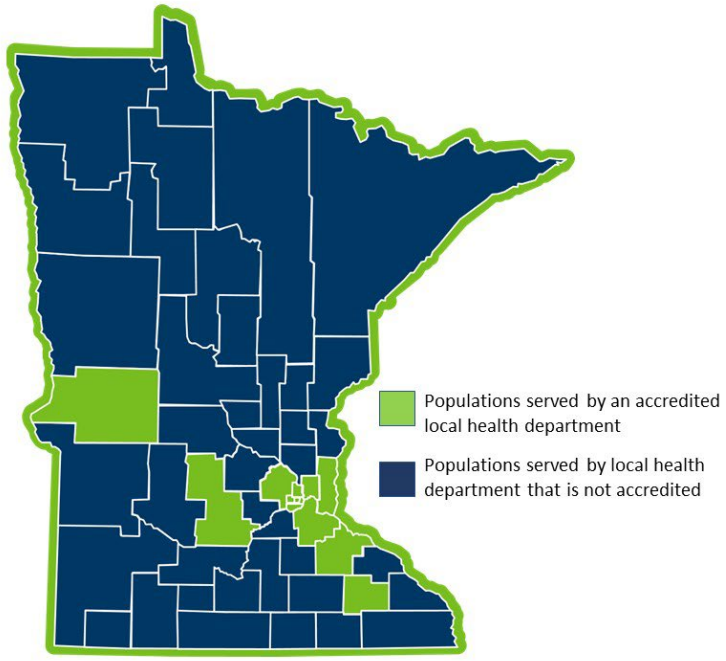
- Bring together the State Community Health Services Advisory Committee and local health directors to develop policies, practices, and guidance to ensure everyone in Minnesota has access to quality public health, regardless of where they live.
- Provide training, technical assistance, and coaching to health departments on foundational public health capabilities, including communications, leadership, workforce development, quality improvement, community assessment, and partnership development.
- Collect, analyze, and share data about the public health system including financing, staffing, and performance.
- Help MDH and local and tribal health departments seek and maintain national public health accreditation.
- Conduct surveys to measure the health status of Minnesotans, analyze local health trend, and serve as a source of health statistics.
- Provide staffing and direction to MDH's Institutional Review Board.

Statewide Health Improvement Initiatives

- Provide funding for and technical assistance to support local and tribal health departments to create community-level policy, systems, and environmental changes.
- Increase Minnesotans' access to programs and services that promote health and well-being in schools, workplaces, early childhood settings, healthcare systems, and community settings.
- Work with local public health, tribal nations, and communities to design and implement community-led approaches and trauma informed practices to address structural based health inequities such as lack of access to healthy food options in urban food deserts, safety issues that limit physical activity, or the intentional targeting of commercial tobacco products marketed to African American and American Indian communities.
- Provide comprehensive technical assistance through peer-to-peer and content-specific consultation calls, webinars, and communities of practice.
- Work with partners to build their capacity to collect data to assess progress and the impact of evidence-based activities.
- Assist Minnesotans who are attempting to quit using commercial tobacco products through the administration of evidence-based cessation services, including a statewide telephone-based Quitline and statewide public awareness activities that encourage utilization of cessation services.

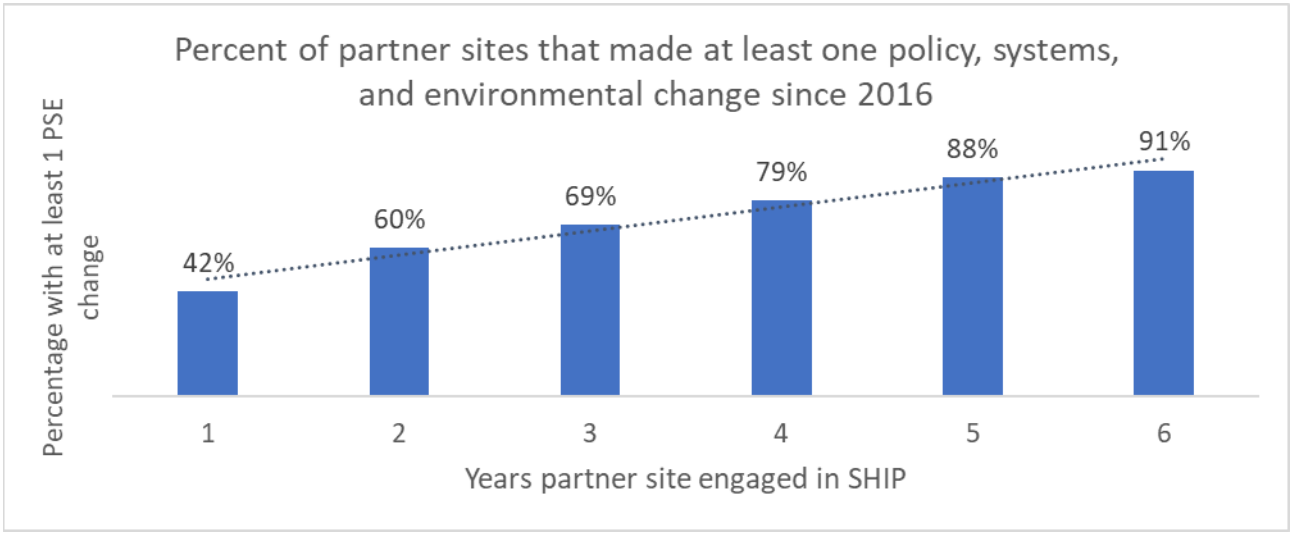
RESULTS

Populations served by nationally accredited local health department



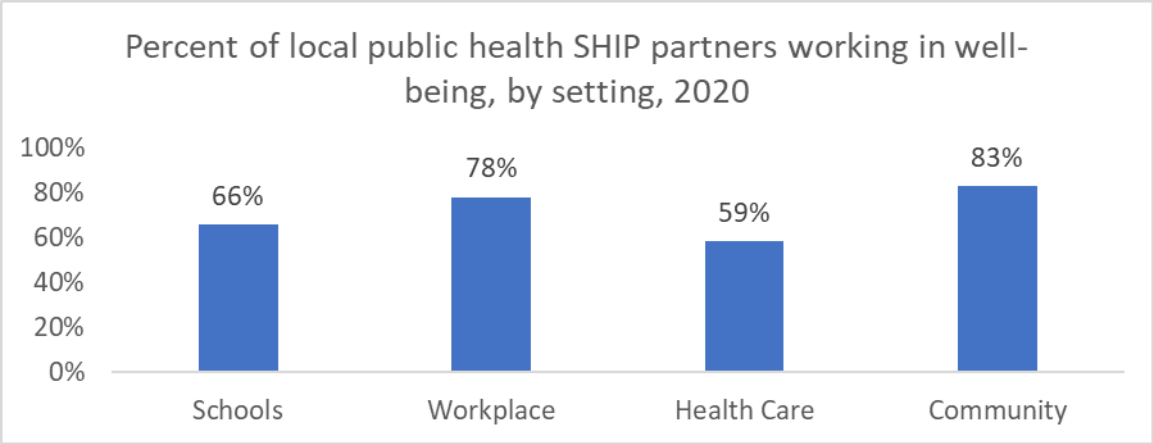
As of 2021, 51% of Minnesota's population is served by a local health department that fulfill foundational public health responsibilities as demonstrated by public health accreditation.

Statewide Health Improvement Partnership (SHIP) partners making policy, system, and environmental changes



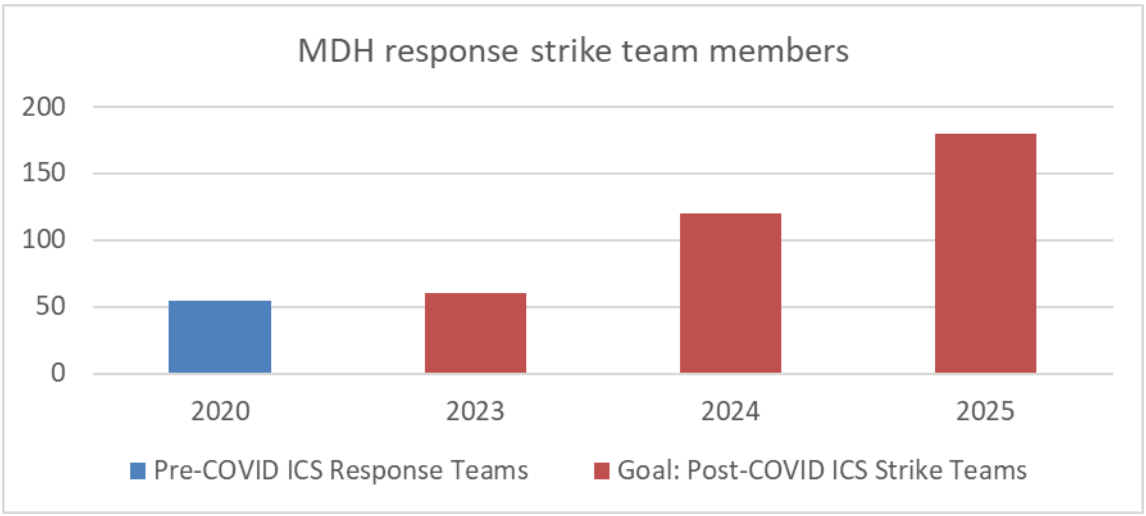
SHIP partner sites are reporting greater success at making policy, systems, or environmental (PSE) changes. The longer a site is engaged with SHIP local public health or MDH, the more likely they are to make PSE changes that support healthier communities.

Local public health SHIP partners working to promote well-being



A change in the SHIP statute in 2020 resulted in the addition of wellbeing as an allowable PSE strategy to improve health outcomes for all Minnesotans. Since that time all local public health SHIP partners have seen significant interest across all settings to implement SHIP well-being strategies such as social and emotional learning activities for students in schools and building trauma informed skills at the leadership level in workplaces to support the mental wellbeing of employees.

Number of MDH incident command system (ICS) response strike team members



In 2020, MDH had 54 trained staff (strike team members) who could quickly and effectively stand up and maintain a response structure in the event of a public health emergency. By 2025, MDH has a goal of having 180 trained strike team members.

STATUTES
M.S. 12A.08 Natural Disaster; State Assistance (https://www.revisor.mn.gov/statutes/?id=12A.08)
M.S. 144.396 Tobacco-Free Communities in Minnesota (https://www.revisor.mn.gov/statutes/?id=144.396
M.S. 144.4197 Emergency Vaccine Administration; Legend Drug (https://www.revisor.mn.gov/statutes/?id=144.4197)
M.S. 145A Community Health Boards (https://www.revisor.mn.gov/statutes/?id=145A)
M.S. 145.986 Minnesota Statewide Health Improvement Initiatives (https://www.revisor.mn.gov/statutes/?id=145.986)
M.S. 151.37 Legend Drugs, Who May Prescribe, Possess (https://www.revisor.mn.gov/statutes/?id=151.37)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	32,924	34,584	50,221	59,747	47,446	47,446	81,921	81,824
1251 - COVID-19 Minnesota	139,034	64,293						
2000 - Restrict Misc Special Revenue	228	85	153	140	70	70	70	70
2001 - Other Misc Special Revenue	784	30	5	13				
2360 - Health Care Access	16,979	17,452	17,364	20,397	17,679	17,679	17,828	17,928
2403 - Gift	0	0	0	39				
3000 - Federal	16,424	164,197	351,582	85,852	42,838	28,967	42,838	28,967
3001 - Federal TANF	1,681	1,974	1,992	2,000				
3010 - Coronavirus Relief	24,112	202,902	40,066					
3015 - ARP-State Fiscal Recovery			(2,786)					
Total	**232,165**	**485,518**	**458,597**	**168,188**	**108,033**	**94,162**	**142,657**	**128,789**
Biennial Change				(90,898)		(424,590)		(355,339)
Biennial % Change				(13)		(68)		(57)
Governor's Change from Base								69,251
Governor's % Change from Base								34
Expenditures by Category								
Compensation	19,947	42,060	14,568	18,959	19,080	18,129	22,372	21,587
Operating Expenses	160,207	354,569	324,716	57,576	25,445	13,061	32,127	19,580
Grants, Aids and Subsidies	52,011	88,686	119,204	91,653	63,508	62,972	88,158	87,622
Capital Outlay-Real Property		155	8					
Other Financial Transaction		48	101					
Total	**232,165**	**485,518**	**458,597**	**168,188**	**108,033**	**94,162**	**142,657**	**128,789**
Total Agency Expenditures	232,165	485,518	458,597	168,188	108,033	94,162	142,657	128,789
Internal Billing Expenditures	1,941	3,179	6,585	4,572	6,176	4,088	6,833	4,746
Expenditures Less Internal Billing	**230,224**	**482,339**	**452,012**	**163,616**	**101,857**	**90,074**	**135,824**	**124,043**
Full-Time Equivalents	**117.76**	**327.82**	**137.10**	**136.17**	**124.64**	**126.73**	**149.44**	**151.53**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		977		5,897				
Direct Appropriation	34,041	35,217	56,824	54,367	47,446	47,446	81,921	81,824
Transfers Out	146	600	517	517				
Cancellations		1,010	189					
Balance Forward Out	971		5,897					
Expenditures	**32,924**	**34,584**	**50,221**	**59,747**	**47,446**	**47,446**	**81,921**	**81,824**
Biennial Change in Expenditures				42,460		(15,076)		53,777
Biennial % Change in Expenditures				63		(14)		49
Governor's Change from Base								68,853
Governor's % Change from Base								73
Full-Time Equivalents	13.46	15.91	14.72	14.55	7.10	6.91	30.65	30.46
1251 - COVID-19 Minnesota								
Balance Forward In		19,688						
Direct Appropriation	144,924	87,830						
Cancellations		43,225						
Balance Forward Out	5,890							
Expenditures	**139,034**	**64,293**						
Biennial Change in Expenditures				(203,327)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents		116.35						
2000 - Restrict Misc Special Revenue								
Balance Forward In	62	17	95	70				
Receipts	185	110	128	70	70	70	70	70
Balance Forward Out	20	42	70					
Expenditures	**228**	**85**	**153**	**140**	**70**	**70**	**70**	**70**
Biennial Change in Expenditures				(20)		(153)		(153)
Biennial % Change in Expenditures				(6)		(52)		(52)
Governor's Change from Base								0
Governor's % Change from Base								0

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Full-Time Equivalents	0.64	0.01	0.37					

2001 - Other Misc Special Revenue

Balance Forward In	40	89	17	13				
Receipts	32	2	1					
Transfers In	800							
Transfers Out		44						
Balance Forward Out	89	17	13					
Expenditures	**784**	**30**	**5**	**13**				
Biennial Change in Expenditures				(796)		(18)		(18)
Biennial % Change in Expenditures				(98)		(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents	4.48	0.35						

2360 - Health Care Access

Balance Forward In	2,959	3,679	2,639	2,718				
Direct Appropriation	17,636	17,679	17,679	17,679	17,679	17,679	17,828	17,928
Cancellations		1,473	235					
Balance Forward Out	3,616	2,433	2,719					
Expenditures	**16,979**	**17,452**	**17,364**	**20,397**	**17,679**	**17,679**	**17,828**	**17,928**
Biennial Change in Expenditures				3,331		(2,403)		(2,005)
Biennial % Change in Expenditures				10		(6)		(5)
Governor's Change from Base								398
Governor's % Change from Base								1
Full-Time Equivalents	14.08	11.74	13.35	13.35	12.55	12.21	13.80	13.46

2403 - Gift

Balance Forward In	11	13	13	39				
Receipts	2	0	26					
Balance Forward Out	13	13	39					
Expenditures	**0**	**0**	**0**	**39**				
Biennial Change in Expenditures				38		(39)		(39)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial % Change in Expenditures				7,067		(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								

3000 - Federal

Balance Forward In	12	33	12,265	13				
Receipts	18,266	165,483	339,330	85,839	42,838	28,967	42,838	28,967
Balance Forward Out	1,854	1,319	13					
Expenditures	**16,424**	**164,197**	**351,582**	**85,852**	**42,838**	**28,967**	**42,838**	**28,967**
Biennial Change in Expenditures				256,813		(365,629)		(365,629)
Biennial % Change in Expenditures				142		(84)		(84)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	85.00	77.45	101.00	108.27	104.99	107.61	104.99	107.61

3001 - Federal TANF

Receipts	1,681	1,974	1,992	2,000				
Expenditures	**1,681**	**1,974**	**1,992**	**2,000**				
Biennial Change in Expenditures				338		(3,992)		(3,992)
Biennial % Change in Expenditures				9		(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								

3010 - Coronavirus Relief

Balance Forward In		53,512	62,831					
Direct Appropriation	75,195	202,256	20,737					
Transfers Out		740						
Cancellations	944	48,212	43,503					
Balance Forward Out	50,138	3,913						
Expenditures	**24,112**	**202,902**	**40,066**					
Biennial Change in Expenditures				(186,949)		(40,066)		(40,066)
Biennial % Change in Expenditures				(82)				
Governor's Change from Base								0

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Governor's % Change from Base								
Full-Time Equivalents	0.10	106.01	7.66					

3015 - ARP-State Fiscal Recovery

Cancellations	2,786				
Expenditures	**(2,786)**				
Biennial Change in Expenditures		(2,786)	2,786		2,786
Biennial % Change in Expenditures					
Governor's Change from Base					0
Governor's % Change from Base					

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
3000 - Federal			125		188	188	188	188
Total			**125**		**188**	**188**	**188**	**188**
Biennial Change			125			251		251
Biennial % Change								
Governor's Change from Base								0
Governor's % Change from Base								0
Expenditures by Category								
Compensation			50		75	75	75	75
Operating Expenses			75		113	113	113	113
Total			**125**		**188**	**188**	**188**	**188**
Full-Time Equivalents			**0.45**		**0.68**	**0.68**	**0.68**	**0.68**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
3000 - Federal								
Receipts			125		188	188	188	188
Expenditures			**125**		**188**	**188**	**188**	**188**
Biennial Change in Expenditures			125			251		251
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents			0.45		0.68	0.68	0.68	0.68

Program: Health Improvement
Activity: Health Policy

https://www.health.state.mn.us/about/org/hp/

AT A GLANCE

- The Health Economics Program conducts research and advanced economic analysis of health care market trends, policy options, and impacts to inform state policy makers.
- Managed Care Systems annually approves 53 medical and 3 dental provider networks and 81 pharmacy benefit manager networks that serve Minnesotans statewide.
- The Office of Rural Health and Primary Care conducts workforce research to inform policy makers and annually distributes over $78 million in grants and loans to health care professionals and provider organizations to ensure that rural and underserved communities have access to care.
- Minnesota's Health Care Homes voluntary certification program includes 411 (58%) primary care clinics that coordinate care among the primary care team, specialists, and community partners to ensure patient-centered whole person care and improve total health and well-being.
- To optimize administrative efficiencies and patient outcomes, the Center for Health Information Policy and Transformation promotes adoption and use of standardized electronic health record systems by Minnesota's hospitals and local public health systems, clinics and nursing homes, and health plans.
- The Adverse Events Reporting System reviews between 350-500 adverse health events, that occur annually at Minnesota's hospitals and ambulatory surgical centers and supports facilities in conducting root cause analyses to identify and learn from factors leading to the event.
- The Office of Vital Records operates Minnesota's vital records system that tracks more than 120,000 annual vital events, such as birth and death certificates, and 17,000 active users of the Minnesota Registration and Certification system.

PURPOSE AND CONTEXT

We support consumers, policymakers, and the health care organizations with information, workforce funding, education, and oversight of health care delivery and access to care. We provide statewide leadership on health care policy, market trends, research, and information exchange; administer loan forgiveness programs for the health care workforce; regulate hospital trauma center designations; regulate products offered by health maintenance organizations (HMOs); and manage the statewide vital record system for birth and death records.

Our role is to:

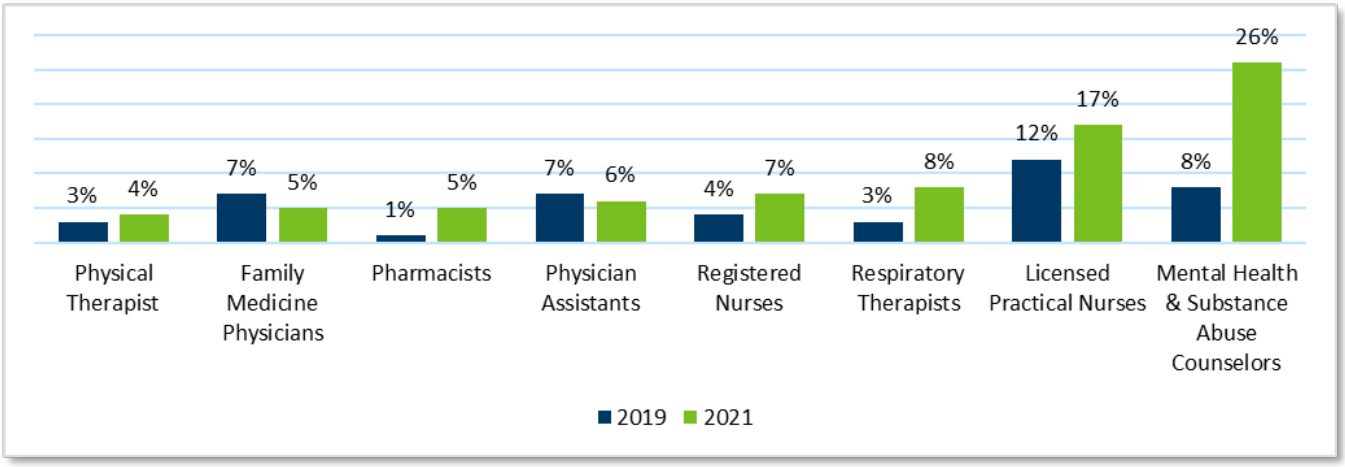
- Measure and report on the health care marketplace, access and quality of care, prescription drug prices, patient safety, and health workforce capacity.
- License and regulate health maintenance organization (HMO) products to ensure that HMO and Medicaid enrollees have adequate access to health care providers and quality insurance coverage.
- Support health professional education and research and provide loan forgiveness to build a strong health workforce in rural and underserved areas.
- Promote the secure exchange of health information among health care providers.
- Engage and coordinate health plans to reduce administrative costs and burden by improving standardization and electronic exchange of health insurance documentation.
- Train and certify primary care clinics to be Health Care Homes that provide high quality, patient-centered and coordinated, team-based care.
- Issue timely birth and death certificates and provide accurate vital records data for public health research.

SERVICES PROVIDED

- Partner with policymakers, providers, and rural and underserved urban communities to encourage a continuum of core health services throughout the state by administering workforce education funding and measuring workforce trends and needs.
- Administer the statewide vital records system that provides birth and death registrations, certificates, and amendments, helping consumers obtain needed identity documents for REAL ID and other benefits and services.
- Monitor and advise on health care access and quality, market conditions and trends, health care spending, health status and disparities, health behaviors and conditions, and the impact of state and federal reform initiatives.
- Manage the Minnesota All Payer Claims Database (MN APCD), a statewide database of anonymous health care claims data. Public use files offer a unique opportunity for the public and researchers to learn about the costs, impacts and health outcomes of health care services and prescription drugs.
- Measure clinical quality and safety in Minnesota by implementing the Statewide Quality Reporting and Measurement system and the Adverse Health Events reporting system, conducting quality audits of managed care plans, and certifying primary care clinics as Health Care Homes.
- Administer the statewide hospital trauma system by certifying trauma center designations, analyzing trauma data, and providing technical expertise to hospitals caring for trauma patients.
- Engage health organizations across the care continuum to best use their technology and data to advance health equity and support health and wellbeing.
- Certify Health Care Homes which has been shown to improve quality outcomes for asthma, vascular care, diabetes, depression, and colorectal measures and improving patient satisfaction.
- Increase efficiencies and reduce costs in the health care system by developing standards and best practices for the exchange of business and administrative data.
- Convene and engage stakeholders annually through the statewide rural health conference (600 attendees), Health Care Homes learning days (300 attendees), and e-health conference (200 attendees).

RESULTS

Job vacancy rates in select health care occupations, 2019 and 2021



Public Use Files from the Minnesota All Payer Claims Database (MN APCD), 2020-2022

Type of Measure	Name of Measure	2020	2021	2022 (projected)
Quantity	MN APCD public use file downloads	588	348	636
Quantity	Unique APCD public use file users	163	72	144

Certified Health Care Homes and county representations, 2019 to 2021

Type of Measure	Name of Measure	2019	2020	2021
Quantity	Certified health care homes in MN	378	389	411
Quantity	Minnesota counties with a certified health care home	64	68	69

The Office of Vital Records registrations and stakeholder management, 2019-2021

Type of Measure	Name of Measure	2019	2020	2021
Quantity	Birth registrations	65,100	62,633	63,515
Quantity	Death registrations	45,396	52,194	51,455
Quantity	Vital record amendments and/or replacements	6,157	5,064	5,195
Quantity	Data report requests fulfilled	6,574	6,730	6,507

STATUTES

M.S. 144.1501 Office of Rural Health and Primary Care, Health Professional Education Loan Forgiveness Act (https://www.revisor.mn.gov/statutes/cite/144.1501)
M.S. 144.211 – 144.227 Vital Statistics Act (https://www.revisor.mn.gov/statutes/cite/144.211 – https://www.revisor.mn.gov/statutes/cite/144.227)
M.S. 144.695 -144.703 Minnesota Health Care Cost Information Act (https://www.revisor.mn.gov/statutes/cite/144.695 – https://www.revisor.mn.gov/statutes/cite/144.703)
M.S. 144.706-144.7069 Adverse Health Reporting System (https://www.revisor.mn.gov/statutes/cite/144.7067)
M.S. 62D Health Maintenance Organizations (https://www.revisor.mn.gov/statutes/cite/62D)
M.S. 62J.17 Capital Expenditure Reporting (https://www.revisor.mn.gov/statutes/cite/62J.17)
M.S. 62J.321 Health Economics Program (https://www.revisor.mn.gov/statutes/cite/62J.321)
M.S. 62J.38 Cost Containment from Group Purchasers (https://www.revisor.mn.gov/statutes/cite/62J.38)
M.S. 62J.321 Data Collection (https://www.revisor.mn.gov/statutes/cite/62J.321)
M.S. 62J.495 – 62J.497 Electronic Health Record Technology (https://www.revisor.mn.gov/statutes/cite/62J.495 – https://www.revisor.mn.gov/statutes/cite/62J.497)
M.S. 62J.63 Center for Health Care Purchasing Improvement (https://www.revisor.mn.gov/statutes/cite/62J.63)
M.S. 62U.02 Payment Restructuring; Quality Incentive Payments (https://www.revisor.mn.gov/statutes/cite/62U.02)
M.S. 62U.04 Payment Reform; Health Care Costs; Quality Outcomes (https://www.revisor.mn.gov/statutes/cite/62U.04)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	9,924	12,352	13,619	22,310	17,061	13,801	24,587	20,784
1100 - Medical Education & Research	79,306	78,934	78,984	68,568	7,725	7,725	0	0
1200 - State Government Special Rev	5,203	4,752	5,274	6,233	5,741	5,741	6,760	7,003
1250 - Health Care Response	40,253	94,014						
2000 - Restrict Misc Special Revenue	1,159	847	769	5,464	118	118	7,694	7,694
2001 - Other Misc Special Revenue	50,762	513	706	4,441	617	617	617	617
2360 - Health Care Access	18,202	17,412	17,280	23,164	20,706	22,965	34,379	38,993
2403 - Gift	2			7				
3000 - Federal	3,014	2,614	21,095	21,339	14,918	3,500	14,918	3,500
Total	**207,824**	**211,439**	**137,728**	**151,526**	**66,886**	**54,467**	**88,955**	**78,591**
Biennial Change				(130,009)		(167,901)		(121,708)
Biennial % Change				(31)		(58)		(42)
Governor's Change from Base								46,193
Governor's % Change from Base								38
Expenditures by Category								
Compensation	11,110	9,136	10,733	13,142	12,684	12,681	17,447	18,546
Operating Expenses	9,570	25,401	10,778	21,230	9,803	8,139	14,647	12,196
Grants, Aids and Subsidies	187,144	176,902	116,216	117,153	44,398	33,646	56,860	47,848
Other Financial Transaction	1		0	1	1	1	1	1
Total	**207,824**	**211,439**	**137,728**	**151,526**	**66,886**	**54,467**	**88,955**	**78,591**
Total Agency Expenditures	207,824	211,439	137,728	151,526	66,886	54,467	88,955	78,591
Internal Billing Expenditures	3,353	3,205	3,773	3,842	3,624	3,365	4,941	4,991
Expenditures Less Internal Billing	**204,471**	**208,234**	**133,955**	**147,684**	**63,262**	**51,102**	**84,014**	**73,600**
Full-Time Equivalents	**114.67**	**88.15**	**101.24**	**99.09**	**95.18**	**93.84**	**132.20**	**135.21**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In	77	2,508	223	3,227				
Direct Appropriation	12,357	11,537	16,798	19,235	17,061	13,801	24,587	20,784
Transfers Out		344	140	152				
Cancellations	4	1,125	35					
Balance Forward Out	2,506	223	3,227					
Expenditures	**9,924**	**12,352**	**13,619**	**22,310**	**17,061**	**13,801**	**24,587**	**20,784**
Biennial Change in Expenditures				13,653		(5,067)		9,442
Biennial % Change in Expenditures				61		(14)		26
Governor's Change from Base								14,509
Governor's % Change from Base								47
Full-Time Equivalents	6.72	5.12	8.66	8.58	8.07	7.87	26.78	30.98
1100 - Medical Education & Research								
Balance Forward In	529	215	427	433				
Receipts	78,991	78,991	78,991	68,135	7,725	7,725	0	0
Transfers In	150	150	150	150	150	150	0	0
Transfers Out	150	150	150	150	150	150	0	0
Balance Forward Out	213	271	433					
Expenditures	**79,306**	**78,934**	**78,984**	**68,568**	**7,725**	**7,725**	**0**	**0**
Biennial Change in Expenditures				(10,688)		(132,102)		(147,552)
Biennial % Change in Expenditures				(7)		(90)		(100)
Governor's Change from Base								(15,450)
Governor's % Change from Base								(100)
Full-Time Equivalents	2.03	1.22	1.06	1.06	1.06	1.06	0.00	0.00
1200 - State Government Special Rev								
Balance Forward In		515		492				
Direct Appropriation	4,317	3,941	5,766	5,741	5,741	5,741	6,760	7,003
Transfers In	1,449	1,449						
Transfers Out	77	531						
Cancellations		623						
Balance Forward Out	486		492					
Expenditures	**5,203**	**4,752**	**5,274**	**6,233**	**5,741**	**5,741**	**6,760**	**7,003**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial Change in Expenditures				1,552		(25)		2,256
Biennial % Change in Expenditures				16		(0)		20
Governor's Change from Base								2,281
Governor's % Change from Base								20
Full-Time Equivalents	35.09	28.60	35.03	35.18	35.18	35.18	41.13	41.13

1250 - Health Care Response

Balance Forward In		89,954						
Direct Appropriation	132,526	10,339						
Cancellations		6,279						
Balance Forward Out	92,273							
Expenditures	**40,253**	**94,014**						
Biennial Change in Expenditures				(134,267)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents		3.36						

2000 - Restrict Misc Special Revenue

Balance Forward In	4,951	5,173	5,256	5,346				
Receipts	849	614	723	118	118	118	7,694	7,694
Net Loan Activity	271	242	136					
Balance Forward Out	4,913	5,182	5,346					
Expenditures	**1,159**	**847**	**769**	**5,464**	**118**	**118**	**7,694**	**7,694**
Biennial Change in Expenditures				4,227		(5,997)		9,155
Biennial % Change in Expenditures				211		(96)		147
Governor's Change from Base								15,152
Governor's % Change from Base								6,420
Full-Time Equivalents	4.51	3.04	2.74	1.56	1.31	1.31	1.31	1.31

2001 - Other Misc Special Revenue

Balance Forward In	2,170	2,674	3,900	3,824				
Receipts	621	564	632	617	617	617	617	617

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Transfers In	50,000							
Transfers Out	1	1						
Balance Forward Out	2,028	2,724	3,825					
Expenditures	**50,762**	**513**	**706**	**4,441**	**617**	**617**	**617**	**617**
Biennial Change in Expenditures				(46,128)		(3,913)		(3,913)
Biennial % Change in Expenditures				(90)		(76)		(76)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	5.93	4.13	1.00					

2360 - Health Care Access

Balance Forward In	840	2,746	1,575	4,011				
Direct Appropriation	19,649	19,289	19,833	19,153	20,706	22,965	34,379	38,993
Transfers In	182							
Transfers Out	182	634						
Cancellations	39	2,578	116					
Balance Forward Out	2,249	1,411	4,011					
Expenditures	**18,202**	**17,412**	**17,280**	**23,164**	**20,706**	**22,965**	**34,379**	**38,993**
Biennial Change in Expenditures				4,830		3,227		32,928
Biennial % Change in Expenditures				14		8		81
Governor's Change from Base								29,701
Governor's % Change from Base								68
Full-Time Equivalents	51.13	35.78	45.54	45.54	42.79	41.65	56.21	55.02

2403 - Gift

Balance Forward In	9	7	7	7				
Balance Forward Out	7	7	7					
Expenditures	**2**			**7**				
Biennial Change in Expenditures				5		(7)		(7)
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
3000 - Federal								
Balance Forward In	77	72	115	142				
Receipts	3,022	2,602	21,122	21,197	14,918	3,500	14,918	3,500
Balance Forward Out	84	60	142					
Expenditures	**3,014**	**2,614**	**21,095**	**21,339**	**14,918**	**3,500**	**14,918**	**3,500**
Biennial Change in Expenditures				36,805		(24,016)		(24,016)
Biennial % Change in Expenditures				654		(57)		(57)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	9.26	6.90	7.21	7.17	6.77	6.77	6.77	6.77

6000 - Miscellaneous Agency								
Balance Forward In	15	0	8	54				
Receipts	76	71	71	72	72	72	72	72
Transfers Out	91	64	25	126	72	72	72	72
Balance Forward Out		8	54					

Program: Health Improvement
Activity: Office of Medical Cannabis

https://www.health.state.mn.us/people/cannabis/index.html

AT A GLANCE

- Approved the enrollment of 38,170 patients and authorized 2,246 healthcare practitioners to certify patients by June 2022.
- Oversee compliance and enforcement of two vertically integrated manufacturers, which includes cultivation, extraction, and retail dispensing at up to 16 cannabis patient centers across Minnesota.
- Added chronic vocal or motor tic disorder as a qualifying medical condition in August 2021.
- Added dried raw cannabis as a delivery method in March 2022.
- Added edible gummies and chews as a delivery method in August 2022.

PURPOSE AND CONTEXT

The Office of Medical Cannabis at MDH connects Minnesota residents with qualifying medical conditions to a registered manufacturer to obtain medical cannabis. Registered health care practitioners must first certify that a patient has a qualifying medical condition. Then patients must sign up for the MDH registry, and if approved, may obtain medical cannabis in pill, liquid, topical, flower, or gummy/chew form from any of the sixteen distribution sites, which are supplied by two state-registered medical cannabis manufacturers.

Minnesota Statutes authorize the commissioner of health to add approved delivery methods or forms and qualifying medical conditions. A seven-member volunteer review panel assists the commissioner's review of the medical conditions without weighing in on delivery methods. Medical conditions being petitioned in 2022 are irritable bowel syndrome, gastroparesis, opioid use disorder and obsessive-compulsive disorder. No new delivery methods or forms are currently under consideration in 2022.

State law requires Minnesota residents with one or more of the qualifying medical conditions who want to access medical cannabis for therapeutic or palliative purposes to join the state's patient registry. As of August 1, 2020, the following were eligible conditions:

- Alzheimer's disease
- Amyotrophic lateral sclerosis (ALS)
- Autism spectrum disorder (must meet DSM-5 criteria)
- Cancer
- Chronic motor or vocal tic disorder
- Chronic pain
- Glaucoma
- HIV/AIDS
- Inflammatory bowel disease, including Crohn's disease
- Intractable pain
- Obstructive sleep apnea
- Post-traumatic stress disorder (PTSD)
- Seizures, including those characteristic of epilepsy
- Severe and persistent muscle spasms, including those characteristic of multiple sclerosis (MS)
- Sickle cell disease
- Terminal illness, with a probable life expectancy of less than one year
- Tourette syndrome

The list of qualifying medical conditions is continually updated on our website and can be found below.

Qualifying Medical Conditions and Delivery Methods
Added by the Commissioner of Health

Qualifying Medical Conditions:	***date approved***	***effective date***
Intractable Pain*	December 1, 2015	August 1, 2016
Post-Traumatic Stress Disorder (PTSD)	December 1, 2016	August 1, 2017
Autism Spectrum Disorder	December 1, 2017	August 1, 2018
Obstructive Sleep Apnea	December 1, 2017	August 1, 2018
Alzheimer's Disease	December 1, 2018	August 1, 2019
Chronic Pain	December 1, 2019	August 1, 2020
Chronic Vocal or Motor Tic Disorder	December 1, 2020	August 1, 2021

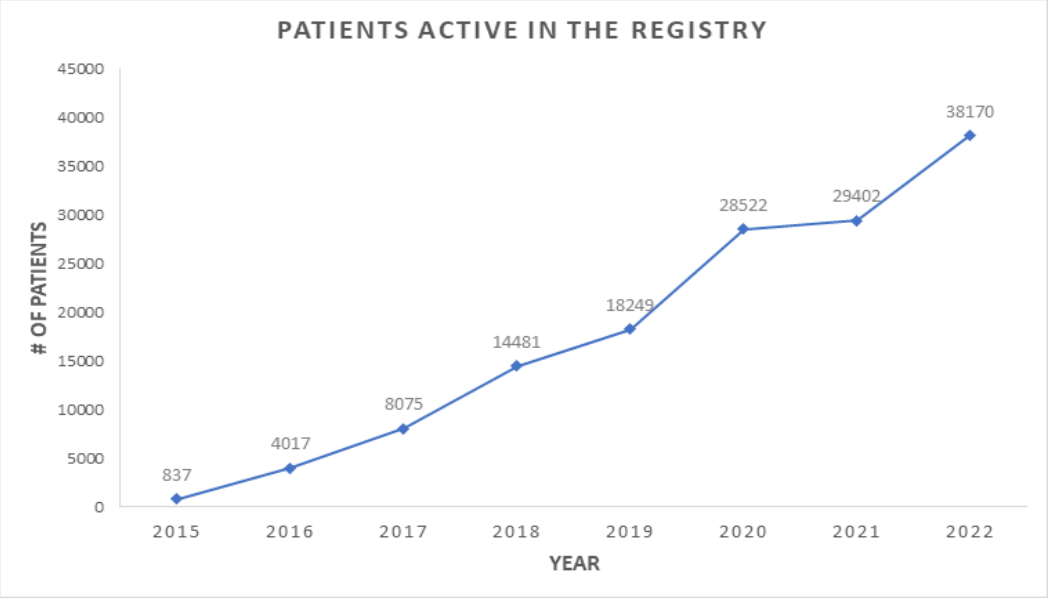
**Added under the authority of Laws 2014, chapter 311, section 20.*

Delivery Methods:	***date approved***	***effective date***
Topical Applications	December 1, 2016	August 1, 2017
Dissolvable oral update	December 1, 2019	August 1, 2020
Water-soluble cannabinoid multiparticulate	December 1, 2019	August 1, 2020
Edibles (gummy or chews)	December 1, 2021	August 1, 2022

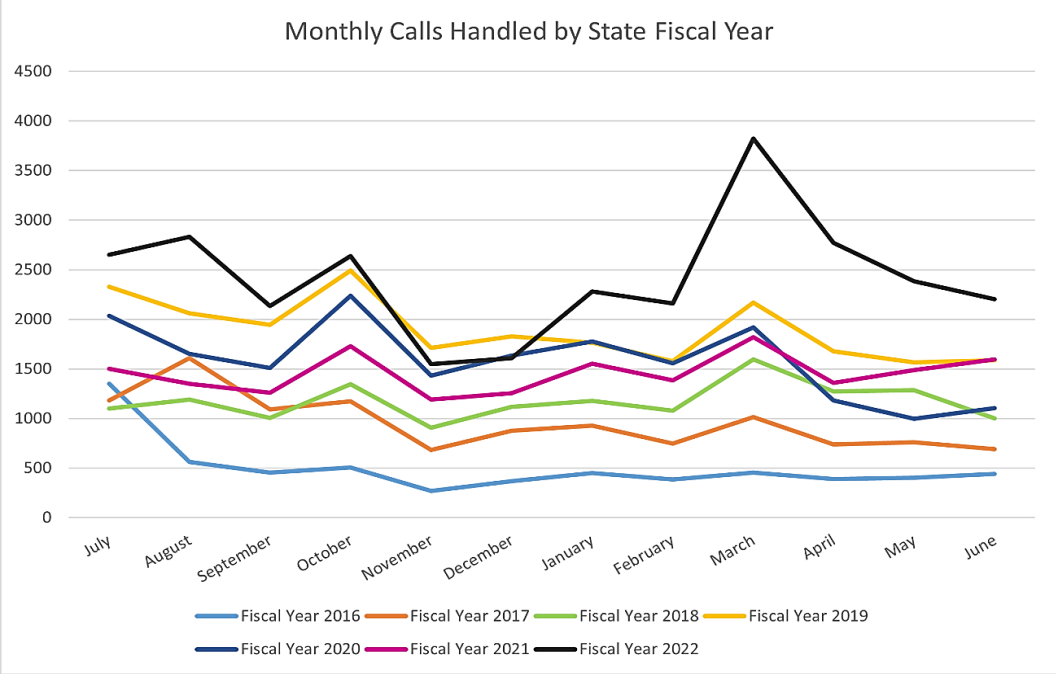
SERVICES PROVIDED

- Administer the statutorily required, online, secure patient registry through which qualified Minnesota residents can acquire medical cannabis to treat certain serious health conditions.
- Administer the track and trace inventory management system.
- Register and oversee the two medical cannabis manufacturers responsible for production and distribution of medical cannabis. The manufacturers may each operate up to eight cannabis dispensaries in the state for a total of sixteen.
- Inspect the cultivation, production, and distribution facilities operated by the manufacturers.
- Conduct program evaluation based on patient and healthcare practitioner self-reported data submitted into the registry through surveys.
- Operate a call center to respond to citizens needing information and assistance quickly and accurately with the medical cannabis program and the patient registry.
- Administer the public petition process for citizens to propose additional qualifying medical conditions or delivery methods.

RESULTS



The number of patients enrolled in the patient registry has grown from 837 in fiscal year 2015 to 38,170 in fiscal year 2022.



As Minnesota adds more qualifying conditions and delivery methods for medical cannabis, we have experienced an increase in the volume of calls to our call center. In fiscal year 2022, dried raw cannabis became available for sale on March 1, 2022. This delivery method was in great demand and led to many new patient enrollments and questions as evidenced by the spike seen during that period.

STATUTES
M.S. 152.22-152.37 Medical Cannabis Patient Registry Program
(https://www.revisor.mn.gov/statutes/cite/152.22)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	259	215	129	1,433	781	781	0	0
1200 - State Government Special Rev	2,091	1,802	3,684	4,457	3,424	3,424	0	0
2403 - Gift				1				
Total	**2,350**	**2,017**	**3,812**	**5,891**	**4,205**	**4,205**	**0**	**0**
Biennial Change				5,336		(1,293)		(9,703)
Biennial % Change				122		(13)		(100)
Governor's Change from Base								(8,410)
Governor's % Change from Base								(100)
Expenditures by Category								
Compensation	1,193	1,470	1,423	1,410	1,410	1,410	0	0
Operating Expenses	1,157	546	2,389	4,481	2,795	2,795	0	0
Grants, Aids and Subsidies		1						
Total	**2,350**	**2,017**	**3,812**	**5,891**	**4,205**	**4,205**	**0**	**0**
Total Agency Expenditures	2,350	2,017	3,812	5,891	4,205	4,205	0	0
Internal Billing Expenditures	375	321	738	611	610	610	610	610
Expenditures Less Internal Billing	**1,975**	**1,696**	**3,075**	**5,280**	**3,595**	**3,595**	**(610)**	**(610)**
Full-Time Equivalents	**13.95**	**15.42**	**14.28**	**14.28**	**14.28**	**14.28**	**0.00**	**0.00**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		626		652				
Direct Appropriation	771	779	781	781	781	781	0	0
Transfers Out		562						
Cancellations		628						
Balance Forward Out	512		652					
Expenditures	**259**	**215**	**129**	**1,433**	**781**	**781**	**0**	**0**
Biennial Change in Expenditures				1,088		0		(1,562)
Biennial % Change in Expenditures				229		0		(100)
Governor's Change from Base								(1,562)
Governor's % Change from Base								(100)
Full-Time Equivalents	0.56	0.06						
1200 - State Government Special Rev								
Balance Forward In		47		1,033				
Direct Appropriation	2,138	1,915	4,717	3,424	3,424	3,424	0	0
Transfers Out		160						
Balance Forward Out	47		1,033					
Expenditures	**2,091**	**1,802**	**3,684**	**4,457**	**3,424**	**3,424**	**0**	**0**
Biennial Change in Expenditures				4,247		(1,293)		(8,141)
Biennial % Change in Expenditures				109		(16)		(100)
Governor's Change from Base								(6,848)
Governor's % Change from Base								(100)
Full-Time Equivalents	13.39	15.36	14.28	14.28	14.28	14.28	0.00	0.00
2403 - Gift								
Balance Forward In		1	1	1				
Receipts	1							
Balance Forward Out	1	1	1					
Expenditures				**1**				
Biennial Change in Expenditures				1		(1)		(1)
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

Program: Health Improvement
Activity: Health Equity

https://www.health.state.mn.us/communities/equity/index.html

AT A GLANCE

- Distribute funds to approximately 160 community-based organizations, Tribal nations, and other partners to support community health, emergency preparedness, and elimination of health disparities.
- Provide support and guidance to Minnesota Department of Health (MDH) and local public health on equitable community engagement.
- Provide internal capacity building, coaching, technical assistance, guidance, support, and tools to embed racial and health equity lenses into program design, planning, implementation, and evaluation.
- Coordinate efforts to embed equity in department-led emergency preparedness activities and outreach to BIPOC, LGBTQ+, and communities with disabilities during the occurrence of a disaster or other emergency.
- Conduct health equity impact assessments or evaluations and contribute to data equity works across MDH.
- Provide support and guidance to MDH programs and divisions on equitable procurement and grantmaking.
- Provide leadership support to internal equity teams and external participation in councils.

PURPOSE AND CONTEXT

State, local, and Tribal public health agencies have a special responsibility to assess and address the root causes of the social determinants of health, including structural and systemic inequities that perpetuate health disparities. MDH must engage in an upstream approach to transform inequitable structures and systems to advance equity and improve the health of all Minnesotans. The Center for Health Equity (CHE) works across MDH and with community partners to advance racial and health equity to ensure all communities and Minnesotans are thriving and healthy. We strive to bring a health equity perspective internally to MDH leaders and staff, as well as externally to local public health departments and other decision-making across sectors and policy areas to reshape our policies and systems in Minnesota and strengthen communities. The MDH vision is “health equity in Minnesota, where all communities are thriving, and all people have what they need to be healthy,” and CHE works to advance this by:

- Leading, connecting, and strengthening networks of health equity leaders and partners.
- Advancing health equity and cultivating health equity leaders in Minnesota communities.
- Amplifying the voices of communities most impacted by health inequities and supporting them to drive their own solutions.
- Providing subject-matter expertise in culturally appropriate community engagement in communities of focus including black and other people of color, LGBTQ+, people with disabilities, and others.
- Providing expertise in embedding equity in emergency preparedness and response.

Fiscal details for Health Equity were included in the Community Health budget activity for the 2022-2023 biennium. We are establishing a standalone budget activity for Health Equity in the 2024-2025 biennium to reflect the department’s organizational structure.

SERVICES PROVIDED

Equitable Community Engagement

- Provide support, technical assistance, and guidance to MDH staff to engage communities through an equitable and inclusive lens and prioritize community voices to empower those who have been historically marginalized.
- Support MDH staff to understand cultural etiquette and customs of each community group to strengthen trust and two-way conversations to maintain community relationships.
- Monitor and analyze health disparities and their relation to health equity, including embedding culturally appropriate public health practices to address social determinants of health.
- Provide training, consultation, and liaison services for those working with Minnesota's diverse cultural communities of focus and coordinate related efforts within MDH.
- Provide subject-matter expertise in equity-related communication programming to assist MDH in engaging public media and messaging.
- Convene a community engagement practice group to share common etiquette customs and manners, success stories, and help model what best behaviors look like for state employees.
- Collaborate with Minnesota communities experiencing health inequities through the Eliminating Health Disparity Initiative (EHDI).
- Provide services to 13,588 community members in early learning, health and wellbeing, economic security, and safe and stable nurturing relationship initiatives through our Community Solutions for Early Childhood Development grant program established in 2020. Community Solutions provides funding to 23 diverse community-based organizations: 18 engage in systems change to facilitate services; 14 conduct institutional and organizational capacity building; two focus on HIV stigma reduction; and two focus on integrating culturally appropriate food security programs.

Health Equity Capacity and Systems, Policy, and Practices Transformation

- Increase MDH's internal equity capacity in program design, planning, implementation, and evaluation.
- Train and develop new hires and current MDH staff in racial and health equity and antiracism training.
- Provide continuous learning opportunities for MDH employees to better understand structural racial and health inequities, including in rural communities.
- Equip MDH supervisors with the knowledge, skills, ideologies, and lenses to dismantle structural racism in their leadership roles and in the agency.
- Develop and implement an equity framework for MDH policy reviews.
- Review internal policies, practices, and guidance to ensure equity.

Equitable Public Health Data Practices

- Provide capacity building support, tools, leadership support, and/or technical assistance within MDH on advancing data equity in public health practice. CHE provides awareness and technical assistance in data collection, analysis, interpretation, and dissemination of such data from an equity lens.
- Create awareness for MDH staff on how publication and data interpretation may reinforce or negatively exacerbate inequities, or conversely, close gaps and reduce disparities.
- Advocate for data disaggregation by race, ethnicity, gender, and sexual orientation, data sharing and respond to public requests for health equity data and resources.

Equity in Public Health Grantmaking

- Through collaboration with MDH's Grant Office, established a framework to ensure grantmaking policies and practices across all divisions prioritize equity, transparency, and accessibility.
- Provide technical assistance internally to advance the identification and implementation of equitable practices during the competitive grantmaking process.
- Ensure transparency and equitable practices during award distribution.

Equitable Emergency Preparedness and Response

- Partner with state and local agencies and community-based organizations engage communities most impacted by public health emergency events.
- Provide culturally and linguistically appropriate emergency prevention and mitigation messages.
- Engage diverse media and communities most impacted in emergency response.
- Connect communities of focus to critical emergency services, supplies, and other services (e.g., testing, vaccination), especially those disproportionately impacted by supply chain disruptions.

RESULTS

Community Engagement & Outreach Activities by Geography Reached

Targeted to metro residents	Targeted to greater Minnesota residents	Targeted to all Minnesota residents	Total community engagement outreach
86	33	118	237

Since May 2020, we have conducted 237 community engagement and outreach activities covering both the Metro and greater Minnesota geographic areas. This number does not include community engagement and outreach activities performed by contractors.

People reached through the Eliminating Health Disparities Initiative by priority populations

Target Population served	2019	2020	2021	Grand Total
African/ African American	20,533	113,415	151,664	285,612
American Indian	15,558	57,759	111,274	184,591
Asian American/ Asian-PI	20,040	19,765	26,025	65,830
Hispanic/ Latinx	16,226	28,555	29,850	74,631
Others	477	17,262	108,394	126,133
Total	**72,834**	**236,756**	**427,207**	**736,797**

Since 2019, we increased our efforts to serve more communities most impacted by inequities through our Eliminating Health Disparities Initiative (EHDI) grant program.

Number of People Reached by Priority Health Areas

Priority Health Areas	2019	2020	2021	Grand Total
Breast & Cervical Cancer	12,118	5,373	12,628	30,119
Diabetes	14,478	13,923	59,758	88,159
Heart Disease & Stroke	10,403	5,222	27,226	42,851
HIV/AIDS	13,028	108,637	122,837	244,502
Immunizations	13,292	20,724	41,122	75,138
Infant Mortality	2,563	51,812	99,435	153,810
Teen Pregnancy	18,169	17,152	40,531	75,852
Unintentional Injury & Violence	8,234	13,913	23,670	45,817
Total	**92,285**	**236,756**	**427,207**	**756,248**

The EHDI program provides prevention services in multiple priority health areas, having served over 750,000 community members since program inception, many of which deal with one or more health inequities.

MDH COVID-19 hotline and resource distribution

Through our COVID-19 Community Coordinators (CCC) initiative, during 2020 and 2021, we provided emergency response services among communities most impacted by the disease through our MDH hotline.

Program funding distributed to community-based organizations

Primary Communities of focus	Number of BIPOC orgs funded	Total funding distributed
African American/Black	11	$1.4 million
American Indian	24	$4.4 million
Asian/Pacific Islander	6	$0.9 million
Latinx	8	$1.4 million
More than one focus community	7	$0.9 million
Total	**56**	**$9.0 million**

Between 2019 and 2021, we provided over $9 million in funding to 56 organizations serving focus communities through our (non-COVID specific) equitable grantmaking efforts including the EHDI, Community Solutions Fund for Early Child Development, and tribal public health grants.

Emergency funding (supplements 3 and 4, ELC etc.) distributed to CBOs

Primary Communities of focus	Number of BIPOC orgs funded	Total funding distributed
African American/Black	29	$5.2 million
American Indian	9	$2.1 million
API	16	$3.0 million
Disability	11	$2.5 million
Latinx	18	$3.6 million
LGBTQ	9	$1.5 million
Refugee/Immigrant	7	$2.4 million
Total	**99**	**$20.4 million**

We provided approximately $20.4 million in grant funding to 99 community organizations through our equitable funding for emergency response between March 2020 to June 2022.

STATUTES

M.S. 145.928 Eliminating Health Disparities (https://www.revisor.mn.gov/statutes/cite/145.928)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General					5,452	5,452	25,148	25,241
3001 - Federal TANF					2,000	2,000	2,000	2,000
Total					**7,452**	**7,452**	**27,148**	**27,241**
Biennial Change				0		14,904		54,389
Biennial % Change								
Governor's Change from Base								39,485
Governor's % Change from Base								265
Expenditures by Category								
Compensation					591	591	6,765	6,943
Operating Expenses					53	53	3,473	3,388
Grants, Aids and Subsidies					6,808	6,808	16,910	16,910
Total					**7,452**	**7,452**	**27,148**	**27,241**
Full-Time Equivalents					**5.17**	**5.05**	**54.25**	**55.13**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Direct Appropriation					5,452	5,452	25,148	25,241
Expenditures					**5,452**	**5,452**	**25,148**	**25,241**
Biennial Change in Expenditures				0		10,904		50,389
Biennial % Change in Expenditures								
Governor's Change from Base								39,485
Governor's % Change from Base								362
Full-Time Equivalents					5.17	5.05	54.25	55.13
3001 - Federal TANF								
Receipts					2,000	2,000	2,000	2,000
Expenditures					**2,000**	**2,000**	**2,000**	**2,000**
Biennial Change in Expenditures				0		4,000		4,000
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								0

Program: Health Protection

AT A GLANCE

Budget activities:

- Environmental Health
- Infectious Disease
- Public Health Laboratory
- Health Regulation

PURPOSE AND CONTEXT

Health – as an individual, a family, and a community – is a cornerstone of well-being and a necessary foundation for fulfilling one's potential. Protecting the health of Minnesotans from hidden harms, such as infectious diseases, health care-related injuries or maltreatment, or environmental risks, is critical for ensuring all Minnesotans and all Minnesota communities can thrive. The Health Protection budget program is built on a foundation of peer-reviewed science, trust, and integrity to achieve the best public health outcomes. This budget program leverages state funds to reduce the community impacts of infectious diseases and protects individuals receiving health care in hospitals, nursing homes, assisted living facilities and other establishments licensed by Minnesota Department of Health (MDH), while also helping to ensure that Minnesotans can expect safe food and drinking water and up to standard regulations in specific establishments.

The purpose, services, results, and authorizing statutes of each activity are described in the following pages. The fiscal page for Health Protection reflects a summation of activities under this budget program area.

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	22,610	23,656	23,666	150,460	26,135	26,135	66,831	67,252
1200 - State Government Special Rev	48,914	50,171	56,311	64,890	61,339	61,339	70,981	73,220
1251 - COVID-19 Minnesota	6,706	1,955						
2000 - Restrict Misc Special Revenue	800	649	742	3,099	717	717	717	717
2001 - Other Misc Special Revenue	25,707	8,033	6,847	29,411	24,664	24,664	24,664	24,664
2050 - Environment & Natural Resources	342		180					
2302 - Clean Water	5,665	5,956	6,416	10,183			11,296	11,904
2403 - Gift	1	1,000	0	50				
2800 - Environmental	326	503	647	1,217	932	932	1,332	1,332
2801 - Remediation	232	191	239	275	257	257	257	257
3000 - Federal	58,045	139,856	411,511	370,259	202,573	112,551	202,573	112,551
3015 - ARP-State Fiscal Recovery			83,908	22,091	3,466		3,466	
8201 - Drinking Water Revolving	622	672	666	762	756	756	756	756
Total	**169,970**	**232,643**	**591,132**	**652,697**	**320,839**	**227,351**	**382,873**	**292,653**
Biennial Change				841,217		(695,639)		(568,303)
Biennial % Change				209		(56)		(46)
Governor's Change from Base								127,336
Governor's % Change from Base								23
Expenditures by Activity								
Environmental Health	45,806	43,222	50,301	62,742	48,904	48,904	95,207	97,220
Infectious Disease	54,419	110,061	458,944	472,039	162,373	72,119	166,721	76,595
Public Health Laboratory	30,257	32,962	33,448	39,765	37,646	35,087	40,632	37,826
Health Regulation	39,488	46,398	48,440	78,151	71,916	71,241	80,313	81,012
Total	**169,970**	**232,643**	**591,132**	**652,697**	**320,839**	**227,351**	**382,873**	**292,653**
Expenditures by Category								
Compensation	87,363	87,472	107,079	122,690	113,130	105,529	130,967	127,654
Operating Expenses	63,327	106,999	409,373	425,338	173,082	101,250	185,814	112,869
Grants, Aids and Subsidies	17,274	36,400	72,788	102,174	32,132	20,077	63,597	51,635
Capital Outlay-Real Property	1,981	1,578	1,655	2,484	2,484	484	2,484	484
Other Financial Transaction	25	195	238	11	11	11	11	11

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Total	**169,970**	**232,643**	**591,132**	**652,697**	**320,839**	**227,351**	**382,873**	**292,653**
Total Agency Expenditures	169,970	232,643	591,132	652,697	320,839	227,351	382,873	292,653
Internal Billing Expenditures	22,290	37,243	48,147	38,804	24,467	20,869	28,634	25,189
Expenditures Less Internal Billing	**147,679**	**195,400**	**542,986**	**613,893**	**296,372**	**206,482**	**354,239**	**267,464**
Full-Time Equivalents	**918.33**	**899.13**	**1,005.07**	**997.64**	**955.05**	**910.80**	**1,090.25**	**1,054.10**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		5,697	172	2,978				
Direct Appropriation	49,348	29,190	27,180	154,228	26,135	26,135	54,831	55,252
Transfers In	3,013	3,013					12,000	12,000
Transfers Out	24,630	7,810	578	274				
Cancellations	25	6,262	130	6,472				
Balance Forward Out	5,096	172	2,978					
Expenditures	**22,610**	**23,656**	**23,666**	**150,460**	**26,135**	**26,135**	**66,831**	**67,252**
Biennial Change in Expenditures				127,860		(121,856)		(40,043)
Biennial % Change in Expenditures				276		(70)		(23)
Governor's Change from Base								81,813
Governor's % Change from Base								157
Full-Time Equivalents	84.58	79.72	87.53	86.19	81.09	79.10	123.09	121.10
1200 - State Government Special Rev								
Balance Forward In		2,353		3,000				
Direct Appropriation	52,716	53,337	59,311	61,890	61,339	61,339	70,981	73,220
Transfers Out	2,226	1,449						
Cancellations		4,070						
Balance Forward Out	1,576		3,000					
Expenditures	**48,914**	**50,171**	**56,311**	**64,890**	**61,339**	**61,339**	**70,981**	**73,220**
Biennial Change in Expenditures				22,116		1,477		23,000
Biennial % Change in Expenditures				22		1		19
Governor's Change from Base								21,523
Governor's % Change from Base								18
Full-Time Equivalents	257.08	254.64	291.71	291.71	291.71	291.71	339.36	339.36
1251 - COVID-19 Minnesota								
Balance Forward In		5,621						
Direct Appropriation	12,265							
Cancellations		3,666						
Balance Forward Out	5,559							
Expenditures	**6,706**	**1,955**						
Biennial Change in Expenditures				(8,660)		0		0

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								

2000 - Restrict Misc Special Revenue

Balance Forward In	271	1,217	1,440	2,256				
Receipts	943	948	1,557	843	717	717	717	717
Transfers In	777							
Balance Forward Out	1,191	1,515	2,256					
Expenditures	**800**	**649**	**742**	**3,099**	**717**	**717**	**717**	**717**
Biennial Change in Expenditures				2,391		(2,407)		(2,407)
Biennial % Change in Expenditures				165		(63)		(63)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	4.56	2.46	2.33	2.33	2.16	2.16	2.16	2.16

2001 - Other Misc Special Revenue

Balance Forward In	8,267	11,381	7,220	5,063				
Receipts	6,690	4,558	5,074	24,348	24,664	24,664	24,664	24,664
Transfers In	46,440		300					
Transfers Out	25,554	1,693	684					
Balance Forward Out	10,135	6,213	5,063					
Expenditures	**25,707**	**8,033**	**6,847**	**29,411**	**24,664**	**24,664**	**24,664**	**24,664**
Biennial Change in Expenditures				2,517		13,070		13,070
Biennial % Change in Expenditures				7		36		36
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	204.89	179.69	181.33	180.92	180.92	180.92	180.92	180.92

2050 - Environment & Natural Resources

Balance Forward In	398	69	214					
Cancellations			33					
Balance Forward Out	56	69						

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures	**342**		**180**					
Biennial Change in Expenditures				(162)		(180)		(180)
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents	0.71							

2302 - Clean Water

Balance Forward In	1,879	3,373	4,713	4,228				
Direct Appropriation	6,497	6,497	5,955	5,955	0	0	11,296	11,904
Cancellations		0	24					
Balance Forward Out	2,712	3,914	4,227					
Expenditures	**5,665**	**5,956**	**6,416**	**10,183**			**11,296**	**11,904**
Biennial Change in Expenditures				4,979		(16,599)		6,601
Biennial % Change in Expenditures				43		(100)		40
Governor's Change from Base								23,200
Governor's % Change from Base								
Full-Time Equivalents	26.34	19.15	19.74	19.25			43.05	51.15

2360 - Health Care Access

Full-Time Equivalents	0.05							

2403 - Gift

Balance Forward In	38	1,039	44	50				
Receipts	1,001	6	6					
Balance Forward Out	1,039	44	50					
Expenditures	**1**	**1,000**	**0**	**50**				
Biennial Change in Expenditures				(951)		(50)		(50)
Biennial % Change in Expenditures				(95)		(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents		3.58						

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
2800 - Environmental								
Balance Forward In		232		285				
Transfers In	555	420	932	932	932	932	1,332	1,332
Cancellations		149						
Balance Forward Out	229		285					
Expenditures	**326**	**503**	**647**	**1,217**	**932**	**932**	**1,332**	**1,332**
Biennial Change in Expenditures				1,035		0		800
Biennial % Change in Expenditures				125		0		43
Governor's Change from Base								800
Governor's % Change from Base								43
Full-Time Equivalents	2.53	1.92	3.64	3.64	3.64	3.64	6.14	6.14
2801 - Remediation								
Balance Forward In		30		18				
Transfers In	257	257	257	257	257	257	257	257
Cancellations		96						
Balance Forward Out	25		18					
Expenditures	**232**	**191**	**239**	**275**	**257**	**257**	**257**	**257**
Biennial Change in Expenditures				91		0		0
Biennial % Change in Expenditures				22		(0)		(0)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	1.96	1.08	1.78	1.78				
3000 - Federal								
Balance Forward In	22	504	1,281	213				
Receipts	61,809	140,523	410,444	370,046	202,573	112,551	202,573	112,551
Balance Forward Out	3,785	1,171	213					
Expenditures	**58,045**	**139,856**	**411,511**	**370,259**	**202,573**	**112,551**	**202,573**	**112,551**
Biennial Change in Expenditures				583,869		(466,646)		(466,646)
Biennial % Change in Expenditures				295		(60)		(60)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	331.45	352.05	409.03	403.84	391.64	349.38	391.64	349.38

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
3015 - ARP-State Fiscal Recovery								
Balance Forward In				21,458				
Direct Appropriation			127,170	633	3,466	0	3,466	0
Cancellations			21,805					
Balance Forward Out			21,458					
Expenditures			**83,908**	**22,091**	**3,466**		**3,466**	
Biennial Change in Expenditures				105,999		(102,533)		(102,533)
Biennial % Change in Expenditures						(97)		(97)
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents			4.09	4.09				
8201 - Drinking Water Revolving								
Balance Forward In	10			6				
Transfers In	612	672	672	756	756	756	756	756
Balance Forward Out			6					
Expenditures	**622**	**672**	**666**	**762**	**756**	**756**	**756**	**756**
Biennial Change in Expenditures				133		84		84
Biennial % Change in Expenditures				10		6		6
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	4.18	4.84	3.89	3.89	3.89	3.89	3.89	3.89

Program: Health Protection
Activity: Environmental Health

https://www.health.state.mn.us/eh

AT A GLANCE

- Inspect, test, and provide technical assistance to nearly 7,000 public water systems.
- Ensure safe food, drinking water, lodging, and swimming pools in 26,000 establishments statewide.
- Certify 12,000 food managers and support 36,000 active food managers annually.
- Regulate the installation of 6,500 new wells and the sealing of 7,000 unused wells annually. Provide educational support that empowers 470,000 private well owners to keep their drinking water safe.
- Promote healthy indoor environments and the reduction of unnecessary radiation exposure for over 11,000 facilities and individual contractors.

PURPOSE AND CONTEXT

Whether it is clean air to breathe, clean water to drink, or wholesome food to eat, having a healthy environment is a key determinant for individual and community health. Environmental Health strives to protect, promote, and improve public health for all who live, work, and play in Minnesota by monitoring and managing environmental health risks and hazards around the state through:

- Ensuring that food served in Minnesota restaurants and other food establishments is safe.
- Keeping drinking water safe.
- Evaluating potential health risks from exposures to toxic environmental hazards.
- Keeping our indoor environments healthy.

SERVICES PROVIDED

The Drinking Water Protection Program

- Ensures compliance with safe drinking water standards at nearly 7,000 public drinking water systems through inspection, contaminant monitoring, plan review, technical assistance, and operator education.
- Promotes prevention-based protective measures for Minnesota's ground and surface waters.
- Works with partners to maintain and upgrade drinking water infrastructure in the state.

Food, Pools, and Lodging Services

- Ensures sanitary conditions in the state's approximately 26,000 public swimming pools, hotels, schools, resorts, restaurants, manufactured home parks, recreational camping areas, and children's camps.
- Partners with locally delegated inspection agencies. Minnesota Department of Health (MDH) licenses and regulates about half of the hospitality businesses across the state and provides training, guidance, and technical assistance to the 28 delegated partners that license and regulate the remaining businesses.
- Provides public information, education, training, and assistance about safe food handling and handwashing to reduce the risk of foodborne illness.

Environmental Surveillance and Assessment

- Evaluates potential health risks to the public from exposures to toxic environmental hazards and recommends actions to minimize exposures and manage risks.
- Develops risk assessment data used by government agencies and others to protect the public from environmental risks, such as those that threaten both groundwater and surface water used for drinking water sources.

- Monitors lead testing of Minnesota children to reduce lead levels in children's blood through in-home lead risk assessment activities. Prior to 2021, in-home lead risk assessment activities were required for all cases at 15 micrograms per deciliter. As a result of legislative changes in the 2021 session, starting July 1, 2021, in-home lead risk assessments are required for all cases at 5 micrograms per deciliter and above.

Indoor Environments and Radiation Programs

- Protects the public from environmental exposure to asbestos, lead hazards, and radiation by licensing, permitting, compliance assistance, and conducting inspections of industry and workers.
- Enforces the Minnesota Clean Indoor Air Act, which prohibits smoking in most indoor public areas and workplaces.
- Provides public and schools with information about the potential health effects of asbestos, lead, radon, mold, and other indoor air contaminants.
- Protects the public from unnecessary radiation through licensing.

Well Management Program

- Protects public health and groundwater by establishing construction and sealing standards for wells and borings used for drinking water and other purposes.
- Licenses and educates contractors who construct, repair, and seal wells and borings.

Water Policy Center

- Collaborates with other water resource management activities across the Executive Branch and local government partners to protect drinking water, recreational waters, and public health.
- Expands private well protection actions through educational strategies and grants that increase voluntary efforts to test and mitigate geologic and human-caused contamination.

RESULTS

Food, Pools, and Lodging Services

The table below presents the quantity of licensing and regulatory activities conducted by Food, Pools, and Lodging Services Section (FPLS). The data does not include activities conducted by delegated partners.

Licensing and regulatory activities conducted by FPLS

Item	FY18	FY19	FY20*	FY21*	FY22**
# of establishment licenses issued	15,175	15,639	14,306	14,179	15,418
# of inspections conducted	16,386	17,460	13,497	14,818	14,966
# of complaints investigated	1,216	1,036	918	2,934	988

*COVID-19 pandemic related Executive Orders, licensed establishment closures/restrictions, regulatory staff reassignment to COVID-19 response and Executive Order enforcement activities may have impacted the numbers for fiscal years 2020 and 2021.

**In fiscal year 2022, FPLS became responsible for licensing and inspection in two counties that were previously delegated to local agencies. This added to the license and inspection numbers for fiscal year 2022. Also in fiscal year 2022, FPLS discontinued licensing the food service in Assisted Living Facilities as this responsibility was transferred to the Health Regulation Division (HRD). FPLS will continue to conduct food safety inspections at all Assisted Living Licensed facilities in coordination with HRD survey activities.

Drinking Water Protection

Drinking Water Protection (DWP) staff work with public water systems to prevent and resolve water quality problems. MDH's on-time completion rate for sanitary surveys in 2021 was 99.9% for community public water systems and 99.6% for noncommunity public water systems, reflective of DWP's efforts to maintain its inspection presence even considering COVID-19 limitations.

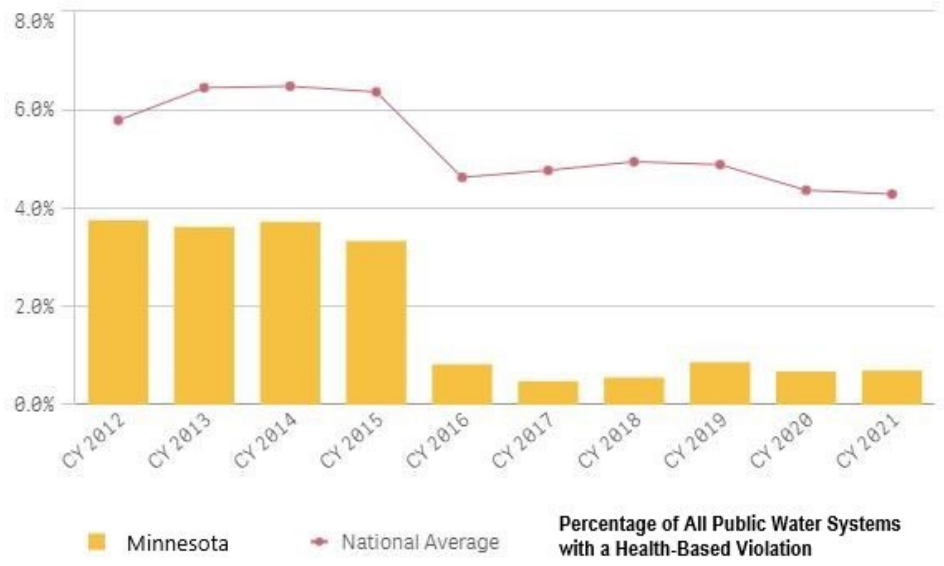
Contaminants	Number of CPWS subject to monitoring	Number of CPWS with violations or Action Level Exceedance	Population served by CPWS with violations or ALEs	Percent of CPWS meeting EPA standards	Number of NPWS monitored*	Number of NPWS with violations or ALEs	Population served by NPWS with violations or ALEs	Percent of NPWS meeting EPA standards
Pesticides and Industrial Contaminants	965	0	0	**100.0%**	476	0	0	**100.0%**
Bacteriological	965	1	25	**99.9%**	5712	13	945	**99.8%**
Nitrate/Nitrite	965	4	23,417	**99.6%**	5712	5	635	**99.9%**
Arsenic	965	7	1,578	**99.3%**	476	2	75	**99.6%**
Radionuclides	965	14	35,369	**98.5%**	N/A	N/A	N/A	**N/A**
Other Inorganic Chemicals	965	0	0	**100.0%**	476	0	0	**100.0%**
Disinfection byproducts**	573	2	868	**99.7%**	47	0	0	**100.0%**
Lead	965	3	2,786	**99.7%**	476	1	130	**99.8%**
Copper	965	29	87,784	**97.0%**	476	4	1495	**99.2%**

*Some contaminants are tested at all 5,712 noncommunity water systems: others are tested only at the 476 non-transient noncommunity water systems.

**Disinfection byproducts are only monitored at systems that disinfect their water or purchase disinfected water

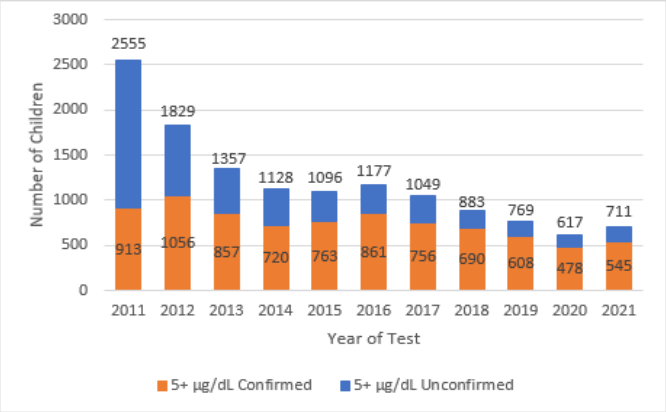
Percentage of Minnesota Public Water Systems with Health-Based Violations Compared to National Average

(Source: US EPA Enforcement and Compliance History Online [ECHO] Data System)

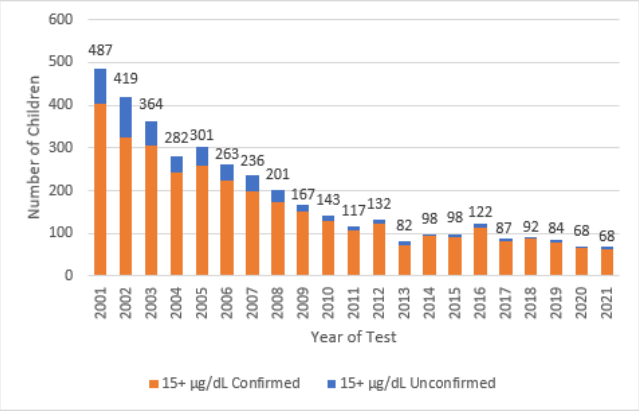


Elevated Blood Lead Levels (EBLL) Monitoring

Number of children with EBLL results above 15 micrograms per deciliter



Number of children with EBLL results above 5 micrograms per deciliter



While much work is needed to continue reducing lead exposures, annual examination of data shows steady rates of testing and decreasing elevated blood lead rates across the state.

STATUTES and RULES

M.R. 4620 Clean Indoor Air (https://www.revisor.mn.gov/rules/4620/)
M.S. 103I.005 Well Management (https://www.revisor.mn.gov/statutes/?id=103I.005)
M.S. 144.12, 144.122. 144.383, 446.081 Drinking Water Protection (https://www.revisor.mn.gov/statutes/?id=144)
M.S. 144.1222 Public Pools; Enclosed Sports Arenas (https://www.revisor.mn.gov/statutes/cite/144.1222)
M.S. 144.9502, M.R, 4717.8000 Environmental Surveillance and Assessment (https://www.revisor.mn.gov/statutes/?id=144.9502)
M.S. 144.9512, 144.1202, 144.412 Environmental Surveillance and Assessment (https://www.revisor.mn.gov/statutes/cite/144)
M.S. 157 Food, Pools & Lodging Services (https://www.revisor.mn.gov/statutes/?id=157)
M.S. 326.70 Asbestos Abatement Act (https://www.revisor.mn.gov/statutes/?id=326.70)
M.S. 327 Hotels, Motels, Resorts, and Manufactured Homes (https://www.revisor.mn.gov/statutes/cite/327)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	2,951	2,369	3,667	5,871	4,739	4,739	37,541	37,695
1200 - State Government Special Rev	27,441	28,731	29,467	31,581	30,524	30,524	32,329	33,580
2000 - Restrict Misc Special Revenue	267	270	237	431	291	291	291	291
2001 - Other Misc Special Revenue	1							
2050 - Environment & Natural Resources	342		180					
2302 - Clean Water	5,368	5,795	6,308	9,975			11,296	11,904
2800 - Environmental	326	503	647	1,217	932	932	1,332	1,332
2801 - Remediation	232	191	239	275	257	257	257	257
3000 - Federal	8,255	4,691	8,890	12,630	11,405	11,405	11,405	11,405
8201 - Drinking Water Revolving	622	672	666	762	756	756	756	756
Total	**45,806**	**43,222**	**50,301**	**62,742**	**48,904**	**48,904**	**95,207**	**97,220**
Biennial Change				24,014		(15,235)		79,384
Biennial % Change				27		(13)		70
Governor's Change from Base								94,619
Governor's % Change from Base								97
Expenditures by Category								
Compensation	28,449	24,916	29,325	34,739	30,494	30,494	40,954	43,362
Operating Expenses	14,692	15,122	16,314	23,746	15,333	15,333	21,935	21,447
Grants, Aids and Subsidies	2,633	3,135	4,598	4,255	3,075	3,075	32,316	32,409
Capital Outlay-Real Property	30	35		1	1	1	1	1
Other Financial Transaction	1	14	63	1	1	1	1	1
Total	**45,806**	**43,222**	**50,301**	**62,742**	**48,904**	**48,904**	**95,207**	**97,220**
Total Agency Expenditures	45,806	43,222	50,301	62,742	48,904	48,904	95,207	97,220
Internal Billing Expenditures	7,503	7,212	8,517	8,850	7,314	7,314	10,649	10,802
Expenditures Less Internal Billing	**38,303**	**36,010**	**41,783**	**53,892**	**41,590**	**41,590**	**84,558**	**86,418**
Full-Time Equivalents	**282.43**	**236.46**	**270.11**	**277.61**	**253.88**	**253.47**	**335.98**	**343.67**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		532		1,132				
Direct Appropriation	3,502	3,543	5,148	4,974	4,739	4,739	25,541	25,695
Transfers In							12,000	12,000
Transfers Out		335	231	235				
Cancellations	25	1,371	118					
Balance Forward Out	527		1,132					
Expenditures	**2,951**	**2,369**	**3,667**	**5,871**	**4,739**	**4,739**	**37,541**	**37,695**
Biennial Change in Expenditures				4,218		(60)		65,698
Biennial % Change in Expenditures				79		(1)		689
Governor's Change from Base								65,758
Governor's % Change from Base								694
Full-Time Equivalents	17.87	13.21	17.74	17.74	16.69	16.28	38.07	37.66
1200 - State Government Special Rev								
Balance Forward In		1,190		1,057				
Direct Appropriation	28,085	29,907	30,524	30,524	30,524	30,524	32,329	33,580
Cancellations		2,366						
Balance Forward Out	644		1,057					
Expenditures	**27,441**	**28,731**	**29,467**	**31,581**	**30,524**	**30,524**	**32,329**	**33,580**
Biennial Change in Expenditures				4,876		0		4,861
Biennial % Change in Expenditures				9		0		8
Governor's Change from Base								4,861
Governor's % Change from Base								8
Full-Time Equivalents	172.10	168.10	181.03	181.03	181.03	181.03	196.20	196.20
2000 - Restrict Misc Special Revenue								
Balance Forward In	241	216	139	140				
Receipts	234	263	238	291	291	291	291	291
Balance Forward Out	208	209	140					
Expenditures	**267**	**270**	**237**	**431**	**291**	**291**	**291**	**291**
Biennial Change in Expenditures				131		(86)		(86)
Biennial % Change in Expenditures				24		(13)		(13)
Governor's Change from Base								0

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Governor's % Change from Base								0
Full-Time Equivalents	1.12	0.97	1.15	1.15	1.15	1.15	1.15	1.15

2001 - Other Misc Special Revenue

Balance Forward In	4	0						
Receipts	1							
Transfers Out	4	0						
Balance Forward Out	0							
Expenditures	**1**							
Biennial Change in Expenditures				(1)		0		0
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

2050 - Environment & Natural Resources

Balance Forward In	398	69	214					
Cancellations			33					
Balance Forward Out	56	69						
Expenditures	**342**		**180**					
Biennial Change in Expenditures				(162)		(180)		(180)
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents	0.71							

2302 - Clean Water

Balance Forward In	1,704	3,201	4,373	4,020				
Direct Appropriation	6,222	6,222	5,955	5,955	0	0	11,296	11,904
Cancellations		0	0					
Balance Forward Out	2,558	3,627	4,020					
Expenditures	**5,368**	**5,795**	**6,308**	**9,975**			**11,296**	**11,904**
Biennial Change in Expenditures				5,119		(16,283)		6,917
Biennial % Change in Expenditures				46		(100)		42

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Governor's Change from Base								23,200
Governor's % Change from Base								
Full-Time Equivalents	24.46	18.43	19.67	19.18			43.05	51.15

2800 - Environmental

Balance Forward In		232		285				
Transfers In	555	420	932	932	932	932	1,332	1,332
Cancellations		149						
Balance Forward Out	229		285					
Expenditures	**326**	**503**	**647**	**1,217**	**932**	**932**	**1,332**	**1,332**
Biennial Change in Expenditures				1,035		0		800
Biennial % Change in Expenditures				125		0		43
Governor's Change from Base								800
Governor's % Change from Base								43
Full-Time Equivalents	2.53	1.92	3.64	3.64	3.64	3.64	6.14	6.14

2801 - Remediation

Balance Forward In		30		18				
Transfers In	257	257	257	257	257	257	257	257
Cancellations		96						
Balance Forward Out	25		18					
Expenditures	**232**	**191**	**239**	**275**	**257**	**257**	**257**	**257**
Biennial Change in Expenditures				91		0		0
Biennial % Change in Expenditures				22		(0)		(0)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	1.96	1.08	1.78	1.78				

3000 - Federal

Balance Forward In	10	8						
Receipts	8,254	4,690	8,890	12,630	11,405	11,405	11,405	11,405
Balance Forward Out	8	8						
Expenditures	**8,255**	**4,691**	**8,890**	**12,630**	**11,405**	**11,405**	**11,405**	**11,405**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial Change in Expenditures				8,573		1,290		1,290
Biennial % Change in Expenditures				66		6		6
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	57.50	27.91	41.21	49.20	47.48	47.48	47.48	47.48

8201 - Drinking Water Revolving

Balance Forward In	10			6				
Transfers In	612	672	672	756	756	756	756	756
Balance Forward Out			6					
Expenditures	**622**	**672**	**666**	**762**	**756**	**756**	**756**	**756**
Biennial Change in Expenditures				133		84		84
Biennial % Change in Expenditures				10		6		6
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	4.18	4.84	3.89	3.89	3.89	3.89	3.89	3.89

Program: Health Protection
Activity: Infectious Disease

https://www.health.state.mn.us/about/org/idepc/index.html

AT A GLANCE

- Managed treatment for 204 new, probable, and confirmed tuberculosis (TB) cases and evaluated 524 individuals exposed.
- Responded to 116 foodborne, waterborne, person-to-person, zoonotic outbreaks.
- Conducted 79 Infection Control Assessment and Resource (ICAR) visits (44 virtual and 35 onsite visits).
- Investigated 1,186 cases of syphilis and ensured treatment for 1,186.
- Processed 640,087 COVID-19 cases and of those, interviewed 180,013.
- Since December of 2020, the MDH vaccine distribution program has processed shipping for 8.2 million doses of COVID-19 vaccine and redistributed over 250,000 doses to avoid wastage.
- Responded to continued increases in hepatitis A and C, syphilis, and HIV that primarily impact persons experiencing homelessness and persons who use injection drugs.
- Tested 6,683 individuals for HIV, and 99.8% received their tests results.
- Assisted over 1,200 Afghans with medical intakes upon arrival to Minnesota (2021 – 2022).
- Coordinated a program that provides free vaccines to one in every three children in Minnesota.

PURPOSE AND CONTEXT

The Infectious Disease, Epidemiology, Prevention, and Control Division provides statewide leadership to ensure Minnesotans are safe from infectious diseases.

Our role:

- Maintain systems to detect, investigate, and mitigate infectious disease outbreaks and threats.
- Collect, analyze, and publish data on infectious diseases.
- Recommend policy for detecting, preventing, or controlling infectious diseases.
- Coordinate with the health care and public health systems to prevent spread of diseases.
- Partner with state agencies and local public health to prevent and control infectious disease.
- Create and maintain relationships to support infectious disease prevention and response for underserved groups, including people experiencing homelessness, tribes and indigenous, immigrants, correctional settings, and seasonal agricultural and food processing workers.
- Provide access to vaccines and medications to prevent and treat infectious diseases.
- Provide advice to health care providers on diagnosis and management of emerging infectious diseases (e.g., Monkey Pox, Coronavirus, Ebola, and Zika).
- Evaluate the effectiveness of our infectious disease activities

SERVICES PROVIDED

Prevention of infectious disease

- Alert health care providers and the public about outbreaks and how to prevent disease spread.
- Manage tuberculosis treatment and provide medications for patients to prevent disease spread.
- Investigate health care associated infections or infection prevention breaches, work collaboratively with health care facilities to prevent the spread of infection, and conduct follow-up on those who were exposed to infectious disease.
- Provide leadership for the statewide immunization information system, used for coordinating mass vaccination for an emergency response (e.g., H1N1 and COVID-19).

- Conduct studies on infectious diseases of concern to the public and the medical community.
- Educate the public, especially high-risk populations, on disease testing, treatment, and prevention.
- Provide funding to local public health agencies and nonprofit organizations for infectious disease prevention activities.
- Prevent the spread of infectious disease, such as hepatitis C and HIV, by encouraging pharmacies to provide clean syringes without a prescription to injection drug users.
- Evaluate the effectiveness of infectious disease public health programs by monitoring disease trends and outcomes.
- Distribute publicly purchased vaccines for children whose families cannot afford them.

Identify and investigate infectious disease threats

- Collect, analyze, and routinely post COVID-19 data on testing, number of positive cases, hospitalizations, and deaths.
- Maintain a 24/7 system to detect, investigate, and control cases of infectious disease, including routine and emerging diseases such as meningitis, rabies exposure, COVID-19, Monkey Pox, Ebola, and Zika.
- Analyze disease reports to identify unusual patterns of infectious disease, detect outbreaks, identify the cause, and implement control measures.
- Maintain a foodborne illness hotline to receive complaints from the public and identify possible foodborne outbreaks quickly.
- Coordinate refugee medical screenings to identify and treat health problems.

Mitigation of disease threats

- Alert the public where and when the risk of infectious disease is the greatest.
- Involve high-risk communities, health care providers, and concerned citizens in responding to infectious disease challenges.
- Enhance infection prevention and antibiotic stewardship by providing assessment and technical assistance to health care facilities.
- Provide evidence-based guidance to high priority settings including jails and prisons, long-term care facilities, K-12 schools, childcare, institutions of higher education, and shelters.

RESULTS

Type of Measure	***Name of Measure***	***Previous Value***	***Date***	***Current Value***	***Date***
Quality	Percent of eligible tuberculosis patients who complete therapy in 12 months*	92.1% or 129/139	2018	89.5 or 102/114	2019
Quality	Percent of infants born to hepatitis B positive pregnant persons who received appropriate and timely follow up at birth	99.5% or 772/776	2018-2019	99.3% or 666/671	2020-2021
Quality	Percent of foodborne disease outbreaks where the source was identified	59% or 13/22	2020	62% or 26/42	2021
Quality	Percent of people who received positive test results through MDH-funded HIV testing programs who were referred to care	57.9% or 11/19	2020	81.9% or 50/61	2021

*2018 and 2019 data are the two most recent years with finalized TB treatment completion data.

STATUTES and RULES

Minnesota Rules, Chapter 4604 and 4605.
(https://www.revisor.mn.gov/rules/?id=4604)(https://www.revisor.mn.gov/rules/4605/)
M.S. 121A.15 (https://www.revisor.mn.gov/statutes/?id=121A.15)
M.S. 13.3805 (https://www.revisor.mn.gov/statutes/?id=13.3805)
M.S. 144.05 (https://www.revisor.mn.gov/statutes/?id=144.05)
M.S. 144.12 (https://www.revisor.mn.gov/statutes/?id=144.12)
M.S. 144.3351 (https://www.revisor.mn.gov/statutes/?id=144.3351)
M.S. 144.3441 (https://www.revisor.mn.gov/statutes/cite/144.3441)
M.S. 144.4171 – 144.4185 (https://www.revisor.mn.gov/statutes/cite/144.4171)
M.S. 144.4801 – 144.491 (https://www.revisor.mn.gov/statutes/cite/144.4801)
M.S. 214.17 – 214.25 (https://www.revisor.mn.gov/statutes/cite/214.17)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	4,028	3,960	3,754	126,120	4,284	4,284	8,632	8,760
1200 - State Government Special Rev	107							
1251 - COVID-19 Minnesota	6,706	1,955						
2000 - Restrict Misc Special Revenue	387	186	224	258				
2001 - Other Misc Special Revenue	18,385	3,935	3,339	4,145	585	585	585	585
2302 - Clean Water	138	58	51	199				
2403 - Gift	1		0	50				
3000 - Federal	24,667	99,967	367,668	319,176	154,038	67,250	154,038	67,250
3015 - ARP-State Fiscal Recovery			83,908	22,091	3,466		3,466	
Total	**54,419**	**110,061**	**458,944**	**472,039**	**162,373**	**72,119**	**166,721**	**76,595**
Biennial Change				766,503		(696,491)		(687,667)
Biennial % Change				466		(75)		(74)
Governor's Change from Base								8,824
Governor's % Change from Base								4
Expenditures by Category								
Compensation	19,644	19,401	30,811	43,289	37,974	30,373	39,575	32,087
Operating Expenses	19,884	57,377	359,193	329,062	93,573	24,975	95,056	26,473
Grants, Aids and Subsidies	14,635	33,257	68,075	97,688	28,826	16,771	30,090	18,035
Capital Outlay-Real Property	251	13	812	2,000	2,000		2,000	
Other Financial Transaction	5	14	52					
Total	**54,419**	**110,061**	**458,944**	**472,039**	**162,373**	**72,119**	**166,721**	**76,595**
Total Agency Expenditures	54,419	110,061	458,944	472,039	162,373	72,119	166,721	76,595
Internal Billing Expenditures	4,378	17,505	27,348	20,595	7,826	4,228	7,897	4,299
Expenditures Less Internal Billing	**50,041**	**92,556**	**431,595**	**451,444**	**154,547**	**67,891**	**158,824**	**72,296**
Full-Time Equivalents	**245.41**	**263.84**	**303.39**	**297.68**	**282.10**	**245.85**	**289.23**	**252.98**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		274		478				
Direct Appropriation	25,034	4,174	4,544	132,114	4,284	4,284	8,632	8,760
Transfers Out	20,889	272	300					
Cancellations		216	13	6,472				
Balance Forward Out	117		478					
Expenditures	**4,028**	**3,960**	**3,754**	**126,120**	**4,284**	**4,284**	**8,632**	**8,760**
Biennial Change in Expenditures				121,886		(121,306)		(112,482)
Biennial % Change in Expenditures				1,526		(93)		(87)
Governor's Change from Base								8,824
Governor's % Change from Base								103
Full-Time Equivalents	14.81	8.97	13.07	13.07	12.30	12.00	19.43	19.13
1200 - State Government Special Rev								
Direct Appropriation	107							
Expenditures	**107**							
Biennial Change in Expenditures				(107)		0		0
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents	0.63							
1251 - COVID-19 Minnesota								
Balance Forward In		5,621						
Direct Appropriation	12,265							
Cancellations		3,666						
Balance Forward Out	5,559							
Expenditures	**6,706**	**1,955**						
Biennial Change in Expenditures				(8,660)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								
2000 - Restrict Misc Special Revenue								

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Balance Forward In	20	28		132				
Receipts	382	172	356	126				
Balance Forward Out	15	15	132					
Expenditures	**387**	**186**	**224**	**258**				
Biennial Change in Expenditures				(91)		(482)		(482)
Biennial % Change in Expenditures				(16)		(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents	2.43	0.39	0.17	0.17				

2001 - Other Misc Special Revenue

Balance Forward In	6,132	10,451	6,353	3,560				
Receipts	863	799	930	585	585	585	585	585
Transfers In	46,440		300					
Transfers Out	25,551	1,693	684					
Balance Forward Out	9,498	5,622	3,560					
Expenditures	**18,385**	**3,935**	**3,339**	**4,145**	**585**	**585**	**585**	**585**
Biennial Change in Expenditures				(14,837)		(6,314)		(6,314)
Biennial % Change in Expenditures				(66)		(84)		(84)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	34.33	22.75	5.54	5.54	5.54	5.54	5.54	5.54

2302 - Clean Water

Balance Forward In	162	159	274	199				
Direct Appropriation	125	125						
Cancellations			24					
Balance Forward Out	149	226	199					
Expenditures	**138**	**58**	**51**	**199**				
Biennial Change in Expenditures				53		(250)		(250)
Biennial % Change in Expenditures				27		(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Full-Time Equivalents	0.88	0.07	0.07	0.07				

2403 - Gift

Balance Forward In	38	39	44	50				
Receipts	1	6	6					
Balance Forward Out	39	44	50					
Expenditures	**1**		**0**	**50**				
Biennial Change in Expenditures				50		(50)		(50)
Biennial % Change in Expenditures						(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								

3000 - Federal

Balance Forward In	12	434	409	2				
Receipts	27,626	100,601	367,260	319,174	154,038	67,250	154,038	67,250
Balance Forward Out	2,971	1,069	2					
Expenditures	**24,667**	**99,967**	**367,668**	**319,176**	**154,038**	**67,250**	**154,038**	**67,250**
Biennial Change in Expenditures				562,211		(465,556)		(465,556)
Biennial % Change in Expenditures				451		(68)		(68)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	192.33	231.66	280.45	274.74	264.26	228.31	264.26	228.31

3015 - ARP-State Fiscal Recovery

Balance Forward In				21,458				
Direct Appropriation			127,170	633	3,466	0	3,466	0
Cancellations			21,805					
Balance Forward Out			21,458					
Expenditures			**83,908**	**22,091**	**3,466**		**3,466**	
Biennial Change in Expenditures				105,999		(102,533)		(102,533)
Biennial % Change in Expenditures						(97)		(97)
Governor's Change from Base								0
Governor's % Change from Base								

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Full-Time Equivalents			4.09	4.09				

Program: Health Protection
Activity: Public Health Laboratory

https://www.health.state.mn.us/about/org/phl/

AT A GLANCE

- Provide testing for contaminants in the environment and evaluate exposures to contaminants in people. In fiscal year 2021, the lab received 39,085 samples and performed 98,860 analyses. In fiscal year 2022, the lab received 42,105 samples and performed 120,435 analyses.
- Provide testing for viruses and other microbes that make people sick, as well as look for outbreaks related to food and water. In fiscal year 2021, the lab performed 165,590 tests on 139,971 samples, which included 114,817 COVID tests (including sequencing). In fiscal year 2022, the lab performed 110,772 tests on 79,275 samples which included 57,581 COVID-19 tests.
- Screen for rare, serious conditions in newborn babies, allowing for early identification and medical intervention. The lab screened 65,223 newborns and 67,442 newborns in fiscal years 2021 and 2022, respectively, for 61 rare, treatable conditions.

PURPOSE AND CONTEXT

The Public Health Laboratory collaborates with local, state, and federal officials, public and private hospitals, laboratories, and other entities throughout the state to keep Minnesotans safe. Services include:

- Detecting infectious disease outbreaks and public health threats.
- Screening newborns for rare conditions to improve their health outcomes.
- Identifying chemical, radiological, and biological hazards.
- Preparing and responding to emergencies.
- Producing high-quality laboratory data to inform public health decisions.

SERVICES PROVIDED

Testing environmental and biological samples for chemical, bacterial, and radiological contaminants.

- Test drinking and non-drinking water for various compounds hazardous to human health and the environment.
- Develop methods to test potentially harmful chemicals in human samples, including drugs of abuse and other emerging public health threats, to help identify the source and reduce or eliminate exposures.
- Develop new methods for analyzing environmental samples for chemicals or materials with a perceived, potential, or real threat to human health or those that lack published health standards (e.g., expanded PFAS testing and monitoring).

Testing samples for rare and common infectious diseases.

- Test to identify disease-causing microbes including flu, salmonella, and other things that make people sick.
- Test for rare and/or emerging threats such as monkeypox, COVID-19, rabies, and antibiotic-resistant bacteria.
- Test to determine if a microbe is resistant to antibiotics and determine how it has become resistant, estimate vaccine efficacy, and determine why some germs cause more severe disease.
- Perform DNA sequencing to identify outbreaks caused by exposure to contaminated food and water.
- Ensure quick discovery and control of outbreaks to minimize the spread of illness.
- Report results to public health and health care professionals who offer treatment and stop the spread of disease-causing microbes.

Screening newborns for rare, serious, and treatable conditions.

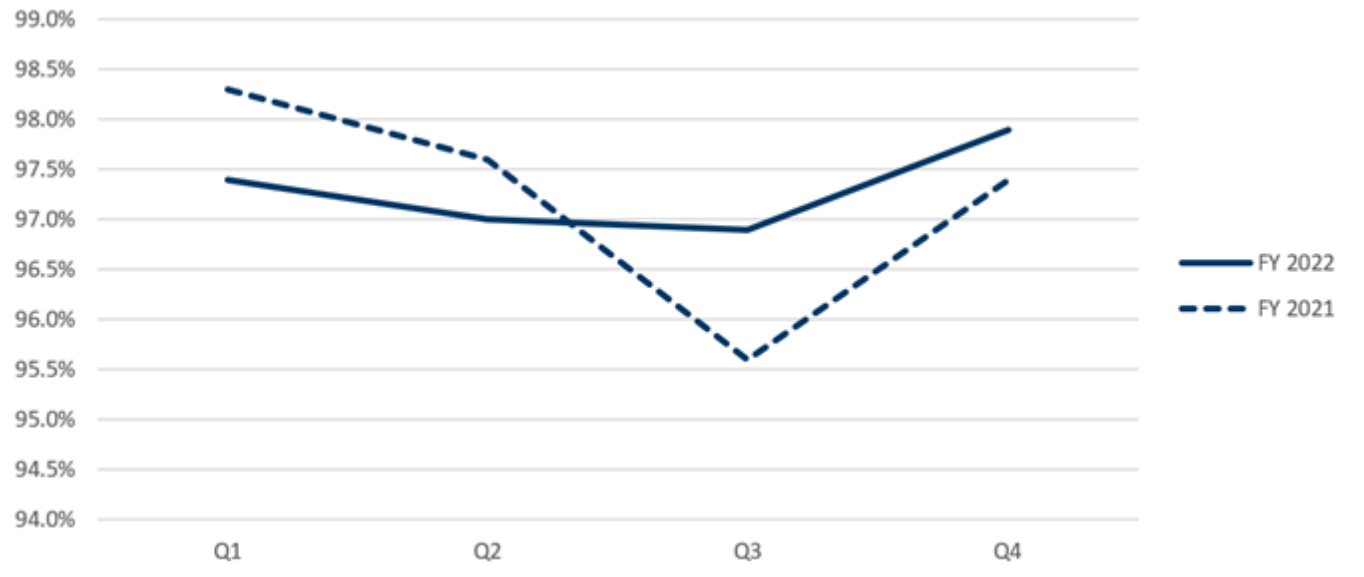
- Screen all Minnesota newborns for 61 treatable, hidden, rare disorders including hearing loss and critical congenital heart disease.
- Ensure detection of treatable disorders and that babies receive follow-up testing and care, resulting in improved long-term health outcomes and quality of life for babies and their parents.
- Educate Minnesota's new and expectant parents and medical providers about newborn screening.
- Begin congenital cytomegalovirus (cCMV) screening in early 2023.

Emergency Preparedness and Response

- Detect and respond to many kinds of hazards, including harmful chemicals, radioactive materials, and biological organisms that can make people sick.
- Serve as a member of Minnesota's Radiological Emergency Preparedness program, which would respond in the event of a release of radioactive chemicals at Minnesota's nuclear power plants.
- Detect harmful germs in air samples through an air-monitoring program.
- Train public and private laboratories to recognize and report possible chemical agents, contagious disease, and other public health threats.
- Respond quickly to a mass casualty event involving harmful chemicals anywhere in the country.
- Conduct rapid testing on clinical or environmental samples of concern (e.g., unknown white powders) and develop and maintain new testing methods of identifying potentially harmful agents.

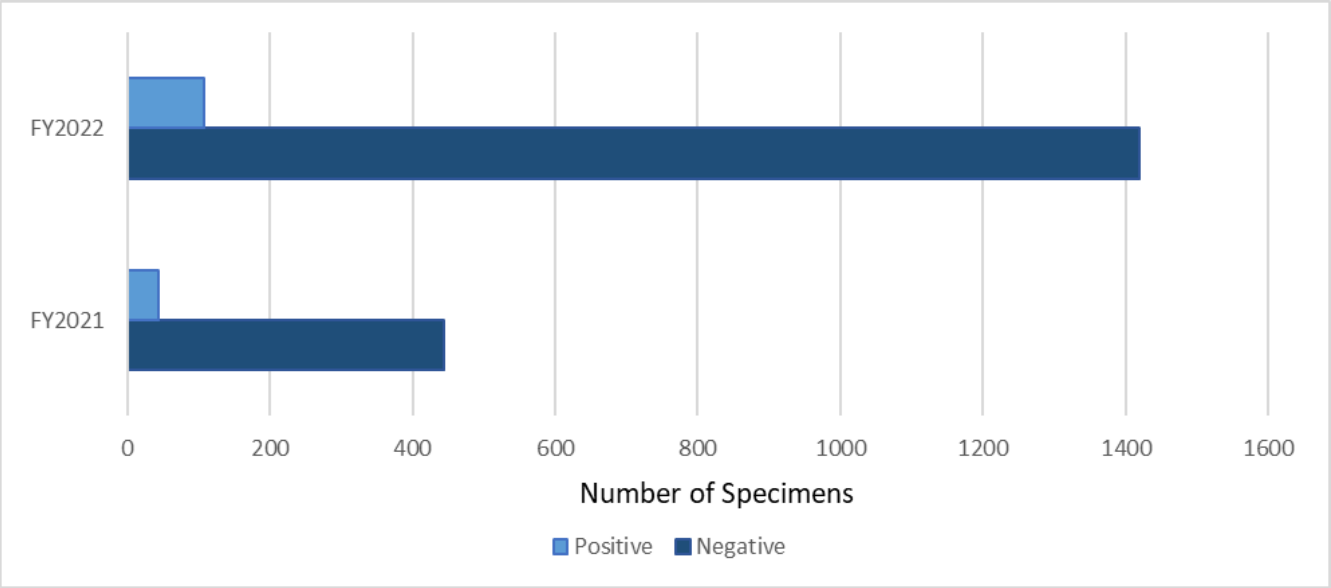
RESULTS

Percent of environmental samples tested and reported to partners within specified timeframe



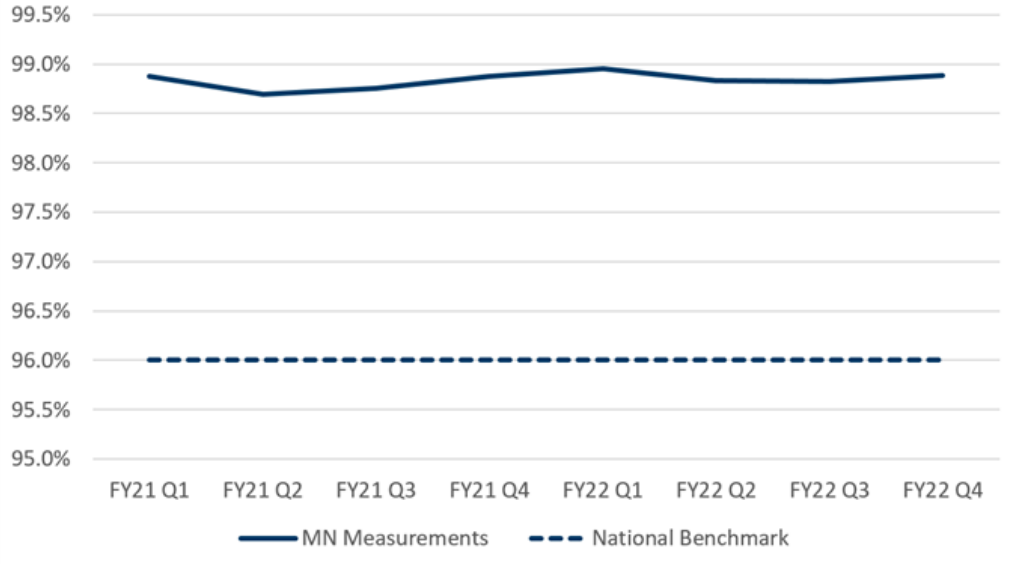
Turnaround times, i.e., the time between the lab receiving a sample and the time results are reported, ensures that our partners receive timely information to make decisions which protect public health. This graph shows the percent of time the laboratory meets the expected turnaround time. Reliable and timely reporting of chemical, bacteriological, and radiological analyses of environmental samples including drinking water, surface water, air, and soil helps state programs reduce the effect that environmental hazards may have on the health of Minnesotans.

Number of specimens tested for antibiotic-resistant bacteria in fiscal year 2021 and 2022



MDH has been working to increase capacity to detect antibiotic resistant bacteria and has observed an increase in the proportion of positive samples. Hospitals and clinics use this information for patient treatment and to help stop the spread of these germs to other patients and the community.

Percent of newborn screening samples collected within 48 hours of birth in fiscal years 2021 and 2022



Collecting newborn screening samples within 48 hours of birth helps to quickly identify infants at risk for newborn screening disorders and allows medical actions to occur swiftly with conditions listed on the screening panel. Early actions result in better health outcomes. Minnesota has exceeded the national benchmark for all quarters reported.

STATUTES

M.S. 13.386 Treatment of Genetic Information Held by Government Entities & Other Persons (https://www.revisor.mn.gov/statutes/?id=13.386)
M.S. 13.3805 Public Health Data (https://www.revisor.mn.gov/statutes/?id=13.3805)M.S. 144.05 General Duties of the Commissioner (https://www.revisor.mn.gov/statutes/?id=144.05)
M.S. 144.064 The Vivian Act (https://www.revisor.mn.gov/statutes/cite/144.064)
M.S. 144.123 Fees for diagnostic laboratory services (https://www.revisor.mn.gov/statutes/?id=144.123)
M.S. 144.125 Tests of Infants for Heritable & Congenital Disorders (https://www.revisor.mn.gov/statutes/?id=144.125)
M.S. 144.1251 Newborn Screening for Critical Congenital Heart Disease (CCHD) (https://www.revisor.mn.gov/statutes/?id=144.1251)
M.S. 144.1255 Newborn Screening Advisor Committee (https://www.revisor.mn.gov/statutes/cite/144.1255)
M.S. 144.128 Commissioner's Duties (Newborn Screening) (https://www.revisor.mn.gov/statutes/?id=144.128)
M.S. 144.192 Treatment of Biological Specimens and Health Data (https://www.revisor.mn.gov/statutes/?id=144.192)
M.S. 144.193 Inventory of Biological and Health Data (https://www.revisor.mn.gov/statutes/?id=144.193)
M.S. 144.966 Early Hearing Detection (https://www.revisor.mn.gov/statutes/?id=144.966)
M.S. 144.99 Enforcement (https://www.revisor.mn.gov/statutes/?id=144.99)
Minnesota Rules Chapter 4605 Communicable Diseases (https://www.revisor.mn.gov/rules/?id=4605)
Minnesota Rules 4615.0400 Definitions (https://www.revisor.mn.gov/rules/?id=4615.0400)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	3,004	2,760	2,798	2,716	2,690	2,690	5,322	4,830
1200 - State Government Special Rev	8,779	8,443	10,312	12,953	12,267	12,267	12,621	12,866
2000 - Restrict Misc Special Revenue	145	194	165	161	161	161	161	161
2001 - Other Misc Special Revenue	5,285	4,098	3,508	5,509	4,322	4,322	4,322	4,322
2302 - Clean Water	158	102	57	9				
2403 - Gift		1,000						
3000 - Federal	12,886	16,364	16,608	18,417	18,206	15,647	18,206	15,647
Total	**30,257**	**32,962**	**33,448**	**39,765**	**37,646**	**35,087**	**40,632**	**37,826**
Biennial Change				9,995		(480)		5,245
Biennial % Change				16		(1)		7
Governor's Change from Base								5,725
Governor's % Change from Base								8
Expenditures by Category								
Compensation	13,344	13,779	14,226	15,757	15,757	15,757	16,788	17,181
Operating Expenses	15,199	17,479	18,253	23,284	21,165	18,606	22,160	18,961
Grants, Aids and Subsidies	7	7	13	231	231	231	1,191	1,191
Capital Outlay-Real Property	1,700	1,531	842	483	483	483	483	483
Other Financial Transaction	7	166	115	10	10	10	10	10
Total	**30,257**	**32,962**	**33,448**	**39,765**	**37,646**	**35,087**	**40,632**	**37,826**
Total Agency Expenditures	30,257	32,962	33,448	39,765	37,646	35,087	40,632	37,826
Internal Billing Expenditures	4,747	5,647	5,874	5,464	5,432	5,432	5,592	5,592
Expenditures Less Internal Billing	**25,510**	**27,314**	**27,574**	**34,301**	**32,214**	**29,655**	**35,040**	**32,234**
Full-Time Equivalents	**152.11**	**142.06**	**144.41**	**140.18**	**139.17**	**132.46**	**147.95**	**141.24**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		470	172	26				
Direct Appropriation	3,396	3,241	2,652	2,690	2,690	2,690	5,322	4,830
Transfers Out		629						
Cancellations		150						
Balance Forward Out	392	172	26					
Expenditures	**3,004**	**2,760**	**2,798**	**2,716**	**2,690**	**2,690**	**5,322**	**4,830**
Biennial Change in Expenditures				(250)		(134)		4,638
Biennial % Change in Expenditures				(4)		(2)		84
Governor's Change from Base								4,772
Governor's % Change from Base								89
Full-Time Equivalents	21.97	16.50	17.07	17.07	16.06	15.66	21.87	21.47
1200 - State Government Special Rev								
Balance Forward In		298		135				
Direct Appropriation	9,046	8,833	10,447	12,818	12,267	12,267	12,621	12,866
Cancellations		688						
Balance Forward Out	267		135					
Expenditures	**8,779**	**8,443**	**10,312**	**12,953**	**12,267**	**12,267**	**12,621**	**12,866**
Biennial Change in Expenditures				6,043		1,269		2,222
Biennial % Change in Expenditures				35		5		10
Governor's Change from Base								953
Governor's % Change from Base								4
Full-Time Equivalents	34.12	31.75	35.46	35.46	35.46	35.46	38.43	38.43
2000 - Restrict Misc Special Revenue								
Balance Forward In	10							
Receipts	135	194	165	161	161	161	161	161
Balance Forward Out		0						
Expenditures	**145**	**194**	**165**	**161**	**161**	**161**	**161**	**161**
Biennial Change in Expenditures				(14)		(4)		(4)
Biennial % Change in Expenditures				(4)		(1)		(1)
Governor's Change from Base								0
Governor's % Change from Base								0

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Full-Time Equivalents	0.95	1.10	1.01	1.01	1.01	1.01	1.01	1.01

2001 - Other Misc Special Revenue

Balance Forward In	2,132	929	867	1,503				
Receipts	3,790	3,759	4,144	4,006	4,322	4,322	4,322	4,322
Balance Forward Out	636	591	1,503					
Expenditures	**5,285**	**4,098**	**3,508**	**5,509**	**4,322**	**4,322**	**4,322**	**4,322**
Biennial Change in Expenditures				(366)		(373)		(373)
Biennial % Change in Expenditures				(4)		(4)		(4)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	27.57	25.25	22.68	22.27	22.27	22.27	22.27	22.27

2302 - Clean Water

Balance Forward In	13	13	66	9				
Direct Appropriation	150	150						
Balance Forward Out	5	60	9					
Expenditures	**158**	**102**	**57**	**9**				
Biennial Change in Expenditures				(194)		(66)		(66)
Biennial % Change in Expenditures				(75)		(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents	1.00	0.65						

2403 - Gift

Balance Forward In		1,000						
Receipts	1,001							
Balance Forward Out	1,001							
Expenditures		**1,000**						
Biennial Change in Expenditures				(1,000)		0		0
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Full-Time Equivalents		3.58						

3000 - Federal

Balance Forward In	0	1	871	211				
Receipts	13,391	16,458	15,948	18,206	18,206	15,647	18,206	15,647
Balance Forward Out	506	94	211					
Expenditures	**12,886**	**16,364**	**16,608**	**18,417**	**18,206**	**15,647**	**18,206**	**15,647**
Biennial Change in Expenditures				5,775		(1,172)		(1,172)
Biennial % Change in Expenditures				20		(3)		(3)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	66.50	63.23	68.19	64.37	64.37	58.06	64.37	58.06

Program: Health Protection
Activity: Health Regulation

https://www.health.state.mn.us/about/org/hrd/

AT A GLANCE

- Monitor 5,080 health care facilities and providers for safety and quality.
- Review qualifications and regulate more than 9,500 health professionals.
- Enforce interagency agreements with the Department of Human Services that conducts 130,000 criminal background checks for healthcare workers at facilities the department regulates.
- Maintain a registry of more than 46,760 active nursing assistants.
- Inspect 535 funeral establishments, 82 crematoriums, and license 1,035 morticians.
- Audit more than 5,600 federal nursing home resident health assessments to ensure accurate submission, completion, and billing for services.
- Review plans and inspect approximately 245 healthcare construction projects per year with total construction costs over $700 million.
- Register more than 2,550 spoken language health interpreters.

PURPOSE AND CONTEXT

Health Regulation Division staff at the Minnesota Department of Health perform a variety of important regulatory functions to protect Minnesotans, such as:

- Issuing state licenses and federal certifications.
- Completing inspections, investigations, reviews, or audits.
- Administering registries.
- Taking compliance or enforcement actions when necessary.
- Providing information to consumers and providers.

HRD regulates 54 different types of providers and organizations including healthcare facilities, health professions, and body artists and piercers. Our regulatory activities protect Minnesotans from before birth with our doula registry program, to after death with our oversight of morticians and funeral establishments. We maintain a strong relationship with the Centers for Medicare and Medicaid Services (CMS) for the many health facilities that are federally certified. We protect the health and safety of Minnesota's nursing home and assisted living residents, home care clients, hospital patients, people with intellectual disabilities, families obtaining services at funeral establishments, birth center clients, body art establishment clients, and other clients of health care.

Much of our work focuses on protecting older Minnesotans and vulnerable adults. As Minnesota's population ages over the next 20 years, older residents will require an increasing amount of health services and the need for health protection will become even more important.

SERVICES PROVIDED

Licensing and Surveys

- Evaluate license, registration, or federal certification submissions from applicants against minimum requirements to ensure all providers meet the same minimum qualifications and are qualified to practice.
- Conduct surveys of facilities and providers to verify compliance with state or federal laws, regulation, and rules as appropriate to their license, registration, or certification and protect the health, safety, and welfare of residents.
- Ensure that fire and safety inspections are conducted and that health facilities meet physical plant requirements that protect the health and safety of patients and residents.
- Review funeral service providers to ensure pre-need funds paid by families are protected and available to pay for services when needed.
- Regulate body art establishments and technicians to prevent blood borne infections.
- Conduct audits of federally certified nursing homes resident assessments to ensure facilities are accurately completing the health assessment and billing Medicaid appropriately for services provided.

Number of Incident Reports Received by Fiscal Year and Facility

	FY 2019	FY 2020	FY 2021
State Licensed Facilities or Providers	6,373	6,817	6,896
Federally Certified Facilities or Providers	10,146	12,844	10,676
Total Incident Reports Received	16,519	19,661	17,572

Licensed Nursing Homes, Assisted Livings, and Home Care Provider Agencies

	FY 2019	FY 2020	FY 2021	FY 2022
Nursing Homes	380	378	373	368
Assisted Living Facilities	0	0	0	2,182
Home Care Providers	1,534	1,862	1,675	928
Total	1,914	2,240	2,048	3,478

Complaints, Investigations, and Enforcement

- Respond to thousands of citizens' calls each year, investigate complaints, and initiate enforcement actions when appropriate against health facilities and providers found to be violating state or federal laws.
- Enforce the laws protecting persons from maltreatment under the Vulnerable Adults Act and the Maltreatment of Minors Act.
- Verify health facilities have properly taken steps to protect residents in the event of emergencies, such as fires, tornadoes, floods, pandemics, and health provider strikes.

RESULTS

Type of Measure	*Name of Measure*	*Previous Value*	*Current Value*	*Date*
Quality	Federal standard: inspect each nursing home at least every 15.9 months	97%	79%	FFY 2020 FFY 2021*
Quality	Inspect each assisted living licensee at least once every two years	N/A	21%**	FY 2021
Quality	Inspect each licensed home care provider at least once every three years	93%	86%	FY 2020 FY 2021

* The federal fiscal year (FFY) period is from October 1 to September 30 of the following year.
** Assisted living licensure implemented on August 1, 2021 (fiscal year 2022) and the first full 24-month cycle will be completed on June 30, 2023.

STATUTES

M.S. 144.0572 Criminal history background checks on applicants, licensees, and other occupations regulated by commissioner of health (https://www.revisor.mn.gov/statutes/cite/144.0572)
M.S. 144.058 Spoken language health care interpreters (https://www.revisor.mn.gov/statutes/cite/144.058)
M.S. 144.0724 Case mix (https://www.revisor.mn.gov/statutes/cite/144.0724)
M.S. 144.50 - .60 Hospital licensure (https://www.revisor.mn.gov/statutes/cite/144.50)
M.S. 144.50 - .56 Boarding care licensure (https://www.revisor.mn.gov/statutes/cite/144.50)
M.S. 144.50 - .56 Supervised living facility licensure (https://www.revisor.mn.gov/statutes/cite/144.50)
M.S. 144A.001 - .1888 Nursing home licensure (https://www.revisor.mn.gov/statutes/cite/144A.001)
M.S. 144A.43 - .483 Home care licensure (https://www.revisor.mn.gov/statutes/cite/144A.43)
M.S. 144A.46 Office health facility complaints (https://www.revisor.mn.gov/statutes/cite/144A.46)
M.S. 144A.61 - .62 Nursing assistant registration (https://www.revisor.mn.gov/statutes/cite/144A.61)
M.S. 144A.70 - .74 Supplemental nursing services agencies (https://www.revisor.mn.gov/statutes/cite/144A.70)
M.S. 144A.75 - .756 Hospice licensure (https://www.revisor.mn.gov/statutes/cite/144A.75)
M.S. 144G Assisted living licensure (https://www.revisor.mn.gov/statutes/cite/144G)
M.S. 146A Complementary and alternative health care practices (https://www.revisor.mn.gov/statutes/cite/146A)
M.S. 146B Body art licensure (https://www.revisor.mn.gov/statutes/cite/146B)
M.S. 148.511 - .5198 Speech language pathologists and audiologists licensing (https://www.revisor.mn.gov/statutes/cite/148.511)
M.S. 148.995 - .997 Doula registration (https://www.revisor.mn.gov/statutes/cite/148.995)
M.S. 149A Mortuary science licensure (https://www.revisor.mn.gov/statutes/cite/149A)
M.S. 153A Hearing instrument dispensing (https://www.revisor.mn.gov/statutes/cite/153A)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	12,627	14,567	13,447	15,753	14,422	14,422	15,336	15,967
1200 - State Government Special Rev	12,588	12,997	16,532	20,356	18,548	18,548	26,031	26,774
2000 - Restrict Misc Special Revenue			116	2,249	265	265	265	265
2001 - Other Misc Special Revenue	2,036	0	0	19,757	19,757	19,757	19,757	19,757
3000 - Federal	12,237	18,834	18,346	20,036	18,924	18,249	18,924	18,249
Total	**39,488**	**46,398**	**48,440**	**78,151**	**71,916**	**71,241**	**80,313**	**81,012**
Biennial Change				40,705		16,566		34,734
Biennial % Change				47		13		27
Governor's Change from Base								18,168
Governor's % Change from Base								13
Expenditures by Category								
Compensation	25,925	29,375	32,717	28,905	28,905	28,905	33,650	35,024
Operating Expenses	13,551	17,021	15,612	49,246	43,011	42,336	46,663	45,988
Grants, Aids and Subsidies		0	103					
Other Financial Transaction	12	1	8					
Total	**39,488**	**46,398**	**48,440**	**78,151**	**71,916**	**71,241**	**80,313**	**81,012**
Total Agency Expenditures	39,488	46,398	48,440	78,151	71,916	71,241	80,313	81,012
Internal Billing Expenditures	5,662	6,878	6,407	3,895	3,895	3,895	4,496	4,496
Expenditures Less Internal Billing	**33,826**	**39,520**	**42,033**	**74,256**	**68,021**	**67,346**	**75,817**	**76,516**
Full-Time Equivalents	**238.38**	**256.77**	**287.16**	**282.17**	**279.90**	**279.02**	**317.09**	**316.21**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		4,421		1,342				
Direct Appropriation	17,416	18,232	14,836	14,450	14,422	14,422	15,336	15,967
Transfers In	3,013	3,013						
Transfers Out	3,741	6,574	47	39				
Cancellations		4,525						
Balance Forward Out	4,061		1,342					
Expenditures	**12,627**	**14,567**	**13,447**	**15,753**	**14,422**	**14,422**	**15,336**	**15,967**
Biennial Change in Expenditures				2,006		(356)		2,103
Biennial % Change in Expenditures				7		(1)		7
Governor's Change from Base								2,459
Governor's % Change from Base								9
Full-Time Equivalents	29.93	41.04	39.65	38.31	36.04	35.16	43.72	42.84
1200 - State Government Special Rev								
Balance Forward In		865		1,808				
Direct Appropriation	15,478	14,597	18,340	18,548	18,548	18,548	26,031	26,774
Transfers Out	2,226	1,449						
Cancellations		1,015						
Balance Forward Out	664		1,808					
Expenditures	**12,588**	**12,997**	**16,532**	**20,356**	**18,548**	**18,548**	**26,031**	**26,774**
Biennial Change in Expenditures				11,303		208		15,917
Biennial % Change in Expenditures				44		1		43
Governor's Change from Base								15,709
Governor's % Change from Base								42
Full-Time Equivalents	50.23	54.79	75.22	75.22	75.22	75.22	104.73	104.73
2000 - Restrict Misc Special Revenue								
Balance Forward In		973	1,301	1,984				
Receipts	192	319	798	265	265	265	265	265
Transfers In	777							
Balance Forward Out	969	1,291	1,984					
Expenditures			**116**	**2,249**	**265**	**265**	**265**	**265**
Biennial Change in Expenditures				2,365		(1,835)		(1,835)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial % Change in Expenditures						(78)		(78)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	0.06							

2001 - Other Misc Special Revenue

Receipts	2,036			19,757	19,757	19,757	19,757	19,757
Expenditures	**2,036**	**0**	**0**	**19,757**	**19,757**	**19,757**	**19,757**	**19,757**
Biennial Change in Expenditures				17,721		19,757		19,757
Biennial % Change in Expenditures				870		100		100
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	142.99	131.69	153.11	153.11	153.11	153.11	153.11	153.11

2360 - Health Care Access

Full-Time Equivalents	0.05							

3000 - Federal

Balance Forward In		61						
Receipts	12,537	18,773	18,346	20,036	18,924	18,249	18,924	18,249
Balance Forward Out	300		0					
Expenditures	**12,237**	**18,834**	**18,346**	**20,036**	**18,924**	**18,249**	**18,924**	**18,249**
Biennial Change in Expenditures				7,310		(1,209)		(1,209)
Biennial % Change in Expenditures				24		(3)		(3)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	15.12	29.25	19.18	15.53	15.53	15.53	15.53	15.53

Program: Health Operations

https://www.health.state.mn.us/about/org/index.html

AT A GLANCE

Budget activity:

- Health Operations

PURPOSE AND CONTEXT

Minnesota's public health system is considered among the best in the nation. It is built upon and maintains strong partnerships among local public health agencies, tribal governments, and a range of other organizations. Health Operations provides overall vision and strategic leadership to sustain the state's public health system and create effective public health policy and practice in Minnesota.

Further detail on the purpose, services, results, authorizing statutes, and fiscal information of the Health Operations activity are described in the following pages.

Program: Health Operations
Activity: Health Operations

https://www.health.state.mn.us/about/mdh.html

AT A GLANCE

- Oversee management of financial resources, incoming federal awards, and outgoing grants.
- Provide human resource services to over 1,655 full-time equivalent staff.
- Manage 10 facilities including two St. Paul office locations, seven regional district offices, and one public health laboratory.
- Provide legal and records management compliance services.

PURPOSE AND CONTEXT

We provide operational support for employees and programs within the agency to ensure strong stewardship of human, financial, and technical resources. We strive to achieve efficient and accountable government services by promoting strong internal controls, evaluating process improvement opportunities, and using project management tools. We assist the agency in navigating complex and sensitive legal and compliance issues. We carry out our mission in partnership with a wide range of external organizations as we aim to protect, maintain, and improve the health of all Minnesotans.

SERVICES PROVIDED

American Indian Health staff work as Tribal liaisons bridging relationships with MDH staff and Tribal staff/leaders and facilitating Tribal consultation visits between Tribal Nations and the commissioner. This work provides department-wide consultation on Tribal relations.

Business Innovation and Support staff provide management of physical property, a framework for results-based accountability, project management services for process improvement, and strategic direction for data systems interoperability. Facility management includes space planning, physical security, lease management, fleet services, and building operations support at MDH district offices, with a focus on sustainability and reducing the impact of our operations on the environment.

Communications staff ensure that accurate, timely, and clear information on a wide range of public health topics is shared with the public, with a special focus on coordinating public awareness and outreach related to emerging public health concerns.

Executive Office staff provide department-wide leadership for all public health issues and operations.

Finance staff provide stewardship of financial resources through budget planning, centralized accounting and procurement services, oversight of cash management, and fiscal reporting for federal grants.

Human Resource Management staff provide strategic personnel management and workforce development, promote equity, diversity, and inclusion, manage employee and labor relations, administer benefits and payroll, ensure a safety work environment and coordinate training programs.

Internal Audit staff provide independent, objective assurance, and consulting activities to MDH management over a variety of financial, programmatic and compliance matters. Staff evaluate and improve the effectiveness of risk management, internal controls, and various governance processes.

Legal Unit staff advise agency and program leaders about often novel, complex, and sensitive legal and compliance issues to help decision making and mitigate risk.

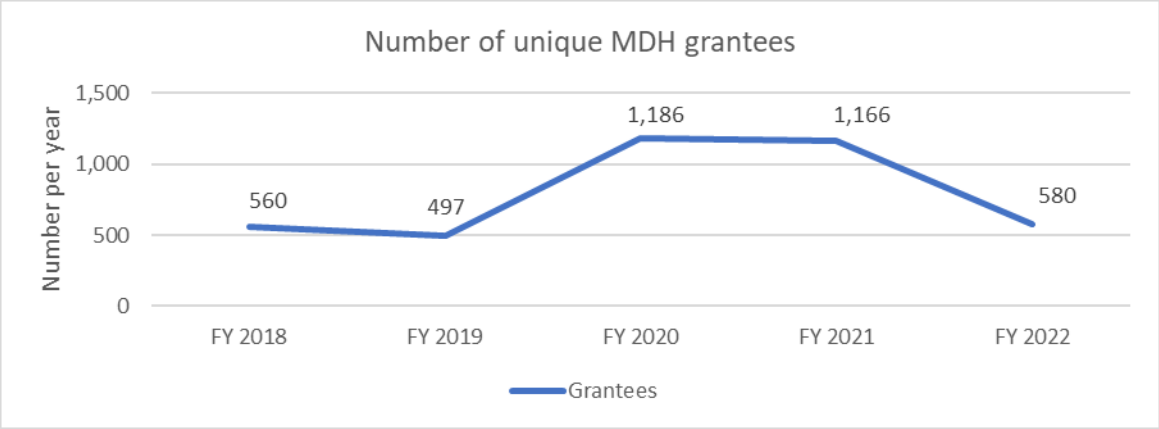
Legislative Relations staff coordinate state legislative activities and monitor federal legislative actions to advance the department's priorities and mission and serve as a point of contact for the public, other departments, legislators, and legislative staff.

MDH works in partnership with MN.IT to manage our information technology resources and ensure that technology meets our business needs. MN.IT staff at MDH provide technical expertise for systems planning and development, ensure data system security, and manage our communication and technology infrastructure.

American Indian Health staff work as tribal liaisons bridging relationships with MDH staff and Tribal staff/leaders and facilitating Tribal consultation visits between Tribal Nations and the commissioner. This work provides department-wide consultation on Tribal relations.

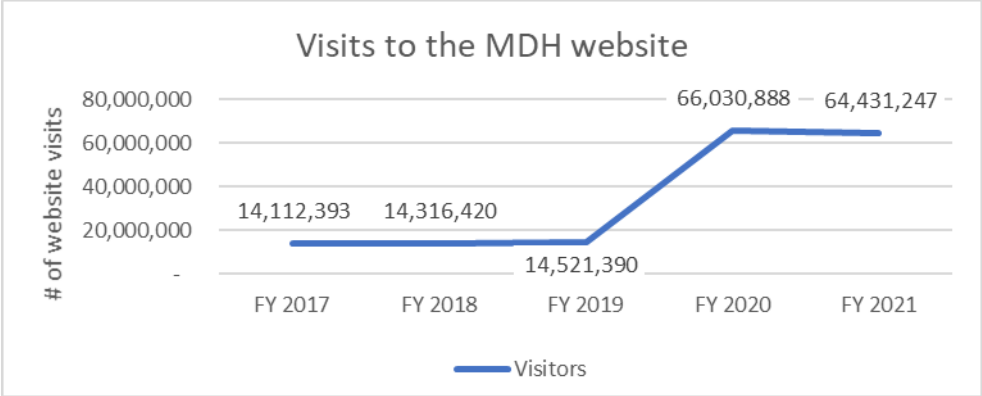
RESULTS

Increase in the number of grantee organizations



MDH offers a wide variety of grant opportunities to counties, non-profits, schools, community organizations, and others. The number of organizations receiving an MDH grant each year averaged 527 between fiscal year 2016 and 2019. In fiscal year 2020, 1,186 organizations received an MDH grant, which is 2.4 times greater than the previous year. The increases in FY2020 and 2021 are largely attributable to new legislative appropriations and additional grant opportunities for pandemic preparedness and response. The decrease in FY2022 is reflective of the decrease in pandemic response activities.

Providing information for partners, providers, and the public



The MDH website includes specific content for the public, health providers, partners, and community organizations. People who visit the website obtain information about public health topics and learn about how they are served by MDH programs. From fiscal year 2017 to 2019, the MDH website had had an average of 14.3 million visits per year. In fiscal year 2020 and fiscal year 2021, the number of visits increased 4.5 times from those in fiscal year 2019.

Type of Measure	***Name of Measure***	***FY 2020***	***FY 2021***	***FY 2022***
Quantity	Number of legislative reports prepared	6**	15	14*
Quantity	Number of bills tracked	249	540	421

* Beginning in 2022, Laws of Minnesota, 2021, Chapter 30, Article 3, Section 10 created a sunset for most of the recurring reports MDH is required to submit. The provision requires MDH to submit a report each year which lists all report mandates set to expire that year.
** The COVID-19 pandemic disrupted MDH's normal work and many reports were delayed from 2020.

STATUTES

M.S. 144 (https://www.revisor.mn.gov/statutes/cite/144)
M.S. 145 (https://www.revisor.mn.gov/statutes/cite/145)
M.S. 145A (https://www.revisor.mn.gov/statutes/cite/145A)
M.S. 62J (https://www.revisor.mn.gov/statutes/cite/62J)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	9,383	13,410	8,696	16,202	12,347	12,231	18,290	18,203
2000 - Restrict Misc Special Revenue	1	0	2	33				
2001 - Other Misc Special Revenue	33,353	30,714	39,247	41,370	41,290	41,290	41,290	41,290
2403 - Gift	1	0	0	25				
3000 - Federal	1,550	998	812	1,584	1,584	1,584	1,584	1,584
Total	**44,289**	**45,122**	**48,757**	**59,214**	**55,221**	**55,105**	**61,164**	**61,077**
Biennial Change				18,560		2,355		14,270
Biennial % Change				21		2		13
Governor's Change from Base								11,915
Governor's % Change from Base								11
Expenditures by Category								
Compensation	13,781	15,744	16,838	19,089	19,089	19,089	19,555	19,584
Operating Expenses	30,455	29,373	31,919	39,858	35,865	35,749	41,342	41,226
Grants, Aids and Subsidies		0						
Capital Outlay-Real Property	28		0	250	250	250	250	250
Other Financial Transaction	25	4	1	17	17	17	17	17
Total	**44,289**	**45,122**	**48,757**	**59,214**	**55,221**	**55,105**	**61,164**	**61,077**
Total Agency Expenditures	44,289	45,122	48,757	59,214	55,221	55,105	61,164	61,077
Internal Billing Expenditures	820	284	577	830	830	830	919	919
Expenditures Less Internal Billing	**43,469**	**44,838**	**48,179**	**58,384**	**54,391**	**54,275**	**60,245**	**60,158**
Full-Time Equivalents	**128.35**	**144.82**	**145.63**	**146.37**	**146.18**	**146.12**	**149.50**	**149.44**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		1,914		3,753				
Direct Appropriation	10,598	7,975	11,570	11,579	12,549	12,433	18,492	18,405
Transfers In	874	3,655	1,064	1,072				
Transfers Out	217	127	184	202	202	202	202	202
Cancellations		7						
Balance Forward Out	1,872		3,753					
Expenditures	**9,383**	**13,410**	**8,696**	**16,202**	**12,347**	**12,231**	**18,290**	**18,203**
Biennial Change in Expenditures				2,105		(320)		11,595
Biennial % Change in Expenditures				9		(1)		47
Governor's Change from Base								11,915
Governor's % Change from Base								48
Full-Time Equivalents	2.55	1.00	3.05	3.05	2.86	2.80	6.18	6.12
1251 - COVID-19 Minnesota								
Balance Forward In		19,484						
Cancellations		19,484						
2000 - Restrict Misc Special Revenue								
Balance Forward In	31	34	34	33				
Receipts	4		0					
Balance Forward Out	34	34	33					
Expenditures	**1**	**0**	**2**	**33**				
Biennial Change in Expenditures				34		(35)		(35)
Biennial % Change in Expenditures				3,616		(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								
2001 - Other Misc Special Revenue								
Balance Forward In	4,259	3,180	6,880	80				
Receipts	30,234	29,519	32,446	41,290	41,290	41,290	41,290	41,290
Internal Billing Receipts	30,058	29,404	32,316	41,145	41,145	41,145	41,145	41,145
Transfers In		41						
Transfers Out	800							

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Balance Forward Out	340	2,027	79					
Expenditures	**33,353**	**30,714**	**39,247**	**41,370**	**41,290**	**41,290**	**41,290**	**41,290**
Biennial Change in Expenditures				16,551		1,963		1,963
Biennial % Change in Expenditures				26		2		2
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	124.48	143.18	141.23	141.23	141.23	141.23	141.23	141.23

2403 - Gift

Balance Forward In	18	22	25	25				
Receipts	5	0						
Transfers In	18							
Transfers Out	18							
Balance Forward Out	22	22	25					
Expenditures	**1**	**0**	**0**	**25**				
Biennial Change in Expenditures				23		(25)		(25)
Biennial % Change in Expenditures				1,289		(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								

3000 - Federal

Receipts	1,550	998	812	1,584	1,584	1,584	1,584	1,584
Expenditures	**1,550**	**998**	**812**	**1,584**	**1,584**	**1,584**	**1,584**	**1,584**
Biennial Change in Expenditures				(153)		772		772
Biennial % Change in Expenditures				(6)		32		32
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	1.32	0.64	1.35	2.09	2.09	2.09	2.09	2.09

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
FEDERAL [3000] FUND							
USDA CFDA 10.331	The Gus Schumacher Nutrition Incentive Program - Improve dietary health through the increased consumption of fruits and vegetables through a "produce prescription" and reduce individual and household food insecurity.	$ -	$ 125	$ 188	$ 188		0.68
USDA CFDA 10.557	Women, Infants and Children (WIC) - Nutrition services and administration.	$ 35,120	$ 36,500	$ 37,000	$ 37,000		37.00
USDA CFDA 10.557	Women, Infants and Children (WIC) - Eligible food purchases.	$ 51,409	$ 77,000	$ 77,000	$ 77,000		-
USDA CFDA 10.557	Women, Infants and Children (WIC) - Formula rebate contract.	$ 3,702	$ 26,000	$ 27,000	$ 27,000		-
USDA CFDA 10.557	Women, Infants and Children (WIC) - Peer breastfeeding.	$ 1,440	$ 1,440	$ 1,500	$ 1,500		-
USDA CFDA 10.557	Women, Infant, and Children (WIC) - Technology for a Better WIC Experience - To plan for and implement technology projects and other modernization efforts that improve the WIC participant experience and streamline operations to reduce unnecessary administrative burden.	$ -	$ 75	$ 225	$ 50		0.68
USDA CFDA 10.557	Women, Infant, and Children (WIC) - Shopping Experience - To improve the in-store shopping experience of WIC shoppers by improving participant access to vendors. Funds will support project management of the WIC Online Ordering Pilot.	$ -	$ 125	$ 354	$ 50		2.27
USDA CFDA 10.557	Midwest States WIC Online Ordering Project (Midwest SWOOP) - A pilot project to enhance the WIC shopping experience by allowing participants to shop online to redeem supplemental food benefits. Partnership is with two other Midwest states, Iowa and Nebraska.	$ -	$ 892	$ 892	$ 892		-
USDA CFDA 10.557	Women, Infants and Children (WIC) - COVID-19 Cash-value voucher/benefit.	$ 5,062	$ -	$ -	$ -		-
USDA CFDA 10.565	Commodity Supplemental Food Program (CSFP) - COVID-19 - Provides nutritious food to low-income elderly individuals.	$ 1,042	$ 1,050	$ 1,050	$ 1,050		0.38
USDA CFDA 10.565	Commodity Supplemental Food Program (CSFP) - COVID-19 - Pass through funds to the CSFP local food bank grantees to cover administrative costs related to CSFP and the COVID-19 response.	$ 42	$ -	$ -	$ -		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
USDA CFDA 10.578	Women, Infants and Children (WIC) - Infrastructure improvements.	$ 42	$ 700	$ 700	$ 700		-
HUD CFDA 14.900	Lead Hazard Reduction Grant Program - Assist local governments in undertaking comprehensive programs to identify and control lead-based paint hazards in rental and owner-occupied housing populations.	$ 719	$ 1,099	$ -	$ -	Match	-
DOJ CFDA 16.320; 16.834	Services for Trafficking Victims - Improve outcomes for child and youth victims of sex and labor trafficking.	$ 386	$ 781	$ 1,450	$ 1,250	Match	1.49
DOJ CFDA 16.831	Juvenile Justice and Delinquency Prevention - Addressing the Needs of Incarcerated Parents and their Minor Children - Promote services in local correctional facilities and communities by improving and supporting parent-child relationships, mental health and well-being, and reduce out-of-home placements that may lead to reduced recidivism, violent crime, and increased community support.	$ 280	$ 250	$ 250	$ 250		0.50
DOJ CFDA 16.838	Comprehensive Opioid, Stimulant, and Substance Abuse Site-based Program - To build an ecosystem of peer-based recovery supports to transition people who have experienced incarceration into supportive community environments where they are able to sustain and strengthen recovery from substance use disorders.	$ -	$ 2,000	$ 2,650	$ 2,350		4.55
DOJ CFDA 16.838	Comprehensive Opioid, Stimulant, and Substance Abuse Program - Facilitates public safety and public health efforts to mobilize immediate responses to and surveillance of a sudden increase or spike in drug overdose events using the Overdose Detection Mapping Application Program (ODMAP).	$ 280	$ 161	$ 740	$ 740		2.36
DOJ CFDA 16.838	Linkage to Care Across Minnesota - Reduce opioid abuse and overdose fatalities and mitigate impacts on crime victims through collaboration between law enforcement agencies and public health entities. Pass-through federal award from Minnesota Department of Public Safety.	$ 1,424	$ 3,252	$ 3,252	$ 3,252		1.48
DOJ CFDA 16.838	Comprehensive Opioid, Stimulant, and Substance Use Site-based Program - To develop, implement, or expand comprehensive programs in response to the overdose crisis and the impacts of use and misuse of opioids, stimulants, or other substances.		$ -	$ 7,000	$ 7,000		15.00

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
DOT CFDA 20.616	Linking crash, vehicle, and behavior characteristics to specific medical and financial outcomes to provide a comprehensive understanding of motor vehicle crash outcomes through the development of data linkage programs through the Crash Outcome Data Evaluation System (CODES). Pass through funding from the Minnesota Department of Public Safety.	$ 86	$ 100	$ 100	$ 100		0.69
DOT CFDA 20.616	National Priority Safety Program - Trauma Data Improvements To address priorities for reducing highway deaths and injuries. Pass through funding from the Minnesota Department of Public Safety.	$ 122	$ 150	$ 150	$ 150		0.89
EPA CFDA 66.032	State/Tribal Indoor Radon Program - Implement a statewide radon mitigation program to reduce the burden of lung cancer.	$ 309	$ 442	$ 442	$ 442	Match	1.00
EPA CFDA 66.201	Multi-Purpose Grant to States and Tribes - Funds analysis of emerging contaminant per- and polyfluoroalkyl substances (PFAs) samples taken from vulnerable drinking water supply wells.	$ 63	$ 74	$ 74	$ 74		-
EPA CFDA 66.419	Water Pollution Control Program - Surface water monitoring activities in streams, wetlands and lakes.	$ 28	$ 96	$ 96	$ 96	Match	-
EPA CFDA 66.432	State Public Water System Supervision (PWSS) - Implement supervisions and enforcement activities of the public water system.	$ 2,547	$ 1,350	$ 1,350	$ 1,350		9.55
EPA CFDA 66.442	Assistance for Small and Disadvantaged Communities Drinking Water Grant - Facilitate compliance with national primary drinking water regulations through infrastructure improvements.	$ 646	$ -	$ -	$ -	Match	-
EPA CFDA 66.444	Lead Testing in School and Child Care Program Drinking Water Grant - Assist local and tribal educational agencies in testing for lead contamination in drinking water at schools and child care facilities in partnership with Minnesota Department of Education (MDE) and Minnesota Department of Human Services (DHS).	$ 228	$ 1,074	$ 1,074	$ 1,074		4.54
EPA CFDA 66.468	Drinking Water Revolving Fund - Support set-aside activities. Pass through funds from Minnesota Public Facilities Authority.	$ 2,396	$ 5,094	$ 5,094	$ 5,094		13.69

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
EPA CFDA 66.469	Great Lakes Consortium Fish - Work with eight states on evaluating fish consumption advisories and improve the delivery of information to the public.	$ 54	$ 293	$ 293	$ 293		0.50
EPA CFDA 66.472	Beach Monitoring Lake Superior - Supports water testing for e. coli at beaches along the Lake Superior Coast.	$ 225	$ 228	$ 228	$ 228		1.65
EPA CFDA 66.605	Performance Partnership Grant - State Lead Program Grants - Supports lead poisoning prevention through credentialing, compliance assistance and monitoring, and enforcement activities.	$ 580	$ 384	$ 384	$ 384		2.88
EPA CFDA 66.605	Lead in Residences - Provides education and compliance assistance to the public and businesses that impact lead in residences.	$ 87	$ -	$ -	$ -		0.00
EPA CFDA 66.608	Drinking Water e-Portal - Compliance Monitoring Data Portal Implementation and Drinking Water e-Portal.	$ 94	$ 65	$ 65	$ 65		0.36
EPA CFDA 66.608	Environmental Information Exchange Network (EN) - Web-based system to securely share environmental and public health information.	$ 50	$ 125	$ 125	$ 125		0.68
DOE CFDA 84.027	Individuals with Disabilities Education Act (IDEA) Part B - Technical assistance to local public health for identifying and serving infants and toddlers with disabilities. Pass-through federal award from the Minnesota Department of Education.	$ 59	$ 60	$ 60	$ 60		0.39
DOE CFDA 84.181	Individuals with Disabilities Education Act (IDEA) Part C - Support to local public health agencies for early identification of infants and toddlers with developmental and social delays. Pass-through federal award from the Minnesota Department of Education.	$ 309	$ 320	$ 320	$ 320		0.19
HHS CFDA 93.008	National Association of County and City Health Officials Medical Reserve Corps Grant Program - Bolsters local community's preparedness and emergency response infrastructures. Pass-through federal award from National Association of County and City Health Officials.	$ 8	$ -	$ -	$ -		-
CDC CFDA 93.068	Alcohol Epidemiology Grant - Promoting population health and health equity through increased capacity in alcohol epidemiology.	$ 92	$ 212	$ 212	$ 167		0.91

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC CFDA 93.069	Public Health Emergency Preparedness (PHEP) - Supports state, local and tribal public health preparedness and response to emergencies that affect the public's health.	$ 10,745	$ 12,734	$ 12,734	$ 12,734		22.27
CDC CFDA 93.070	Climate Resilience and Adaptation - Protect, maintain and improve public health through preparation and adaptation to climate change.	$ 23	$ -	$ -	$ -		0.23
CDC CFDA 93.070	Environmental Public Health Tracking - Supports a tracking system to integrate data about environmental hazards with data about diseases that are possibly linked to the environment, and provide public access via a data portal.	$ 838	$ 842	$ 842	$ 842		5.88
CDC CFDA 93.070	Minnesota Comprehensive Asthma Control - Supports statewide activities to train health professionals, educate individuals with asthma and their families, and explain asthma to the public.	$ 563	$ 868	$ 775	$ 600		5.65
CDC CFDA 93.070	Minnesota State-Wide Biomonitoring Surveillance in Pre-School Children - Establishes a statewide biomonitoring program for systematically measuring exposures to chemicals of concern in children.	$ 355	$ 171	$ 171	$ 171		1.42
CDC CFDA 93.070	Minnesota State-Wide Biomonitoring Surveillance in Pre-School Children - Establishes a statewide biomonitoring program for systematically measuring exposures to chemicals of concern in children.	$ 21	$ 36	$ 36	$ 36		0.33
CDC CFDA 93.070	State-Based Public Health Laboratory Biomonitoring Programs - Enhance the state-wide biomonitoring program to measure exposures to chemicals of concern in children that may be found in drinking water, air pollution, agricultural pesticides, and other sources.	$ 632	$ 558	$ 558	$ 558		2.81
CDC CFDA 93.070	Environmental Health Specialist (EHS) Network - Identify and prevent environmental factors contributing to foodborne and waterborne illness outbreaks.	$ 213	$ 217	$ 217	$ 217		1.09
CDC CFDA 93.070	Environmental Public Health and Emergency Response - Strengthening State Capacity - Identify and address environmental health hazards and build internal capacity for data gathering, program evaluation, and visualization.	$ 69	$ 69	$ 69	$ 69		0.63

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC CFDA 93.070	Environmental Public Health Tracking - Supports a tracking system to integrate data about environmental hazards with data about diseases that are possibly linked to the environment, and provide public access via a data portal.	$ -	$ -	$ -	$ -		-
CDC CFDA 93.073	Birth Defects Information System (BDIS) - Supports surveillance of birth defects in Minnesota.	$ 397	$ 525	$ 525	$ 525		3.41
CDC CFDA 93.073	Population-based Surveillance of Outcomes, Needs, and Well-being of Children and Adolescents with Congenital Heart Defects - To establish a population-based cohort of children and adolescents living with congenital heart defects (CHDs) to participate in a survey intended to improve understanding of healthcare barriers, needs and experiences of caregivers, and strengths and limitations of population-based surveillance among children and adolescents with CHD.	$ -	$ 300	$ 400	$ 400		1.82
CDC CFDA 93.073	Understanding Clinical Data and Pathways to Inform Surveillance of Children with Fetal Alcohol Spectrum Disorders - Funding for a feasibility project to enhance understanding of existing healthcare data and explore opportunities to leverage these data for public health surveillance of children with fetal alcohol spectrum disorders (FASD).	$ -	$ 450	$ 650	$ 450		2.02
CDC CFDA3 93.079	Promote Adolescent Health - School-based programs for HIV/STD Prevention.	$ 32	$ 30	$ 30	$ 30		0.20
CDC CFDA 93.0800	Sickle Cell Data Collection Program - Establish the first sickle cell data collection system in Minnesota.	$ 174	$ 425	$ 405	$ 255		2.14
CDC CFDA 93.084	U.S. Public Health Pathogens Genomics Centers of Excellence - Create and apply novel genomic and bioinformatic tools to monitor and respond to a wide range of public health threats.	$ -	$ 3,600	$ 3,600	$ 3,600		9.09
CDC CFDA 93.084	Vector borne Center of Excellence - Funding from the University of Madison to establish a center of excellence for managing vector borne diseases. Pass-through federal award from the University of Wisconsin.	$ 34	$ -	$ -	$ -		0.00

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC CFDA 93.084	Global Travelers' Health National Research Center Consortium, Guidance, and Outreach Programs - Reduce the number of malaria cases among U.S. travelers to West Africa by expanding message creation for malaria prevention. Pass through funding from the Massachusetts General Hospital.	$ 202	$ 51	$ 51	$ 51		0.51
HHS CFDA 93.088	Advancing System Improvements for Key Issues in Women's Health - Minnesota Maternal Death Context - To reduce maternal violent death and to expand maternal mortality surveillance and implement evidence-based interventions to improve maternal health outcomes.	$ 7	$ 31	$ 31	$ 31		0.09
HHS CFDA 93.088	Advancing System Improvements for Key Issues in Women's Health - Minnesota Maternal Death Context - To reduce maternal violent death and to expand maternal mortality surveillance and implement evidence-based interventions to improve maternal health outcomes.	$ 119	$ 546	$ 452	$ 275		1.73
ACF CFDA 93.092	Personal Responsibility Education Program (PREP) - Supports efforts to decrease teen pregnancy/STIs in high-risk adolescent populations.	$ 579	$ 904	$ 904	$ 904		1.35
FDA CFDA 93.103	Whole Genome Sequencing of Foodborne Pathogens - Track foodborne pathogens to improve outbreak response and effective monitoring of preventative controls.	$ 64	$ -	$ -	$ -		-
FDA CFDA 93.103	FDA Regional Retail Food Safety Seminar - Funding to attend training on the Voluntary National Retail Food Regulatory Program Standards for the regulation of foodservice and retail food establishments. Pass through funding from the National Environmental Health Association.	$ 3	$ -	$ -	$ -		-
FDA CFDA 93.103	Update of Outbreak Investigation Resources and Environmental Assessment Training - To develop the Outbreak Response Protocol as a framework to investigate foodborne outbreaks. Pass through funding from the National Environmental Health Association.	$ -	$ 19	$ -	$ -		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
FDA CFDA 93.103	FDA Regional Retail Food Safety Seminar - Funding to attend training on the Voluntary National Retail Food Regulatory Program Standards for the regulation of foodservice and retail food establishments. Pass through funding from the National Environmental Health Association.	$ -	$ 7	$ -	$ -		-
FDA CFDA 93.103	Standardization & Communication Center - Funding will support standardization of inspection staff to achieve uniformity in food inspections across the state and support building a secure Communication Center SharePoint site to house training modules, resources, and code interpretations. Pass through funding from the National Environmental Health Association.	$ -	$ 100	$ -	$ -		-
FDA CFDA 93.103	Minnesota Food Code Fact Sheet Translations Project - To develop and implement intervention strategies that advance and conform with the Voluntary National Retail Food Regulatory Program Standards. Pass through from the Association of Food and Drug Officials (AFDO).	$ 20	$ -	$ -	$ -		-
HRSA CFDA 93.110	Minnesota State System Development Initiative (SSDI) - Supports data review and analysis of maternal and child health issues.	$ 99	$ 100	$ 100	$ 100		0.79
HRSA CFDA 93.110	Early Childhood Comprehensive Systems: Health Integration Prenatal-to-Three Program - Build integrated maternal and early childhood systems of care that are equitable, sustainable, comprehensive, and inclusive of the health system, and that promote early developmental health and family well-being and increase family-centered access to care and engagement of the prenatal-to-3 year old (P–3) population.	$ 60	$ 325	$ 325	$ 256		-
HRSA CFDA 93.110	State Maternal Health Innovation Program - To align and strengthen the implementation of maternal health programs to improve maternal health outcomes. Funding will build capacity for data collection and quality improvement work, implementation of statewide quality improvement care initiatives, and support for building a skilled maternal health workforce to reduce maternal morbidity and mortality.	$ -	$ 750	$ 1,000	$ 1,250		4.00

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HRSA CFDA 93.110	Pediatric Mental Health Care Access New Area Expansion - Expand and enhance reach of the statewide psychiatric consultation service provider and online mental health resource directory tool (FastTracker) to link children and adolescents with mental health treatment.	$ -	$ 225	$ 75	$ -		0.23
HRSA CFDA 93.110	Minnesota State System Development Initiative (SSDI) - Supports data review and analysis of maternal and child health issues.	$ 110	$ 100	$ 100	$ -		0.69
HRSA CFDA 93.110	Pediatric Mental Health Care Access New Area Expansion - To promote mental health integration into pediatric primary care by better equipping pediatric primary care providers (PCPs) to screen for and respond to mental health concerns in children and adolescents.	$ 365	$ 445	$ 445	$ 445	Match	1.00
NIH CFDA 93.113	Human Health Exposure Analysis Resource (HHEAR) - Targeted Analysis - Analyze data to better understand the influence of environmental factors in human health over a lifetime.	$ 204	$ 230	$ 230	$ 230		0.29
NIH CFDA 93.113	Human Health Exposure Analysis Resource (HHEAR) - Development Core -Analyze data to better understand the influence of environmental factors in human health over a lifetime.	$ 58	$ 88	$ 88	$ 88		0.42
CDC CFDA 93.116	Tuberculosis Elimination and Laboratory - Supports TB prevention and control activities including state operations and grants to CHBs.	$ 1,174	$ 976	$ 976	$ 1,500		6.85
CDC CFDA 93.116	Tuberculosis Elimination - Supports TB prevention and control activities including state operations and grants to CHBs.	$ 55	$ 91	$ 91	$ 91		0.83
CDC CFDA 93.116	Strengthening Civil Surgeons' Capacity to Improve Latent Tuberculosis Infection Surveillance - To enhance current latent tuberculosis infection (LTBI) surveillance among refugee and immigrants, improve LTBI treatment outcomes, and increase reporting by civil surgeons.	$ -	$ 600	$ 150	$ -		0.68
HRSA CFDA 93.130	State Primary Care Offices - Support primary care service delivery and workforce to serve medically-underserved populations through community-based providers; site development for participating in National Health Service Corps programs.	$ 224	$ 206	$ 206	$ 206		1.36

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC CFDA 93.136	Core Injury and Violence Prevention - Supports comprehensive injury prevention and control activities, with a focus on traumatic brain injury.	$ 20	$ 80	$ -	$ -		-
CDC CFDA 93.136	Rape Prevention and Education - Supports statewide prevention and education programs that address sexual violence.	$ 989	$ 1,065	$ 1,527	$ 920		5.75
CDC CFDA 93.136	Prevent Fatal and Nonfatal Overdose from Prescription and/or Illicit Opioids - Improve the use of the state's prescription monitoring program, strengthen data collection and analysis, and implement prevention programs that change practices.	$ 3,441	$ 7,029	$ 5,323	$ 5,323		20.59
CDC CFDA 93.136	Agency for Toxic Substance and Disease Registry (ATSDR) Cooperative Agreement - Build environmental public health capacity to assess and respond to issues involving human exposure to hazardous substances in the environment by identifying exposure pathways, educating affected communities, and reviewing health outcome data.	$ 577	$ 607	$ 607	$ 607		4.00
CDC CFDA 93.136	Core State Injury Prevention Program (Core SIPP) - To reduce unintentional injuries, self-directed injuries, and death by engaging in state-based data and surveillance, strengthening strategic collaborations and partnerships, conducting assessment and evaluation, and monitoring the effectiveness of State Injury Prevention Program (SIPP) activities.	$ 298	$ 558	$ 525	$ 478		3.44
CDC 93.136	Preventing Adverse Childhood Experiences Data to Action (PACE) - Preventing Adverse Childhood Experiences Data to Action (PACE) - To reduce unintentional injuries, self-directed injuries, and death by engaging in state-based data and surveillance, strengthening strategic collaborations and partnerships, conducting assessment and evaluation, and monitoring the effectiveness of State Injury Prevention Program (SIPP) activities.	$ 229	$ 669	$ 650	$ 400		3.32
CDC CFDA 93.136	National Violent Death Reporting System (NVDRS) - Provide communities with a clearer understanding of violent deaths.	$ 215	$ 579	$ 349	$ 279		2.67

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC CFDA 93.136	Suicide Prevention and Adverse Childhood Events - CARES Act COVID-19 - Supports comprehensive injury and violence prevention and control activities focused on suicide and adverse childhood events prevention. Enhances existing activities to address the COVID-19 response using virtual/online implementation, evaluation, and dissemination strategies.	$ 19	$ -	$ -	$ -		-
OMH CFDA 93.137	Demonstrating Effective Policies to Promote Black Youth Mental Health - Improve Black youth mental health by identifying, analyzing, implementing, and evaluating specific policy changes. Partnership with the Brooklyn Bridge Alliance for Youth.	$ -	$ 300	$ 400	$ 400		0.40
OMH CFDA 93.137	Promoting Equitable Access to Language Services in Health and Human Services - Identify and implement strategies to enhance language access services through policy development and implementation, technology utilization, education of those with limited English proficiency, and education for health providers.	$ -	$ -	$ -	$ -		0.00
HRSA CFDA 93.155	Rural Health Research Centers - SHIP COVID Testing & Mitigation - Distribute funds evenly among the 86 eligible hospitals to support COVID-19 testing and vaccinations	$ 18,051	$ 17,809	$ 10,918	$ -		-
HRSA CFDA 93.165	National Health Service Corps (NCHS) Loan Repayment - To encourage more medical professionals to practice in underserved areas.	$ 90	$ 645	$ 645	$ 645	Match	-
CDC CFDA 93.184	Disabilities Prevention - Develop, implement, and measure the effectiveness of interventions that promote the health and wellness of people with disabilities and prevent secondary conditions across the lifespan.	$ 87	$ 150	$ 150	$ 150		0.60
CDC CFDA 93.185	Disparity in Adolescent Vaccination in Rural Areas - Administer surveys to both rural and urban areas to understand disparities and analyze data.	$ 26	$ -	$ -	$ -		0.00
CDC CFDA 93.197	Lead Poisoning Prevention - Supports state lead poisoning prevention efforts that develop policies, educate the public and track blood-lead levels.	$ 380	$ 891	$ 891	$ 891		5.63

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
AHRQ CFDA 93.225	Comparing Two Approaches to Care Coordination for High-Cost/High-Need Patients in Primary Care - To improve health outcomes by integrating primary care into larger health care systems and public health. Pass through funds from the Health Partners Institute.	$ 100	$ 64	$ -	$ -		0.40
ACF CFDA 93.235	Abstinence Education Program - Reduce the teen pregnancy and sexually transmitted infections rates.	$ 636	$ 1,044	$ 693	$ 693		1.11
HRSA CFDA 93.236	Grants to States to Support Oral Health Workforce Activities - To develop and implement innovative programs to address the dental workforce needs of designated dental health professional shortage areas (Dental HPSAs) using innovative workforce models to address the national priority of developing a healthcare workforce that maximizes patient and family engagement and combines geriatrics oral health and primary care.	$ -	$ 400	$ 600	$ 400	Match	2.73
HRSA CFDA 93.241	Rural Hospital Flexibility Program - Supports critical access hospitals in quality improvement, patient safety, performance improvement, and provision of rural emergency medical services.	$ 966	$ 1,124	$ 1,075	$ 1,075		2.05
SAMHSA CFDA 93.243	988 State and Territory Cooperative Agreements - To recruit, hire, and train behavioral health workforce to staff local 988 Lifeline centers to respond, intervene, and provide follow-up to individuals.	$ 449	$ 1,923	$ 1,625	$ 1,625		1.00
SAMHSA CFDA 93.243	Youth Suicide Prevention and Early Intervention - Build local capacity and strengthen the coordination, implementation and evaluation of statewide (including tribal communities) youth suicide prevention and early intervention strategies to decrease suicide by 10% in five years, 20% in 10 years towards zero deaths.	$ 431	$ 935	$ 1,035	$ 735		4.00
SAMHSA CFDA 93.243	Prescription Drug and Opioid Addiction - The purpose of this program is to provide resources to help expand and enhance access to Medications for Opioid Use Disorder (MOUD).		$ -	$ 750	$ 750		2.00

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
SAMHSA CFDA 93.243	First Responders-Comprehensive Addiction and Recovery Act Program - To support first responders and members of other key community sectors to administer a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act (FD&C Act) for emergency reversal of known or suspected opioid overdose.		$ -	$ 800	$ 800		2.00
HRSA CFDA 93.251	Universal Newborn Hearing Screening and Hearing Program - Supports efforts to detect hearing impairments in infants and reduce any negative impacts through early intervention.	$ 218	$ 260	$ 235	$ 235		0.59
CDC CFDA 93.262	Minnesota Occupational Health and Safety Surveillance - Determines rates, trends, and causes of work-related injury and illness.	$ 92	$ 180	$ 180	$ 160		1.25
CDC CFDA 93.262	Bend, Don't Break - Managing Stress in Agriculture - To enhance and expand stress assistance programs to better support farmers, ranchers, and others involved in agriculture.	$ 20	$ 34	$ 50	$ 50		-
CDC CFDA 93.262	Upper Midwest Agricultural Safety and Health - Conduct outreach and surveillance for zoonotic diseases in agricultural workers.	$ 159	$ 120	$ 224	$ 120		1.00
CDC CFDA 93.262	Upper Midwest Agricultural Safety and Health - Lab Component - Conduct outreach and surveillance for zoonotic diseases in agricultural workers.	$ 5	$ 3	$ 3	$ 3		-
CDC CFDA 93.262	Minnesota Occupational Health and Safety Surveillance - Vaccine Task Force (VTF) - Distribution and administration of COVID-19 vaccine to ensure the health, safety, and welfare of all Minnesotans.	$ 76	$ 76	$ -	$ -		-
CDC CFDA 93.262	Minnesota Occupational Health and Safety Surveillance - Workers Safety & Health - COVID-19 Supplemental - To prevent workplace injury and illness of public sector workers.	$ 49	$ 28	$ -	$ -		-
CDC CFDA 93.268	Minnesota Statewide Immunization and Vaccine for Children - Core - Plan for and implement immunization services and increase access to vaccination in convenient and trusted settings. Offer immunization provider outreach and education.	$ 6,501	$ 8,642	$ 8,582	$ 8,582		36.45

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC CFDA 93.268	Minnesota Statewide Immunization and Vaccine for Children - COVID-19 Supplement - This component will cover a range of COVID-19 vaccination activities. Funds may be used for obligations prior to enactment related to vaccine promotion, preparedness, tracking, and distribution.	$ 160,322	$ 221,920	$ 72,000	$ 6,412		30.94
CDC CFDA 93.268	Minnesota Statewide Immunization and Vaccine for Children - COVID-19 Supplement - Round 4 - This component will cover a range of COVID-19 vaccination activities. Funds may be used for obligations prior to enactment related to vaccine promotion, preparedness, tracking, and distribution.	$ 8,546	$ 28,310	$ 14,156	$ 14,156		18.46
CDC CFDA 93.268	Minnesota Statewide Immunization and Vaccine for Children - COVID-19 Supplement - This component will cover a range of COVID-19 vaccination activities. Funds may be used for obligations prior to enactment related to vaccine promotion, preparedness, tracking, and distribution.	$ 817	$ 4,279	$ 2,140	$ 2,139		0.40
CDC CFDA 93.270	Adult Viral Hepatitis Prevention and Control - Improving the state response to Hepatitis B and C.	$ 252	$ 315	$ 315	$ 315		1.91
NIH CFDA 93.310	Community Partnerships to Advance Science for Society (ComPASS) Program - To develop, implement, assess, and disseminate co-created community-led, health equity structural interventions, in partnership with research organizations, that intervene upon structural factors that produce and perpetuate health disparities.		$ -	$ 750	$ 750		2.00
NIH CFDA 93.273	Alcohol Research Programs - Collaborate with law enforcement agencies to identify patterns of alcohol use through tracking data in the Place of Last Drink program in order to address problematic locations and serving practices. Pass-through funding from University of Minnesota.	$ 17	$ 17	$ -	$ -		-
CDC CFDA 93.283	Advancing the Centers of Excellence in Newcomer Health - Improve health outcomes for refugees arriving in the United States and the communities they live.	$ 856	$ 1,000	$ 1,000	$ 1,000		1.36

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC CFDA 93.283	Malaria Project - University of Minnesota - Improve health outcomes for refugees arriving in the United States and the communities they live.	$ 77	$ -	$ -	$ -		-
CDC CFDA 93.283	National Resource Center for COVID-19 Contact Tracing, Prevention, and Mitigation Program - Support for conducting mitigation, prevention, and control measures including contact tracing and other programs for at-risk refugees, immigrants, and migrants through a National Resource Center. Pass through funds from the University of Minnesota.	$ 148	$ 433	$ -	$ -		-
HRSA CFDA 93.301	Small Rural Hospital Improvement - Strengthen Critical Access Hospitals and rural health systems; improve quality, safety and access.	$ 1,042	$ 962	$ 955	$ 955		1.00
CDC CFDA 93.305	National Tobacco Control - Funding continues programmatic efforts to reduce morbidity and its related risk factors and to reduce premature death associated with tobacco use. It also continues surveillance efforts to measure the public health impact of these programs.	$ 1,444	$ 1,500	$ 1,500	$ 1,500		8.60
CDC CFDA 93.314	Early Hearing Detection & Intervention (EHDI) - Supports a centralized newborn hearing screening tracking and surveillance system capable of accurately identifying, matching, collecting, and reporting data.	$ 141	$ 160	$ 160	$ 160		0.58
CDC CFDA 93.317	Emerging Infections Program (EIP) - Minnesota is one of 10 states serving as a sentinel site for emerging infectious disease surveillance. Supports state operations for specialized studies of emerging infections.	$ 4,431	$ 4,626	$ 4,900	$ 5,000		33.40
CDC CFDA 93.317	Emerging Infections Program (EIP) - Lab Component - Minnesota is one of 10 states serving as a sentinel site for emerging infectious disease surveillance. Supports state operations for specialized studies of emerging infections.	$ 1,797	$ 1,905	$ 1,905	$ 1,905		10.84
CDC CFDA 93.317	Emerging Infections Program (EIP) - Monkeypox Supplement - To estimate the effectiveness of JYNNEOS MPX vaccine in preventing laboratory-confirmed or probable symptomatic MPX infection among adults and vaccine effectiveness by other factors of public health importance.	$ -	$ 298	$ 100	$ -		0.09

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC CFDA 93.317	Emerging Infections Program (EIP) COVID-19 Surveillance and Reporting - Performs population-based tracking on the spread of infectious and emerging infectious diseases specifically addressing the COVID-19 public health emergency.	$ 1,050	$ 2,700	$ 2,360	$ 95		8.20
CDC CFDA 93.317	Epidemiology and Laboratory Capacity (ELC) - Supports public health infectious disease infrastructure for surveillance, laboratory capacity and IT capacity.	$ 202	$ 301	$ 240	$ 125		1.25
CDC CFDA 93.323	Epidemiology and Laboratory Capacity (ELC) Legionella - Supports public health infectious disease infrastructure for surveillance, laboratory capacity and IT capacity.	$ 16	$ 34	$ 34	$ 34		0.09
CDC CFDA 93.323	Epidemiology and Laboratory Capacity (ELC) - Core - Supports public health infectious disease infrastructure for surveillance, laboratory capacity and IT capacity.	$ 3,918	$ 11,067	$ 14,637	$ 14,637		76.70
CDC CFDA 93.323	Epidemiology and Laboratory Capacity (ELC) - Core - Lab Component - Supports public health infectious disease infrastructure for surveillance, laboratory capacity and IT capacity.	$ 4,731	$ 4,800	$ 4,800	$ 4,800		17.44
CDC CFDA 93.323	Epidemiology and Laboratory Capacity (ELC) - Funds for COVID testing-related activities and non-testing activities such as enhancing laboratory, surveillance, informatics and workforce capacity; strengthening testing; advancing electronic data exchange at public health labs; Improving surveillance and reporting of electronic health data; data enhancements to public health systems for investigation, response and prevention; and, investment in public health partnerships to improve their capacity.	$ 2,623	$ 1,065	$ 1,000	$ 65		6.59
CDC CFDA 93.323	Epidemiology and Laboratory Capacity (ELC) - Increase COVID-19 testing across the state and improve the public health infrastructure that supports an effective response to disease outbreaks.	$ 1,555	$ 717	$ 717	$ 60		4.82
CDC 93.323	Epidemiology and Laboratory Capacity (ELC)- COVID-19 - Increase COVID-19 testing across the state and improve the public health infrastructure that supports an effective response to disease outbreaks.	$ 1,603	$ 1,901	$ 1,704	$ -		6.72

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC CFDA 93.323	Epidemiology and Laboratory Capacity (ELC) COVID-19 Supplement - Supports public health infectious disease infrastructure for surveillance, laboratory capacity and IT capacity. Supports healthcare provider training on healthcare acquired infections as part of the COVID-19 response activities.	$ 1,274	$ 375	$ 375	$ 31		0.47
CDC CFDA 93.323	Epidemiology and Laboratory Capacity (ELC)- COVID-19 - Funds for COVID testing-related activities and non-testing activities such as enhancing laboratory, surveillance, informatics and workforce capacity; strengthening testing; advancing electronic data exchange at public health labs; Improving surveillance and reporting of electronic health data; data enhancements to public health systems for investigation, response and prevention; and, investment in public health partnerships to improve their capacity.	$ 913	$ 1,081	$ 1,081	$ 90		1.11
CDC 93.323	Epidemiology and Laboratory Capacity (ELC)- COVID-19 - Increase COVID-19 testing across the state and improve the public health infrastructure that supports an effective response to disease outbreaks such as improving surveillance and reporting of electronic health data and strengthening laboratory testing.	$ 57,525	$ 20,053	$ 4,500	$ -		3.00
CDC 93.323	Epidemiology and Laboratory Capacity (ELC)- COVID-19 - Reopening Schools - Increase COVID-19 testing across the state and improve the public health infrastructure that supports an effective response to disease outbreaks such as improving surveillance and reporting of electronic health data and strengthening laboratory testing.	$ 158,279	$ 9,447	$ 8,013	$ 668		-
CDC CFDA 93.323	Epidemiology and Laboratory Capacity (ELC)- COVID-19 - Increase COVID-19 testing across the state and improve the public health infrastructure that supports an effective response to disease outbreaks such as improving surveillance and reporting of electronic health data and strengthening laboratory testing.	$ 846	$ 1,005	$ 1,005	$ -		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC CFDA 93.323	Epidemiology and Laboratory Capacity (ELC)- COVID-19 - Funds for COVID testing-related activities and non-testing activities such as enhancing laboratory, surveillance, informatics and workforce capacity; strengthening testing; advancing electronic data exchange at public health labs; Improving surveillance and reporting of electronic health data; data enhancements to public health systems for investigation, response and prevention; and, investment in public health partnerships to improve their capacity.	$ 651	$ 1,760	$ 1,700	$ 60		-
CDC CFDA 93.323	Epidemiology and Laboratory Capacity (ELC)- COVID-19 - Increase COVID-19 testing across the state and improve the public health infrastructure that supports an effective response to disease outbreaks such as improving surveillance and reporting of electronic health data and strengthening laboratory testing.	$ 768	$ 2,030	$ 2,000	$ 30		-
CDC CFDA 93.323	Epidemiology and Laboratory Capacity (ELC)- COVID Testing in Homeless Sites & Other Congregate Facilities - To provide support to homeless service sites, encampments, and other congregate living facilities for the detection and mitigation of COVID-19 outbreak.	$ 223	$ 250	$ 225	$ 25		0.04
CDC CFDA 93.323	Epidemiology and Laboratory Capacity (ELC)- COVID-19 - To provide critical resources to support healthcare infection prevention and control activities and epidemiologic surveillance related activities to detect, monitor, mitigate, and prevent the spread of SARS-CoV-2/COVID-19 in healthcare settings. Funds Long Term Care/Nursing Home Strike Teams to build and maintain the infection prevention infrastructure necessary to support resident, visitor, and facility healthcare personnel safety.	$ 1,388	$ 300	$ 275	$ 25		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC CFDA 93.323	Epidemiology and Laboratory Capacity (ELC)- COVID-19 - To provide critical resources to support healthcare infection prevention and control activities and epidemiologic surveillance related activities to detect, monitor, mitigate, and prevent the spread of SARS-CoV-2/COVID-19 in healthcare settings. Funds Long Term Care/Nursing Home Strike Teams to build and maintain the infection prevention infrastructure necessary to support resident, visitor, and facility healthcare personnel safety.	$ 1,324	$ 2,050	$ 2,050	$ -		-
CDC CFDA 93.323	Epidemiology and Laboratory Capacity (ELC)- COVID-19 - To provide critical resources to support healthcare infection prevention and control activities and epidemiologic surveillance related activities to detect, monitor, mitigate, and prevent the spread of SARS-CoV-2/COVID-19 in healthcare settings. Funds Long Term Care/Nursing Home Strike Teams to build and maintain the infection prevention infrastructure necessary to support resident, visitor, and facility healthcare personnel safety.	$ 770	$ 2,050	$ 2,050	$ -		-
CDC CFDA 93.323	Epidemiology and Laboratory Capacity (ELC)- COVID-19 - Increase COVID-19 testing across the state and improve the public health infrastructure that supports an effective response to disease outbreaks such as improving surveillance and reporting of electronic health data and strengthening laboratory testing.	$ 196	$ 475	$ 450	$ 25		2.73
CDC CFDA 93.334	Public Health Programs to Address Alzheimer's Disease and Related Dementias - Develop and implement public health strategies to promote brain health of individuals with Alzheimer's disease and related dementias, address cognitive impairment, and support the needs of caregivers.	$ 424	$ 732	$ 500	$ 500	Match	2.73
CDC CFDA 93.336	Behavioral Risk Factor Surveillance (BRFSS) Telephone Surveys - COVID-19 Supplemental - Enhancement of the quality of health data collected through the BRFSS survey.	$ 774	$ 774	$ 774	$ 774		0.50

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC CFDA 93.336	Behavioral Risk Factor Surveillance (BRFSS) Telephone Surveys - COVID-19 Supplemental - Enhancement of the quality of health data collected through the BRFSS survey.	$ 22	$ -	$ -	$ -		-
CDC CFDA 93.354	Public Health Crisis Response - State-level emergency response to public health incidents actions as determined by CDC. Award allows for quick action, including activation of emergency operations centers, surge staffing, risk communication and crisis-specific resources needed for the response.	$ 837	$ -	$ -	$ -		-
CDC CFDA 93.354	Emergency Response Public Health Crisis Response - State level emergency response to public health incidents. Funds for COVID-19 include disease surveillance, epidemiology, laboratory capacity, infection control, mitigation, and other preparedness and response activities.	$ 2,995	$ 6	$ 6	$ 6		-
CDC CFDA 93.354	Cooperative Agreement for Emergency Response - Supplemental funding for Mpox response to increase vaccine accessibility, demand, and uptake among recommended populations, and strengthen preparedness for potential reintroduction cases of Mpox.		$ 88	$ 350	$ 204		2.00
CDC CFDA 93.354	Public Health Emergency Response: Cooperative Agreement for Emergency Response - Ensure schools have access to school health consultation services to address COVID-19 planning, response, and recovery needs; Increase ability of local public health departments to assess, monitor, and report on staffing needs and hiring goals related to emergency preparedness and response; and Support mental and behavior health of response staff and build psychological resiliency for all MDH staff.	$ 14,517	$ 1,500	$ 1,500	$ -		1.36
CDC CFDA 93.366	Minnesota Actions to Improve Oral Health Work Force - Decrease dental caries, oral health disparities and other co-morbid chronic diseases associated with poor oral health.	$ 400	$ 593	$ 850	$ 500		4.64

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC CFDA 93.367	Strengthening U.S. Public Health Infrastructure, Workforce, and Data Systems - To meet critical infrastructure needs by expanding the public health workforce; advancing data modernization; and building the foundational capabilities identified as weaknesses during the COVID-19 response, including equity, communications, and community partnership development.	$ -	$ 23,408	$ 7,303	$ 8,565		51.69
CDC CFDA 93.391	Address COVID-19 Health Disparities Among Populations at High Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities - Build on best practices to expand or develop new mitigation and prevention resources and services to reduce COVID-19 disparities. A portion of funds will be dedicated to rural areas to ensure equitable access to COVID-19 related services.	$ 5,553	$ 20,263	$ 9,000	$ -		3.18
NIH CFDA 93.393	10,000 Families Study - University of Minnesota - To investigate radon and chemicals of concern in drinking water which are suspected risk factors for hematologic cancers. Pass through funds from the University of Minnesota.	$ 82	$ 77	$ 77	$ 77		0.11
CDC CFDA 93.421	Minnesota Pregnancy Risk Assessment Monitoring System (PRAMS) - Monitors maternal experiences and behaviors just before, during and after pregnancy. Pass through funding from the South Dakota Department of Health.	$ 7	$ 23	$ 30	$ 30		-
CDC CFDA 93.421	Influenza and Zoonotic Education amount Youth in Agriculture Program - Collaborate with animal health and agricultural communities to promote effective disease prevention and preparedness through promotion of youth zoonotic disease education and infection mitigation behaviors. Pass-through federal award from the Council of State and Territorial Epidemiologists.	$ -	$ 3	$ 1	$ -		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC 93.421	Memorandum of Understanding Toolkit - Guiding health agencies to establish a memorandum of understanding with pharmacies to support a coordinated response to influenza pandemics and other vaccine-related emergencies. Pass-through federal award from Association of State and Territorial Health Officials (ASTHO).	$ 13	$ 3	$ -	$ -		-
CDC CFDA 93.421	Diabetes Prevention - Implement evidence-based, cost effective interventions for people with disability to prevent type 2 diabetes and other chronic health conditions by encouraging healthy habits, increasing physical activity, and improving problem-solving and coping skills. These activities work to achieve health equity for people with disability. Pass-through federal funding from the National Center on Health, Physical Activity, and Disability.	$ 137	$ -	$ -	$ -		-
CDC CFDA 93.421	State Physical Activity and Nutrition Program - Support infrastructure development and project implementation in up to 5 communities to meet the unique needs of priority populations. A National Training Partnership and collaborations with experts will assist in providing technical assistance to meet program metrics and deliverables. Pass-through federal award from National Association of Chronic Disease Directors.	$ 206	$ 75	$ 75	$ -		0.13
CDC 93.421	Farm to Early Care and Education Implementation Grant - Connect young children with nutritious, locally-grown foods and support farmers in their communities and offer food and farming-related educational activities for children. Pass through funds from the Association of State Public Health Nutritionists (ASPHN).	$ 150	$ 90	$ -	$ -		-
CDC CFDA 93.421	State Innovations to Advance Breastfeeding - To implement environmental and policy changes to full support breastfeeding families and increase access to skilled lactation support. Pass through funds from the Association of State and Territorial Health Officials (ASTHO).	$ 25	$ -	$ -	$ -		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC CFDA 93.421	Enhance Identification and Investigation of Unexplained Respiratory Deaths - Develop and implement protocols to identify and investigate unexplained respiratory deaths occurring outside the healthcare setting in collaboration with medical examiners/coroner partners. Pass-through federal award from the Council of State and Territorial Epidemiologists.	$ 596	$ 249	$ 235	$ 35		0.80
CDC CFDA 93.426	Innovative State and Local Public Health Strategies - Prevention of diabetes, heart disease and stroke, and improved management of conditions.	$ 1,830	$ 2,040	$ 4,250	$ 3,250		25.00
CDC CFDA 93.988	A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes - To decrease risk for type 2 diabetes among adults with prediabetes and improve self-care practices, quality of care, and early detection of complications among people with diabetes.		$ -	$ 850	$ 850		2.00
ACF CFDA 93.434	Minnesota Preschool Development Grants - Improves child development outcomes related to the well-being of children of color and American Indian children to enter kindergarten prepared and ready to succeed. Improves the transition from early care and education settings to elementary school through collaboration and coordination of early childhood care. Align and coordinate systems in order to ease navigation through the system for families. Pass-through federal award from Minnesota Department of Education.	$ 1,695	$ 1,637	$ 2,482	$ 952		5.80
CDC CFDA 93.435	Heart Disease & Stroke Prevent Programs - Innovative State and Local Public Health Strategies - Prevention of heart disease and stroke and improved management of conditions.	$ 2,610	$ 2,724	$ 3,400	$ 2,400		10.00

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC CFDA 93.436	Well-Integrated Screening and Evaluation for Women Across the Nation (Wisewoman) - Evidence-based strategies to help reduce risk, complications and barriers to prevention and control of heart disease and stroke among eligible women, including provision of screening services. Also includes Implementation and evaluation of innovative strategies for prevention.	$ 932	$ 1,575	$ 1,318	$ 1,375	Match & MOE	3.75
HRSA CFDA 93.516	Community Health Worker and Paraprofessional Training Program - To expand the public health workforce through the training of new Community Health Workers (CHWs) and paraprofessionals and extend the knowledge and skills in order to increase access to care, improve public health emergency response, and address the public health needs of undeserved communities.	$ -	$ 1,000	$ 1,550	$ 1,350		1.70
HRSA CFDA 93.516	Public Health Training Centers Program - Advise regional training initiatives focused on health outcomes and social determinants of health. Pass-through federal award from University of Michigan.	$ 25	$ 20	$ 20	$ 20		0.18
ACF CFDA 93.563	Child Support Enforcement - Filing voluntary parentage acknowledgements and replacing the associated birth record. Pass-through federal award from Minnesota Department of Human Services.	$ 91	$ 246	$ 246	$ 246		1.00
ACF CFDA 93.566	Refugee Cash and Medical Assistance Program - Coordinate all refugee medical screening activities and develop a statewide system to ensure health assessments are performed for refugees. Pass through funding from the Minnesota Department of Human Services.	$ 406	$ 400	$ 400	$ 400		1.46
ACF CFDA 93.576	Refugee Health Promotion - Supports state operations and grants to CHBs to ensure refugees receive a medical screening and healthy start as they resettle.	$ 153	$ -	$ -	$ -		-
CDC CFDA 93.755	Surveillance for Diseases Among Immigrants and Refugees - Minnesota Center Of Excellence Network training and epidemiology In Refugee Health.	$ 91	$ 4	$ -	$ -		-
CMS CFDA 93.777	Clinical Laboratory Improvement Amendments (CLIA) - Provides inspections of clinical laboratories to ensure they are meeting federal standards.	$ 188	$ 303	$ 303	$ 303		2.36

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CMS CFDA 93.777	Impact Hospice - Certify health care facilities and perform surveys and investigations of those facilities.	$ -	$ 233	$ 233	$ 233	Match	1.17
CMS CFDA 93.777	Medicare Title 18 - Certify health care facilities and perform surveys and investigations of those facilities.	$ 9,052	$ 10,418	$ 9,619	$ 9,233	Match	-
CMS CFDA 93.777	State Survey and Certification of Health Care Providers and Suppliers - Complete backlog of recertification surveys for 58 federally-certified nursing homes	$ 7,727	$ 7,318	$ 7,005	$ 6,716	Match	-
CMS CFDA 93.777	Case Mix - Certify health care facilities and perform surveys and investigations of those facilities.	$ 965	$ 1,764	$ 1,764	$ 1,764	Match	12.00
CMS CFDA 93.778	Minnesota Health Access Survey - Federal matching for Health Access Survey.	$ 250	$ 50	$ 250	$ 50	Match	-
CMS CFDA 93.778	Health Information Technology - Electronic public health data reporting and exchange. Pass-through federal award from Minnesota Department of Human Services.	$ 237	$ 1,234	$ 1,234	$ 1,234	Match	1.51
CMS CFDA 93.778	Health Information Technology - Infectious Disease Component - Electronic public health data reporting and exchange. Pass-through federal award from Minnesota Department of Human Services.	$ 678	$ -	$ -	$ -	Match	1.00
CMS CFDA 93.778	Health Information Technology - Public Health Laboratory Component - Electronic public health data reporting and exchange. Pass-through federal award from Minnesota Department of Human Services.	$ 221	$ 503	$ 503	$ 503	Match	3.31
CMS CFDA 93.778	Child & Teen Check Ups - Supports provider training for early and periodic screening, diagnosis and treatment.	$ 208	$ 483	$ 483	$ 483		3.45
CMS CFDA 93.778	Immunization Outreach to Medicaid Eligible Population - Grants to local public health and community health boards to conduct annual immunization recall reminder notifications for not up to date children and adolescents.	$ 20	$ 20	$ 20	$ 20		0.18
CMS CFDA 93.778	Immunization Outreach to Medicaid Eligible Population - To support electronic health record technology, Minnesota Immunization Information Connection (MIIC), that stores electronic immunization records. Pass through funds from the Minnesota Department of Human Services.	$ 653	$ 511	$ 511	$ 511		-
SAMHSA CFDA 93.788	State Targeted Response to the Opioid Crisis - Naloxone distribution	$ 262	$ -	$ -	$ -		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC CFDA 93.800	Colorectal Cancer Screening - Increase colorectal cancer screening through use of evidence-based interventions and other strategies in partnership with health systems. Provide screen and follow-up services for a limited number of eligible people.	$ 578	$ 1,418	$ 1,000	$ 1,000		3.87
CDC CFDA 93.810	Minnesota Stroke Registry Program - Supports a hospital-based stroke registry that is used to improve care for stroke patients.	$ 564	$ 636	$ 636	$ 622		23.04
HHS CFDA 93.817	Hospital Preparedness Program (HPP) - Ebola Preparedness and Reponses - Prepares the state's health care system to save lives during emergencies and disasters.	$ 94	$ -	$ -	$ -		-
HHS CFDA 93.817	Hospital Preparedness Program (HPP) Cooperative Agreement Preparedness and Response - COVID-19 Supplement 1 - Prepares the state's health care system to save lives during emergencies and disasters. Supports the preparation of health care systems for a surge in COVID-19 patients.	$ 76	$ -	$ -	$ -		0.00
CDC CFDA 93.845	Alcohol Epidemiology Grant - Promoting population health and health equity through increased capacity in alcohol epidemiology.	$ 89	$ 167	$ 150	$ 150		0.75
HRSA CFDA 93.870	Maternal, Infant and Early Childhood Home Visiting (MIECHV) - Supports efforts to improve the health and developmental outcomes for at-risk children through evidenced-based home visiting programs.	$ 9,380	$ 8,826	$ 8,827	$ 8,827		10.60
HRSA CFDA 93.870	Maternal, Infant and Early Childhood Home Visiting (MIECHV) - COVID-19 Supplemental Supports efforts to improve the health and developmental outcomes for at-risk children through evidenced-based home visiting programs.	$ 3	$ 1,185	$ 1,300	$ 385		0.45
CDC CFDA 93.889	Hospital Preparedness Program (HPP) - Bioterrorism - Prepares the state's health care system to save lives during emergencies and disasters.	$ 3,405	$ 3,900	$ 3,900	$ 3,900		5.74
CDC CFDA 93.898	Improve access to timely breast and cervical cancer screening and diagnostic services for underserved women.	$ 4,312	$ -	$ -	$ -	Match & MOE	-
CDC CFDA 93.898	Cancer Prevention and Control - Prevent and minimize the impact of cancer through policies, systems and environmental change. Support the Minnesota Cancer Reporting System.	$ 1,952	$ 5,958	$ 5,958	$ 5,958	Match & MOE	20.96

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HRSA CFDA 93.913	State Office of Rural Health - Provides information and assistance to rural health care provider so that health services are available where needed, and to recruit and retain health professionals.	$ 223	$ 223	$ 223	$ 223	Match	1.36
HRSA CFDA 93.917	Ryan White HIV - Improve HIV prevention, care, treatment and support. Pass through from Department of Human Services (DHS).	$ 1,414	$ 1,535	$ 1,535	$ 1,535		2.86
HRSA CFDA 93.493	Rural Hospital Flexibility Program - Funds to implement a mobile version of the Rural Obstetric Simulation Training that will be provided on-site at Community Memorial Hospital in Cloquet.				$ 100		0.00
CDC CFDA 93.940	Integrated HIV Surveillance and Prevention Programs - Support an integrated HIV prevention and surveillance program to prevent new HIV infections and achieve viral suppression among persons living with HIV and supports healthy outcomes.	$ 2,938	$ 2,984	$ 3,000	$ 3,000		14.24
CDC CFDA 93.945	Minnesota Public Health Approaches to Addressing Arthritis - Implement state-based approaches to improve arthritis management and quality of life for adults with arthritis.	$ 330	$ 466	$ 550	$ 550		2.39
CDC CFDA 93.945	Minnesota Physical Activity and Nutrition Program - Work with state and local partners that support communities to improve nutrition and increase physical activity.	$ 1,016	$ 981	$ 981	$ 923		2.95
CDC CFDA 93.945	Closing the Gap with Social Determinants of Health Accelerator Plan - To build on the extensive policy, systems and environmental (PSE) change work and further focus its work to reach communities within Nobles County by developing an accelerator plan to address two important social determinants of health: community-clinical linkages and social connectedness.	$ 71	$ 75	$ 75	$ 75		0.02
CDC CFDA 93.946	Collaborative (MNPQC) - Improves clinical maternal and infant health outcomes through improvements in data quality, use, reporting and follow up.	$ 407	$ 300	$ -	$ -		-
CDC CFDA 93.946	Safe Motherhood and Infant Health Initiative - Sudden Unexpected Infant Death (SUID) and Sudden Death in the Young (SDIY) case registry.	$ 133	$ 132	$ 160	$ 160		1.20

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
CDC CFDA 93.946	Minnesota Pregnancy Risk Assessment Monitoring System (PRAMS) - Monitors maternal experiences and behaviors just before, during and after pregnancy.	$ 167	$ 160	$ 160	$ 160		1.50
CDC CFDA 93.977	Strengthening STD Prevention and Control for Health Departments - Increase the capacity of MDH to prevent and control STD's through surveillance and outreach to focus on those populations bearing the greatest burden of disease.	$ 1,682	$ 5,275	$ 5,275	$ 5,275		10.02
HHS CFDA 93.981	Improving Student Health & Academic Achievement through Nutrition, Physical Activity & Management of Chronic Conditions - Improving student health and academic achievement through nutrition, physical activity, and the management of chronic conditions in school. Pass through funds from the Minnesota Department of Education.	$ 429	$ 126	$ 126	$ 126		0.95
CDC CFDA 93.991	Preventive Health and Health Services (PHHS) Block Grant - To prevent and control chronic diseases, address emerging health issues and gaps, respond quickly to disease outbreaks, build public health capacity and address emerging needs.	$ 4,337	$ 3,943	$ 3,926	$ 3,926	MOE	21.45
HRSA CFDA 93.994	Maternal & Child Health Block Grant - Supports public health services to low-income, high-risk mothers and children, including children with special health needs.	$ 10,546	$ 10,909	$ 9,256	$ 9,256	Match & MOE	15.79
FEMA CFDA 97.036	FEMA Funding for Vaccination – Disaster Grants – Public Assistance - Prepaid Testing - Reimbursement for certain costs incurred during a major disaster or emergency declared by the president.	$ 49,249	$ -	$ -	$ -		-
FEMA CFDA 97.036	FEMA Funding for Vaccination – Disaster Grants – Public Assistance - Testing - Reimbursement for certain costs incurred during a major disaster or emergency declared by the president.	$ 55,618	$ -	$ -	$ -		-
FEMA CFDA 97.036	FEMA Funding for Vaccination – Disaster Grants – Public Assistance - Vaccine - Reimbursement for certain costs incurred during a major disaster or emergency declared by the president.	$ 22,040	$ -	$ -	$ -		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
FEMA CFDA 97.036	FEMA Funding for Vaccination – Disaster Grants – Public Assistance - Reimbursement for certain costs incurred during a major disaster or emergency declared by the president.	$ 126,298	$ -	$ -	$ -		-
FEMA CFDA 97.036	FEMA Funding for Vaccination – Disaster Grants – Public Assistance - Reimbursement for certain costs incurred during a major disaster or emergency declared by the president.	$ 354	$ -	$ -	$ -		-
DHS CFDA 97.091	Homeland Security Biowatch - Maintains the Biowatch Program's early warning system through an ambient air monitoring network in the Minneapolis-St. Paul Metropolitan area.	$ 1,130	$ 1,096	$ 1,096	$ 1,096		3.05
	3000 Federal Fund Totals	**$ 934,107**	**$ 693,199**	**$ 490,164**	**$ 366,422**		**810.05**
FEDERAL TANF [3001] FUND							
	Family Home Visiting - Home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. Family home visiting grant program according to Minnesota Statutes, section 145A.17, distributed to community health boards and tribal governments.	$ 8,430	$ 8,557	$ 8,557	$ 8,557		-
	Family Planning - Family planning grants under Minnesota Statutes, section 145.925.	$ 1,156	$ 1,156	$ 1,156	$ 1,156		2.06
	Infant Mortality - Decrease racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.	$ 1,992	$ 2,000	$ 2,000	$ 2,000		-
	3001 Federal TANF Fund Totals	**$ 11,579**	**$ 11,713**	**$ 11,713**	**$ 11,713**		**2.06**
CORONAVIRUS RELIEF [3010] Fund							
USDT CFDA 21.019	CRF Mobile Testing -Implement mobile testing teams for COVID-19 testing sites in the community and in response to hot spots, along with enhanced testing in congregate settings.	$ (402)	$ -	$ -	$ -		-
USDT CFDA 21.019	CRF Tracing Software - For case management software system to perform necessary functional and data management support for case investigation and contact tracing of COVID-19 cases.	$ 0	$ -	$ -	$ -		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
USDT CFDA 21.019	CRF Nurse Triage Line - For a nurse triage line to call out results for COVID tests and answer follow up questions related to COVID symptoms and concerns.	$ 217	$ -	$ -	$ -		-
USDT CFDA 21.019	CRF On Demand Saliva Testing - For on demand, at home saliva testing availability to every educator and employee of public and private K12 school, preschool and childcare facility.	$ 3,708	$ -	$ -	$ -		-
USDT CFDA 21.019	CRF Timely Test Long Term Care - To maintain and expand the testing infrastructure in LTC settings; to accommodate anticipated increased demand related to the spread of the virus and expanded visitation by friends and family members of residents.	$ 1,190	$ -	$ -	$ -		-
USDT CFDA 21.019	CRF Additional Testing Capacity - To purchase additional capacity for COVID test processing across the state.	$ 28,070	$ -	$ -	$ -		-
USDT CFDA 21.019	CRF Case Investigation/Contact Tracing - To provide capacity for community-based organizations to address underserved communities' needs for COVID testing and access to related resources, and for staffing and contracts to address contact tracing and case investigation needs.	$ 1,663	$ -	$ -	$ -		-
USDT CFDA 21.019	CRF Tribal Public Health Grants - To support Tribal public health responses to the COVID pandemic.	$ 926	$ -	$ -	$ -		-
USDT CFDA 21.019	CRF Mobile Testing - To continue and expand community based testing strategies throughout the state, including testing in response to outbreaks and enhanced testing in congregate settings, such as long term care.	$ 1,375	$ -	$ -	$ -		-
USDT CFDA 21.019	CRF Provider Grants - For eligible health care providers' costs related to planning for, preparing for, or responding to an outbreak of COVID-19.	$ 3,319	$ -	$ -	$ -		-
	Coronavirus Relief [3010] Fund Totals	**$ 40,066**	**$ -**	**$ -**	**$ -**		**-**
AMERICAN RESCUE PLAN (ARP) STATE FISCAL RECOVERY [3015] FUND							
USDT CFDA 21.027	COVID Vaccine Incentives - To provide gift card incentives for receiving COVID vaccinations through direct purchase and distribution.	$ 2,500	$ -	$ -	$ -		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
USDT CFDA 21.027	COVID Vaccine Incentives - To provide gift card incentives for receiving COVID vaccinations through direct purchase and MDH distribution, and through grants to partnering organizations for incentive distribution, including administrative costs on gift cards and to award, distribute, and monitor, and report out on grants.	$ 10,281	$ 3,519	$ -	$ -		-
USDT CFDA 21.027	COVID Vaccine Incentives - To fund a cash incentive program to encourage more youth and children to go get their complete vaccine series, and for a scholarship program to be awarded via drawing from those youth and children who have completed their series.	$ 6,039	$ 2	$ -	$ -		-
USDT CFDA 21.027	Emergency Temp Staffing Pool - To expand the emergency staffing pool to provide temporary staff to skilled nursing facilities and add beds for individuals who no longer need hospital-level care.	$ 125	$ -	$ -	$ -		-
USDT CFDA 21.027	Rapid At Home Test Program - To expand community based COVID testing to K12 schools and child care facilities.	$ 4,831	$ 169	$ -	$ -		-
USDT CFDA 21.027	COVID Antiviral Distribution - To prepare for and implement distribution of COVID-19 antiviral medication and cover costs of packaging and distribution to providers.	$ -	$ 400	$ -	$ -		-
USDT CFDA 21.027	COVID Response Staffing - To fund leadership and response coordination costs required for coordinating and carrying out overall state COVID testing and vaccination response strategies.	$ 1,802	$ 2,698	$ -	$ -		-
USDT CFDA 21.027	Community Based Testing - To offer access to no cost barrier free COVID testing throughout the state at community based testing locations with both PCR and rapid antigen tests.	$ 25,330	$ 14,670	$ -	$ -		-
USDT CFDA 21.027	Hospitals Staffing - To procure emergency staffing support for hospitals experiencing extreme staffing shortages that are compromising the ability to provide patient care during COVID waves.	$ 33,000	$ -	$ -	$ -		-
USDT CFDA 21.027	ARPA Reimbursement	$ (2,786)	$ -	$ -	$ -		

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY 2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
USDT CFDA 21.027	Coronavirus State and Local Fiscal Recovery Funds - To provide teleheatlh, COVID-19 therapeutics including vaccines, and other mitigation and response efforts.		$ 633	$ 3,466	$ -		-
	American Rescue Plan (ARP) State Fiscal Recovery [3015] Totals	**$ 81,122**	**$ 22,091**	**$ 3,466**	**$ -**		**-**
	Federal Fund – Agency Total	**$ 1,066,873**	**$ 727,003**	**$ 505,343**	**$ 378,135**		**812.11**

Narrative

The Minnesota Department of Health relies on substantial federal investments to protect, maintain, and improve the health of all Minnesotans. The department uses federal funding to plan for and respond to public health emergencies, supply and equip a modern laboratory, track the spread of deadly diseases and debilitating conditions, promote health, maintain a highly skilled workforce, and support communities with expertise and grant funding. The forecast for federal funding in fiscal years 2024-25 is based on projected awards, but actual amounts are subject to annual congressional appropriations and federal agency determination.

Awards that require a match or maintenance of effort, typically are block grants that are "soft" matched with existing state funds.

Acronyms:

- ACF – Administration for Children and Families
- ACL – Administration for Community Living
- AFDO – Association of Food and Drug Officials
- AHRQ – Agency for Healthcare Research and Quality
- ASPHN – Association of State Public Health Nutritionists
- ASTHO – Association of State and Territorial Health Officials
- ATSDR – Agency for Toxic Substances and Disease Registry
- CDC – Centers for Disease Control and Prevention
- CFDA – Catalogue of Federal Domestic Assistance
- CMS – Centers for Medicare and Medicaid Services
- DHS – U.S. Department of Homeland Security
- DOE – U.S. Department of Education
- DOJ – U.S. Department of Justice
- DOT – U. S. Department of Transportation
- EPA – Environmental Protection Agency
- FDA – Food and Drug Administration
- HHS – U.S. Department of Health and Human Services
- HRSA – Health Resources and Services Administration
- HUD – U.S. Department of Housing and Urban Development
- MOE – Maintenance of Effort
- NIH – National Institutes of Health
- OMH – Office of Minority Health
- SAMHSA - Substance Abuse and Mental Health Services Administration
- USDA – U.S. Department of Agriculture
- USDT – U.S. Department of Treasury

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
Health Improvement					
General Fund:					
Family Planning Grants (MS 145.925)	RFP – Competitive Nonprofit organizations, community health boards, and tribal governments	$ 5,197	$ 5,197	$ 5,197	$ 5,197
Positive Alternatives Grants (MS 145.4235)	RFP – Competitive Private, Nonprofit organizations	$ 3,357	$ 3,357	$ 3,357	$ 3,357
Fetal Alcohol Syndrome Grants (MS 145.9265; MS 144.0742)	Single Sole Source Nonprofit organization	$ 2,000	$ 2,000	$ 2,750	$ 2,750
Hearing Aid Loan Bank Grants (MS 144.0742)	Single Sole Source Nonprofit Organization	$ 69	$ 69	$ 69	$ 69
Special Health Needs Grants (MS 144.05)	RFP - Competitive Clinics	$ 160	$ 160	$ 160	$ 160
Birth Defects Information System (MS 144.2215)	Non-competitive – Formula Community health boards	$ 403	$ 432	$ 432	$ 432
Families with Deaf and Hard of Hearing Children Grants (MS 144.966 Subd 3a)	RFP-Competitive Nonprofit organizations	$ 590	$ 590	$ 590	$ 590
American Sign Language for Families Grants (MS 144.966 3a)	RFP-Competitive Nonprofit organizations	$ 156	$ 156	$ 156	$ 156
Nurse Family Partnership (MS 145A.145)	RFP - Competitive Tribal governments and community health boards	$ 2,000	$ 2,000	$ 2,000	$ 2,000
Evidence-based Home Visiting Grants (MS 145.87)	RFP- Competitive Nonprofit organizations, community health boards, and Tribal governments	$ 16,740	$ 16,740	$ 16,740	$ 15,345
Healthy Babies Grants (211 007 16 003 02i)	Non-competitive Nonprofit organization	$ 260	$ 260	$ -	$ -
Anti-Racism Curriculum Grant (MS 144.1461)	Non-competitive Higher education	$ 294	$ -	$ -	$ -
Online Music Instruction Grant (22 099 01 045 000)	RFP - Competitive Community music education and performance center	$ -	$ 300	$ -	$ -
Poison Control System Grants (MS 145.93)	RFP - Competitive Non-profit organizations, for-profit organizations, and units of government	$ 2,379	$ 2,379	$ 2,379	$ 2,379

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
Suicide Prevention Grants (MS 145.56)	RFP - Competitive Local public health and social service agencies, non-profit organizations; units of government, schools and/or school districts, health care organizations, faith communities, and emergency response organizations	$ 3,298	$ 3,298	$ 3,298	$ 3,298
Sage Cancer Screening Grants (MS 144.0742)	Single sole sources Nonprofit organizations and clinics	$ 516	$ 518	$ 518	$ 518
Safe Harbor Provider Grants (MS 145.4717)	RFP - Competitive Regional organizations	$ 3,120	$ 3,120	$ 3,120	$ 3,120
Non-narcotic Pain Grants (MS 144.0742)	RFP - Competitive Tribal governments, local governments, health care providers, health plan companies/systems, wellness centers, and other health-based centers and organizations	$ 649	$ -	$ -	$ -
Local Public Health Grants (MS 145A.131)	Formula Community health boards	$ 28,665	$ 28,665	$ 28,665	$ 28,665
Tobacco Use Prevention Grants (MS 144.396)	Competitive Community health boards, nonprofit organizations, colleges and universities, professional health associations, health care organizations, and local units of government.	$ 4,921	$ 4,921	$ 4,921	$ 4,921
Tribal Governments Grants (MS 145A.14 2a)	Formula Tribal governments	$ 1,160	$ 1,166	$ 1,166	$ 1,166
Eliminating Health Disparities Initiative (MS 145.928)	RFP - Competitive Community health boards; faith-based organizations; social service and community nonprofit organizations; community clinics	$ 3,125	$ 3,142	$ 3,142	$ 3,142
Public Health Infrastructure (211 007 16 003 02d)	RFP - Competitive Community health boards and Tribal governments	$ 6,000	$ 6,000	$ 6,000	$ 6,000
Community Solutions Grants (MS 144.0742) (191 009 14 003 02f)	RFP - Competitive Community-based organizations; local government; non-governmental organizations; Tribal organizations	$ 599	$ 765	$ -	$ -
Tribal Public Health Infrastructure (MS 145A.14)	Formula Tribal governments	$ 500	$ 500	$ 500	$ 500
Mental Health Cultural Community Continuing Education Grants (211 007 16 003 02g)	RFP - Competitive Individuals	$ 500	$ 500	$ -	$ -
Rural Hospital Capital Grants (MS 144.148)	RFP - Competitive Rural hospitals	$ 1,755	$ 1,755	$ 1,755	$ 1,755

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
Indian Health Grants (MS 145A.14 2)	RFP – Competitive Clinics	$ 174	$ 174	$ 174	$ 174
Community Clinic Grants (MS 145.9268)	RFP - Competitive Community clinics	$ 311	$ 311	$ 311	$ 311
Advanced Life Support Grants (MS 144.6062)	Non-competitive Individuals	$ 508	$ 508	$ 508	$ 508
Dental Safety Net Grants (MS 145.929 1)	Competitive formula Nonprofit organizations (oral health providers)	$ 50	$ 50	$ 50	$ 50
Mental Safety Net Grants (MS 145.929 2)	Competitive formula Community mental health centers and nonprofit community clinics	$ 160	$ 175	$ 175	$ 175
Hospital Safety Net Grants (MS 145.929 3)	Competitive formula Hospitals	$ 590	$ 590	$ 590	$ 590
Federally Qualified Health Centers (FQHC) Subsidy Grants (MS 145.9269)	Formula Clinics	$ 2,425	$ 2,425	$ 2,425	$ 2,425
MERC Formula Grants (MS 62J.692 4) See also: 1100 MERC Formula Grants	Formula Higher education institutions, clinics, and hospitals	$ 1,000	$ 1,000	$ 1,000	$ 1,000
Home and Community Based Services (HCBS) Scholarship Grants (MS 144.1503)	RFP - Competitive HCBS providers	$ 1,431	$ 1,450	$ 1,450	$ 1,450
Health Professional Loan Forgiveness (MS 144.1501) See also: 2360 Health Professional Loan Forgiveness	RFP - Competitive Individuals	$ 2,764	$ 3,197	$ 2,625	$ -
Mental Health Grants for Health Care Professionals (22 099 01 046 000)	RFP - Competitive Health care entities	$ -	$ 1,000	$ -	$ -
Mental Health Loan Forgiveness (MS 144.1501 2)	RFP - Competitive Individuals	$ -	$ 1,600	$ 1,600	$ 1,600
Health Professionals Clinical Training Expansion Grants (MS 144.1505 2, 5)	RFP - Competitive Health professional training programs	$ -	$ 1,202	$ 500	$ 500
Primary Care Residency Expansion Grants (MS 144.1506)	RFP - Competitive Clinics and hospitals	$ 96	$ 2,904	$ 1,500	$ 1,500
Medical Education and Research Costs Fund:					

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
MERC Formula Grants (MS 62J692) See also: 1000 and 2360 MERC Formula Grants	RFP - Competitive Higher education institutions, clinics, and hospitals	$ 57,127	$ 57,127	$ 7,575	$ 7,575
Clinical Dental Education Innovations (MS 62J.692)	Formula Clinics and hospitals	$ 1,122	$ 561	$ -	$ -
University of Minnesota Primary Care Training Grants (MS 62J.692)	Formula Higher education institutions, clinics, and hospitals	$ 2,157	$ 1,079	$ -	$ -
Hennepin Healthcare (HCMC) Clinical Education (MS 62J.692)	Formula Clinics and hospitals	$ 1,035	$ 518	$ -	$ -
University of Minnesota Medical Education (MS 62J.692)	Formula Higher education institutions and clinics	$ 17,400	$ 8,700	$ -	$ -
Health Care Access Fund:					
Statewide Health Improvement Grants (MS 145.986)	Competitive Community health boards and Tribal governments	$ 14,340	$ 14,634	$ 14,634	$ 14,634
Health Professional Loan Forgiveness (MS 144.1501) See also: 1000 Health Professional Loan Forgiveness	RFP - Competitive Individuals	$ 2,356	$ 5,167	$ 4,115	$ 6,740
MERC Formula Grants (MS 62J.692) See also: 1100 MERC Formula Grants	Formula Higher education institutions, clinics, and hospitals	$ 1,000	$ 1,000	$ 1,000	$ 1,000
Community Clinic Grants (MS 145.9268)	RFP - Competitive Community clinics	$ 219	$ 250	$ 250	$ 250
Rural Hospital Planning and Transition Grants (MS 144.147)	RFP - Competitive Rural hospitals	$ 263	$ 300	$ 300	$ 300
Greater Minnesota Residency Grants (MS 144.1912)	Formula Clinics and hospitals	$ 984	$ 1,000	$ 1,000	$ 1,000
Health Care Intern Grants (MS 144.1464)	RFP - Non competitive Clinics, hospitals, providers, and nursing homes	$ 300	$ 300	$ 300	$ 300
National Health Service Match (MS 144.05; MS 144.0742)	RFP - Competitive Individuals	$ 100	$ 100	$ 100	$ 100

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
Federally Qualified Health Centers (FQHC) Subsidy Grants (MS 145.9269)	Formula Clinics	$ 219	$ 219	$ 219	$ 219
International Medical Graduates Residency Grants (MS 144.1911)	RFP - Competitive Individuals	$ 867	$ 867	$ 867	$ 867
Dental Safety Net Grants (MS 145.929 1)	Competitive formula Nonprofit organizations (oral health providers)	$ 45	$ 63	$ 63	$ 63
Mental Safety Net Grants (MS 145.929 2)	Competitive formula Community mental health centers and nonprofit community clinics	$ 208	$ 219	$ 219	$ 219
Hospital Safety Net Grants (MS 145.929 3)	Competitive formula Hospitals	$ 721	$ 725	$ 725	$ 725
Health Protection					
General Fund:					
Lead Abatement Grants (MS 144.9512)	RFP - Competitive Nonprofit organizations	$ 471	$ 479	$ 479	$ 479
Healthy Homes Grants (MS 144.9513)	RFP - Competitive Nonprofit organizations and community health boards	$ 370	$ 240	$ 240	$ 240
Refugee Health & TB Grants (MS 144.05; MS 144.0742)	Formula Community health boards	$ 245	$ 245	$ 245	$ 245
HIV Prevention Grants (MS 145.924)	RFP - Competitive Community health boards, state agencies, state councils, and non-profit organizations	$ 1,269	$ 1,281	$ 1,281	$ 1,281
Tuberculosis Grants (MS 144.05; MS 144.0742)	Non-competitive Community health boards	$ 115	$ 115	$ 115	$ 115