Governor's Revised Recommendations for Health

2022 – 2023 BINNEIAL BUDGET SUPPLEMENTAL

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Governor's Revised Recommendations for Health: 2022 – 2023 Budget Supplemental

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Overview

The governor's recommendations were released on January 26, 2022, for consideration during the 2022 legislative session, and then revised on March 17, 2022. Minnesota Management and Budget published a summary of the governor's recommendations on their website. This report includes change item narratives for the recommendations to the Minnesota Department of Health for the 2022–2023 biennial budget period.

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Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: 988 National Suicide Prevention Lifeline

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	0	(1,321)	(1,321)
Revenues	0	0	0	0
Special Revenue Fund				
Expenditures	0	8,671	10,014	10,014
Revenues	0	10,014	10,014	10,014
Net Fiscal Impact = (Expenditures – Revenues)	0	(1,343)	(1,321)	(1,321)
FTEs	**0**	**4.25**	**4.25**	**4.25**

Recommendation:

The governor recommends funding to transition Minnesota's current National Suicide Prevention Lifeline Centers (NSPL) phone number into the federally mandated 988 number. The 988 service will include phone, text, and chat capacity. The governor recommends the imposition of a 12 cent 988-telecom surcharge on all wired lines, wireless, prepaid wireless, and voice over internet protocol (VOIP) lines. Of the total revenue collected from the monthly statewide 988 telecom surcharge, a portion will be provided annually in grants across Minnesota to fund local call center staff and keep the 988 lines in operation. The surcharge revenue will deposit into a dedicated account for suicide prevention.

Rationale/Background:

The Minnesota Department of Health (MDH) coordinates suicide prevention efforts in Minnesota per Minnesota Statute, section 145.56 and in accordance with the Minnesota State Suicide Prevention Plan. The overarching goal of the state plan is to reduce suicide in Minnesota by 10 percent in five years, 20 percent in ten years, ultimately working towards zero deaths. The third goal of the plan is to "promote timely access to assessment, intervention and effective care for individuals with heightened risk for suicide by developing a comprehensive, easily accessible 24-hour crisis care plan for the State that includes phone, text, chat, face-to-face response and follow-up care statewide." This is the focus of the National Suicide Prevention Lifeline (NSPL).

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. 2020 marked the sixth year in a row where more than 600 Minnesotans died by suicide. Deaths by suicide in Minnesota do not occur equally across communities. American Indians in Minnesota and older white males have among the highest rates. Suicide is the second leading cause of death among youth (ages 10–19) and young adults (ages 20–34) in Minnesota.

In October 2020, the National Suicide Hotline Designation Act of 2020 was signed into law at the federal level. This federal legislation requires the Federal Communications Commission (FCC) to designate 988 as the new three-digit dialing code for the NSPL. The FCC has said that all telecommunication providers must make 988 operational for all users by July 16, 2022. 988 will be implemented across all 50 states and U.S. territories. The new federal legislation permits states to levy a fee on mobile and IP enabled service to be used for 988 crisis centers and related services. The national expectation is that each state must prepare to cover all chats and texts to the 988 line 24 hours a day, seven days a week. Currently, Minnesota does not answer chat and text for the National Suicide Prevention Lifeline. This is an expansion in service that will need to occur within the first year that 988 is implemented.

U.S. states and territories are being asked to submit a strategic plan to Substance Abuse and Mental Health Services Administration (SAMHSA) by January 2022 on how 988 will be implemented in their respective states, including funding mechanisms to sustain 988. Beginning on July 16, 2022, 988 will replace the current NSPL number of 1-800-273-TALK (8255). The NSPL will continue to be America's mental health safety net by providing emotional support for people in distress, reducing suicides and mental health crises, and providing a pathway to well-being for all.

In Minnesota, there are four providers that are part of the NSPL network: First Link, First Call, Carver County, and Greater Twin Cities United Way (GTCUW). One provider, First Link, is based in Fargo, North Dakota but is contracted to answer Lifeline calls from 19 counties along the Minnesota and North Dakota border. Three of the four centers (First Call, First Link, and GTCUW) also operate 211 which provides free and confidential health and human services information for people. Two centers (First Call and Carver County), answer calls for local mobile crisis teams in addition to Lifeline calls. First Call also answers the Minnesota Farm and Rural Helpline. These four providers answer calls from the NSPL for Minnesota and are currently supported through state appropriated funding by the Minnesota Department of Health.

Currently an evaluation is underway by Columbia University, to determine the scale of preventing suicide that lifeline call centers make. The Substance Abuse and Mental Health Service Administration (SAMHSA) is the federal agency that oversees the NSPL and is funding the evaluation and focusing on three areas:
Clinical follow-up of suicidal individuals who have received care from emergency departments and hospitals;

1. Interventions using emerging technologies, specifically chat interventions.
2. Phone interventions for callers at imminent risk of suicide.
3. The evaluation results will help all states better configure their call/text/chat responses to be most effective.

988 represents a key opportunity to shift towards connecting individuals in suicidal and mental health crises with community resources and support. The change to 988 is the first step to make a fundamental shift in how people in crisis are engaged in our communities. Currently, there are multiple points of entry to access a crisis line. The long-term goal for Minnesota is to have a centralized platform for all crisis calls in our state. Our 988 Implementation Plan is focused on building the capacity of Lifeline Centers and partnerships between existing crisis services. This will make it easier for Minnesotans in crisis to access the localized help they deserve and decrease the stigma surrounding suicide and mental health related issues.

Proposal:

This proposal will enhance the existing suicide lifeline program and add additional responsibilities. Currently, the 4 NSPL call centers only answer phone calls for all 87 counties in Minnesota. The additional responsibilities will include the ability to answer online chats and text messages as the 988 number will be marketed as a line to also receive mental health and suicide prevention crisis support. When the NSPL call centers start answering the proposed 988 calls plus chats and text messages, it is anticipated they will see a 59% increase in contacts.

The current lifeline centers will need to increase their staff capacity and provide additional training for staff to prepare for the increased call volume, along with text messages and chats with the expanded 988 lifeline structure come July 2022. Chat and text require specialized training on how to communicate clearly and effectively with someone who is communicating through an electronic device such as the computer and or cell phone. Currently, about 33,000 calls per year are made to the Lifeline from Minnesota. It is projected that this number will increase to about 53,800. Chat and text volumes are expected to be about 36,200 and 2,100, respectively based on metrics from Vibrant Emotional Health, the organization which provides oversight of the entire NSPL national network.

This proposal will provide $8 million in FY 2023, ramping up to over $9 million in FY 2024 in competitive grants to recruit additional call centers to join the network to answer calls, texts, and chats. The previously appropriated general fund dollars in grants for the four lifeline centers will be added to the proposed appropriation starting in fiscal year 2024 and each year thereafter which will result in a $1,321,000 savings to the general fund.

This proposal will ensure Minnesota can meet national guidance for implementation of 988 and support the capacity of the current lifeline centers to maintain operations to answer 988 calls. This will also ensure that lifeline centers in Minnesota can expand services to include 988 chat and text 24 hours a day, seven days a week, by providing localized service.

To support these efforts, a telecom surcharge is being proposed. Telecommunication providers in Minnesota will need to collect a monthly fee of 12 cents per each wired, wireless, prepaid wireless, and VOIP line from their consumers. The revenue from this surcharge will be collected by the Department of Public Safety and the 988 revenue will be deposited into a special revenue fund at the Department of Health and appropriated for use by the commissioner for suicide prevention activities.

This proposal complements the work of our partners at the Department of Human Services who provide support to mobile crisis, warm lines, crisis text lines, and crisis beds. This NSPL grant program will provide enhanced suicide prevention and mental health connection statewide.

Impact on Children and Families:

988 will serve as a one stop in connecting families with access to local mental health support and resources they may be seeking. 988 also provides that easy to remember number along with multiple options of connecting with a real live person through call, chat, or text. The current ten-digit lifeline number is not easy to remember; we anticipate with the new 988 easy to remember number, many more youth will access these services as the service is free and confidential to the consumer.

Equity and Inclusion:

With an easy to remember and easy to dial number like 988, more people will be connected to the support they may need. 988 will be available statewide and nationwide.

988 is meant to serve all Minnesotans and will reduce barriers for individuals seeking support during a suicidal or mental health crisis. We will build a robust training component for the Minnesota Lifeline Centers, so staff are comfortable in working with all Minnesotans regardless of race and ethnicity. In building and expanding capacity for the Lifeline Centers in Minnesota, one focus will be to ensure callers, chatters, and texters can be provided relevant and appropriate resource referrals within the community in which they reside.

Because this is a confidential line, callers are not required to provide demographic information. Demographic detail is currently only captured when a caller discloses this information during the call.

32,656 Minnesotans called the NSPL number in 2020. Below is listed the counties with the highest call volume to the NSPL for 2020 The County-level data for 2021 has not been made available by the Lifeline Administrator.

1. Hennepin County – 21,097 calls (65% of all Minnesota calls were from Hennepin County)
2. Saint Louis County – 1,163 calls
3. Stearns County – 931 calls
4. Olmstead County – 855 calls
5. Isanti County – 567 calls

The Veterans Crisis Line is a sub-network of the National Suicide Prevention Lifeline. This will not change with the switch to 988. A veteran in crisis will be able to 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 providing culturally sensitive and appropriate service would encourage callers, chatters, and texters to reach out for support. Having 988 in place will move Minnesota forward in creating a transformative system that will link individuals to the appropriate mental health and 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.

Results:

Since 2017, Minnesota calls to the National Suicide Prevention Lifeline have risen by 55%. In 2021, 33,887 calls, 4,099 chats, and 1,306 texts were made from a Minnesota area code to the NSPL. The NSPL began chat and text services in July 2020.

Of those 33,887 calls, Minnesota Lifeline centers were able to answer 43% of them in-state. Calls that cannot be answered in-state are routed to a national back-up center out-of-state. Minnesota did not have 24/7 call coverage for the Lifeline until April 2021 which has contributed to the low in-state answer rate. Moving forward, the goal is to answer 95% or higher of calls that are routed to Minnesota Lifeline centers.

During a dialogue between a caller and the crisis counselor, the crisis counselor may provide additional information and referrals to local resources, for further assistance. The department projects that approximately 70% of the callers may need one or more informational referrals to local resources and of the 70%, it is anticipated that 100% of those referrals will be made. We anticipate the remaining 30% of callers will not require additional information or referrals.

The hope for 988 is that it will play a vital role in increasing timeliness to crisis services, community stabilization, and engagement in care and decrease use of emergency department visits for suicidal ideation. Using hospital discharge data, the department proposes to decrease emergency department visits for suicidal ideation by a minimum of 10%.

Type of Measure	***Name of Measure***	***Current***	***Future***	***Dates***
Quantity	Answer 95% of the MN NSPL / 9-8-8 calls, text, and chats in Minnesota without being re-routed to national back-up center out of state.	42%	95%	FY2022-2025
Quantity	Number of callers reporting first time contact with a mental health system.	No baseline available	10,800 or 25% of call volume	FY2022-2025
Quantity	Number of calls where referrals are needed, they are given (i.e., housing, mental health, substance use, etc.)	No baseline available	30,240 or 70% of call volume	FY2022-2025
Quality	Quality assurance of calls reported from callers.	No baseline available	25% of call volume	FY2022-2025

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Results	Decreased use of emergency departments for suicidal ideation visits	No baseline available	10%	FY2022-2025

Statutory Change(s):
Minnesota Statutes, sections 145.56, 403.11, and 403.113

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Address Growing Health Care Costs

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	3,375	4,175	4,175
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	3,375	4,175	4,175
FTEs	**0**	**11.1**	**13.6**	**13.1**

Recommendation:

The governor recommends a general fund appropriation to implement four separate initiatives to improve health care affordability by establishing a health care spending target program, expanding on the prescription drug price transparency initiative, creating an evidence base for developing policy initiatives to limit growth in spending, and assessing readiness of, and planning for, rural communities to participate in value-based payment arrangements.

Rationale/Background:

Health care spending is rising 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., 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 insurance coverage and care. The package of initiatives proposed here will establish targets of health spending in order to moderate the rate of 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.

Specifically, this proposal includes four initiatives:

1. *Establish spending growth targets*. $899,000 in fiscal year 2023 and $1,118,000 each year thereafter is for governance of a public/private health care spending target commission, establish 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. *Extend prescription drug price transparency*. $1,090,000 in fiscal year 2023 and $843,000 each year thereafter is to 2 extend prescription drug price transparency beyond manufacturers to include pharmacy benefit managers and wholesalers, thereby generating more complete information for monitoring spending and possible regulatory action.
3. *Analysis of cost drivers.* $106,000 in fiscal year 2023 and $281,000 each year thereafter to 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
4. *Assess community readiness.* $1,280,000 in fiscal year 2023 and $1,933,000 each year thereafter to 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:
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.

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 them, will move addressing spending growth (or health care inflation) into a more central position in the discussion of health care delivery system reform. New evidence on drug spending, and waste and inefficiency, emerging from 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 2023, with results from new data emerging in fiscal year 2024. Measurement of spending performance against targets would begin in fiscal year 2025.

Data from the enhanced prescription drug price initiative would be publicly available in fiscal year 2024.

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. Minnesota would develop a readiness

assessment and proposed plan that builds on other initiatives in the state, including the Medical Assistance IHP program.

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quality	Stakeholder engagement to establish spending targets: number of participants	0	20+	2022 7/2023
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%	2022 6/2025

Statutory Change(s):
None

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Assisted Living Licensure and Home Care

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
State Government Special Revenue Fund				
Expenditures	0	4,168	4,168	4,168
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	4,168	4,168	4,168
FTEs	**0**	**28.44**	**28.44**	**28.44**

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 if fiscal year 2023, the recommended increase in the assisted living licensure base is $1,792,000 and the increase in the home care base is $2,376,000.

Rationale/Background:

The legislature established assisted living licensure in the Laws of 2019. Now that licenses have been issued and the first year of the program is active, MDH has more accurate estimates of revenue based on the number of participating providers than prior to 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 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.

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. 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.

Beginning if fiscal year 2023, the recommended increase in the assisted living licensure base is $1,792,000 and the increase in the home care base is $2,376,000.

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.

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
Result	Meet statutory guidelines for number of home care inspection surveys per year	No	Yes	6/30/23

Statutory Change(s):

None

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Climate Resiliency

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	1,977	989	988
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	1,977	989	988
FTEs	**0**	**5**	**5**	**5**

Recommendation:

The governor recommends a general fund appropriation of $1,977,000 in fiscal year 2023 and $1,977,000 each year thereafter to guide public health resilience and participate in interagency efforts that support local communities. Activities include a combination of financial and technical assistance and data analysis to implement, strengthen, evaluate, and track public health resiliency efforts in the face of climate change across the state, with a focus on private and public water systems. Expenditures include $1,000,000 in grants in fiscal year 2023 and $100,000 in grants per fiscal year starting in fiscal year 2024 for organizations to plan for the health impacts of extreme weather events and develop adaptation actions. The recommendation 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 hazards, like extended drought, heavy precipitation, and flooding will adversely impact drinking water sources of all types. People dependent on private wells are particularly vulnerable; approximately 21% of the state's total population are served by a private well. Compared to public wells, private wells are not drilled as deeply, routinely tested, nor often adequately treated. Research by MDH has shown that by mid-century, 80% of Minnesota counties with over 20,000 flood-sensitive private wells will experience June extreme rainfall levels historically associated with disaster-level flooding. Counties (34 out of the 87 counties in MN) with very high vulnerability are located mainly in central and southern regions and will account for over 60% of the state's overall population growth by mid-century, underscoring the need to expand private well protections.

With the loss of CDC funding, MDH has had limited ability to contribute to the governor's Climate Change subcabinet and participate in climate related planning and events. Climate change is the greatest global health challenge of the 21st century because it threatens the very basic elements we depend upon for life, including safe and available drinking water, clean air, our food supply, and our health. The threats of climate change have touched Minnesotans through droughts destroying crops, wildfires making outdoor air unhealthy to breathe for everyone, and heat waves causing heat-related illnesses. From the health of our housing, to changes in our outdoor environment that influence diseases caused by parasites, to our mental health, there is nothing that climate change does not affect.

Proposal:

This interagency initiative, coordinated with the Minnesota Pollution Control Agency, Department of Nature Resources, and other state agencies, will increase the resilience of Minnesota and its communities to impacts, such as increasingly heavy precipitation, flooding, extreme heat, wildfire smoke, and invasive pests. This proposal supports the Governor's Executive Order 19-37 on climate change action. The funding would be used in part for grants to local communities to facilitate planning and response actions, technical assistance, data analysis, and evaluation.

MDH will initially provide grants to local public health, tribal health, soil and water conservation districts, or other local organizations for planning for the health impacts of extreme weather events and developing adaptation actions, with a focus on private water supplies and small rural water systems. Smaller, more rural water systems are also more vulnerable to the impacts of climate change, so this will also be considered in grant funding. MDH will also provide technical assistance, grant administration, outreach and communication and program oversight with this funding. MDH will support one position at the Minnesota Rural Water Association (MRWA) to assist with outreach to smaller rural systems to enhance their asset management framework to include an analysis of current infrastructure. This expansion of the asset management tool will identify and prioritize infrastructure modifications needed for adaptation. MDH will also track the health impacts of climate change through evaluating datasets, research projects, identify data gaps, and train and raise awareness by presenting at statewide venues on the public health impacts of climate change.

The recommendation supports MDH staff for GIS mapping and data analysis; grant administration, outreach, and communications; targeting and prioritizing public water supplies where drinking water infrastructure is most at risk to extreme weather and climate change threats; program evaluation, a new research and evaluation; and program leadership.

Impact on Children and Families:

Climate change impacts everyone economically, socially, and from a health perspective, but some people are more susceptible to climate change, particularly children. For example, children are more sensitive to heat stress and air pollution and drink a higher proportion of water per their body weight. Studies also show that the mental health of our youth is already being impacted by climate change.

Equity and Inclusion:

Climate change exacerbates existing economic and health inequities, so the impacts of climate change are disproportionately felt by those who are least able to adapt, making it a major health equity issue. Increased vulnerabilities to climate change include less resources to respond, stay safe, and recover from an extreme weather event and existing health disparities that are triggered or made worse by flooding, heavy precipitation, unhealthy air quality, heat, and other climate-related hazards.

Results:

MDH will provide up to 20 grants in fiscal year 2023 and two grants per fiscal year starting in 2024 to local public health, tribal health, soil and water conservation districts, or other local organizations for planning for the health impacts of extreme weather events and developing adaptation action plans, with a focus on private water supplies and small rural water systems. Plans will strengthen and make our water systems more resilient from environmental hazards to ensure safe water supplies. An evaluation of grantees work will be conducted to evaluate results.

Statutory Change(s):

None

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Community Healing

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	2,019	1,514	1,514
Revenues	0	0	0	0
American Rescue Plan Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	2,019	1,514	1,514
FTEs	**0**	**2.0**	**2.0**	**2.0**

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 recovery and healing for communities of focus who have been disproportionately impacted by COVID. Of the total amount in FY 2023 and in FY 2024, $1,190,000 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 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. Mental health and psycho-social-spiritual resilience education and skills-building can 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 recommendation 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

[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.

grants for mental health resources, post-COVID 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. Of the total amount in FY 2024 and each year thereafter $1,190,000 will be provided in grants to these communities.

For this recommendation, 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. Organizations and tribes will need to use culturally relevant, linguistically appropriate, and timely community engagement activities to meet the needs related to community healing; work with the state and its partners to address those community needs; and connect communities to trusted information and resources related to mental health and wellbeing support. MDH encourages applicants to use a trauma-informed lens to approach this work.

Per an article in the Greater Good Magazine by the University of California, Berkley, providing consistent opportunities for social and emotional learning for both parents and adults, improves listening, communication, and school connectedness among families. This grant will fund programs that are expected to grow compassion and pro-social behavior which are fundamental for social connection, civic and school engagement, and healthy family and work relationships.[2] These improve cognitive development, educational outcomes, employment success, and reduces both internalizing symptoms (self-injurious behaviors, suicide ideation) and externalizing behaviors (aggression, substance abuse).

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.

The recommendation will fund 2.0 FTE for the first two years– a 1.0 FTE grants specialists coordinator, a 0.5 FTE management analyst 2, and research analyst senior annually. The grant specialist will oversee the grantees and provide technical assistance and training where needed to meet the needs of the grant as outlined in grantee workplans. The management analyst would provide fiscal support to grantees to ensure proper spending and the research analyst would provide evaluation support to grantees to track individual and collective impact(s) of the programs implemented.

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 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

[2] Can We Build a Better Normal After the Pandemic? (berkeley.edu)

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.

Children and families, especially BIPOC, LGBTQ, and individuals with disabilities have experienced a pile-up of toxic stress during the COVID pandemic. The number of children dealing with hunger has doubled from 14%to 28%[3] and between 18-36%of children still have not returned to full-time school.[4] Depression, anxiety, loneliness, and suicide ideation are increasing. Fourteen percent of parents reported worsening behavioral health for their children between March and June 2020 per the National Association of Medicaid Directors. Based on a publicly available online depression screening through Mental Health American, an estimated 34%of the population in Minnesota were experiencing frequent suicidal ideation. In this report, Pennington County in Minnesota was noted as one of the counties with the highest percentage of suicidal ideation in the nation, with an estimated 58%of the population reporting frequent suicidal ideation.

Here are some additional data points:

- Before the pandemic, children from BIPOC and LGBTQ populations reported significantly lower rates of mental well-being than their white and straight peers.
- Youth who identify as LBGTQ reported dramatically lower rates of mental well-being than straight peers, including a 16%difference in reporting positive community relationships, 26%difference in positive identity, 18%difference in social competency, and 26%difference in empowerment.
- Only 39%of American Indian youth, 42%of Hispanic youth, and 48%of African American youth reported a positive identity compared to 52%of non-Hispanic White youth. This pattern follows for community relationships, empowerment, social integration, personal growth, peer, and family relationships.

Minnesota Adolescent Mental Well-Being (state.mn.us)

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 LPH and tribes, will make final selections of grantees/contractors 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.

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

[3] Children's food insecurity increasing during COVID-19 pandemic | News | Harvard T.H. Chan School of Public Health
[4] Monthly School Survey Dashboard (ed.gov)

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
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):
To be determined

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Community Health Workers

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	1,462	1,097	1,098
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	1,462	1,097	1,098
FTEs	**0**	**3.5**	**2.5**	**2.5**

Recommendation:

The governor recommends an investment from the general fund 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 Community Health Worker Alliance to promote the profession and their scope of practice and to conduct program evaluation and provide technical assistance.

Rationale/Background:

Community health workers (CHWs) are essential, public health workers and collectively, a health equity workforce. CHWs were at the frontlines of their communities during the pandemic, they represent the populations that were disproportionately impacted by COVID and are well-positioned to play a critical role in community well-being. 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.

Minnesota is challenged by some of the most severe health disparities in the nation. COVID-19 and the response to COVID-19 has certainly highlighted that American Indian, Black, and Latinx communities have poorer health outcomes than white communities and can benefit from culturally appropriate, community-driven solutions. Community Health Workers (CHWs) are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. As trusted liaisons between health and social services and the community, CHWs facilitate access to services, improve the quality and cultural competency of service delivery, and address the social conditions that impact health status, called social determinants of health (SDOH). A CHW also builds individual and community capacity by increasing health literacy and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy. 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. Further, 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 as CHWs educated individuals and communities about COVID-19, translated complex information into messages and formats that resonated with communities, and organized and supported testing and vaccination clinics in spaces with vulnerable populations.

CHWs continue to be on the frontlines addressing 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). In the early stages of the pandemic, CHWs were integral in providing necessities such as hand sanitizer and masks as well as organizing grocery and medication delivery and advising on living-space logistics when one family member was diagnosed with COVID-19. These needs remain in rural and underserved communities and with the emerging variants, questions about vaccines and lack of trust for vaccines in some communities, CHWs continue to be a critical workforce.

Minnesotans are positioned to benefit substantially from this community-based workforce. Minnesota has been a frontrunner in supportive CHW structures 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, even though reimbursable services are limited according to Minnesota Statute 256B.0625, Subdivision 49 to care coordination and patient education services provided by a CHW if the CHW has received a certificate from the Minnesota State Colleges and Universities System-approved community health worker curriculum. Minnesota is fortunate to have the CHW Alliance, a statewide, health equity nonprofit that acts as a convener, catalyst, and expert in CHW strategies. Further, there are multiple existing programs that aim to connect CHWs to communities through a variety of referral structures.

However, while the framework exists to have a strong and vibrant CHW workforce that reaches communities that experience disproportionately poorer health outcomes, many barriers exist to CHWs serving to their full potential and full community reach such as limited access to training and certification; lack of awareness of agencies, organizations, and businesses that could greatly support and benefit from CHW services; and restrictive reimbursement protocols.

Proposal:

This recommendation will expand the existing CHW initiatives, promote the CHW profession, and support data collection and evaluation to track and analyze the impact of CHWs on the health and well-being of Minnesotans. This will be accomplished by:

1) **Funding for the CHW Alliance to:**
    a. **Develop Capacity for CHWs to Address Health Disparities including COVID-19 and Social Determinants of Health in Minnesota:** Initiatives include expanding the Alliance's role as a clearinghouse and center of excellence for CHW tools, best practices, guidelines, and materials and strengthening partnerships with schools offering the CHW certificate program to increase the number of CHW certificate holders with eligibility for reimbursement.
    b. **Establish a CHW Awareness Campaign:** Initiatives include developing a broad communications plan with key messages to (1) build understanding of the CHW capabilities for critical audiences and potential CHW employers and (2) strengthen connections with decision-makers at DHS and health plans; Design and launch a public education campaign including outreach by CHW leaders to the cultural and ethnic media serving communities.
    c. **Increase Organizational Readiness of Employers:** Initiatives include: expand partnerships with employers to build awareness of the CHW profession and create CHW positions within health, social services, public safety, schools, family home visiting programs, food processing, factories, childcare and elder programs which offer case management and other services for low income seniors; provide technical assistance to employers on organizational readiness to employ CHWs who bring a health equity lens and a cultural change to traditional places of employment.

2) **Funding for program evaluation and technical assistance:**
    a. **Explore the National Landscape** Initiatives include: Research through literature reviews (both peer-reviewed and gray literature sources) and national networking to explore the structure, cost, challenges, and impact of existing CHW models;
    b. **Explore the Minnesota Landscape** Initiatives include: Conduct an environmental scan to assess and understand the CHW models that exist in Minnesota;

c. **Rigorously Evaluate the Existing CHW Models in Minnesota** Initiatives include: track quantitative indicators of success and/or health improvement in areas served by CHWs; explore qualitatively the community relationships and clinical relationships between clients and CHWs; analyze the impact of current CHW models in regard to the costs, benefits, and challenges of the existing models in different geographic and demographic areas;
d. **Create a Sustainable Plan for CHW Infrastructure** Initiatives include: based on analysis, propose a statewide, sustainable infrastructure plan that supports the varied needs of diverse communities in Minnesota with the best-fitting CHW model.

MDH staff needed for implementation include: State Program Administrator Principal (1.0 FTE); State Program Administrator Intermediate (1.0 FTE); a Research Analysis Specialist Senior (1.0 FTE); and Management Analyst 1 (0.5 FTE). This team of staff will conduct the evaluation and reporting initiatives as well as assist with grant management, fiscal oversight and accountability, and overall project management. For FY24 and ongoing, administration will be reduced by 1.0 FTE.

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. CHWs become family advisors and connectors – even when a CHW's prescribed focus may be on an elder, they address questions and provide referrals and resources for the grandchildren as well.

Equity and Inclusion:

Good health is not shared equally by all people and communities across Minnesota. American Indian, Black, and lower income populations have disproportionately higher rates of poor health outcomes (COVID-19 diagnosis and death, overdose, suicide, homicide, sexual violence, car crashes, house fires, and more). The CHW initiative will help to address these 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 support equitable access to health care and information. 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.

Results:

The impact of improving and supporting the CHW infrastructure in MN will be evaluated in several ways.

Type of Measure	***Name of Measure***	***Current***	***Future***	***Dates***
Quantity	Number of CHW certificate holders	300	450	FY2020 FY 2025
Quantity	Number reached with communications messaging	No known baseline	1,000,000 Minnesotans	FY 2025
Quality	CHW models nationwide	N/A	Types of models in the nation	FY 2025

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quality	CHW models in MN	N/A	Descriptive measure of extant models	FY 2025
Results	Cost analysis per model	N/A	ROI should be publishable	FY 2025
Results	Geographic reach of CHWs	No known baseline	Map of state coverage will be produced	FY 2025
Results	Number served (individuals and communities)	No known baseline	Built into the map or dashboard	FY 2025
Results	Field of CHW placement/employment	No known baseline	Reported via dashboard	FY 2025

Statutory Change(s):
New statute

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Community Solutions

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	10,000	10,000	10,000
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	10,000	10,000	10,000
FTEs	**0**	**5.75**	**5.75**	**5.75**

Recommendation:

The governor recommends a general fund appropriation for the continued support of the Community Solutions for Healthy Child Development Grants. This recommendation 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, $8,750,000 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.

Creation of 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 & 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 year 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:

This recommendation seeks to expand and strengthen the Community Solutions program that was previously established in 2020. A competitive grant process will be conducted to award an estimated 50 grant awards 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. Grantees will be:

- 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.

Fiscal components of the expansion of the Community Solutions Equity Grants portion of the recommendation include:

- 5.75 FTEs including grants specialist senior, planner intermediate, management analyst 2, and research analyst senior positions beginning in FY 2023 and ongoing. The grant specialists will oversee the grantees and provide technical assistance and training where needed to meet the needs of the grant as outlined in the grantee workplans. The planners will provide community engagement and grant management support for 50 new grantees. The management analyst will provide fiscal support to grantees to ensure proper spending and the research analyst will provide evaluation support to grantees to track individual and collective impacts of the programs implemented.
- Grant funding for 50 community-based organizations that have historically served African American, Asian Pacific, Latino, and or American Indian communities
    - Total Community Solutions grant funding is $8,750,000 beginning in FY 2023 and continuing into FY 2024 and 2025 and ongoing.

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 –

[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

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 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:

In Minnesota, children of color and American Indian children, 18 and under, are currently over 30 percent of the population. American Indian and children of color have fewer opportunities to succeed in school and this starts with access to early childhood opportunities. Minnesota is home to roughly 423,100 children under the age of six of which about 30 percent are children of color or American Indian children. Of the 30 percent, 69 percent 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. 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. 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.

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:

- a better alignment across public agencies
- the flexibility to acknowledge and accommodate cultural differences
- 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.

Results:

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quantity	Geographic regions reached by grantees	4	8	2023-25
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	2023 -25
Quality	Number of implemented strategies	23+	46	2023-25

Statutory Change(s):

To be determined

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Disability as a Health Equity Issue

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	1,575	1,585	1,585
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	1,575	1,585	1,585
FTEs	**0**	**8.0**	**8.0**	**8.0**

Recommendation:

The governor recommends funding to reduce health disparities among people with disabilities. These funds will support a comprehensive cross-agency, cross-sector approach to reduce disability related health disparities; create a health surveillance plan and implementation of community needs assessment; and provide community grants that support the establishment of inclusive evidence-based chronic disease prevention and management services to address identified gaps and disparities.

Rationale/Background:

In Minnesota, over one in five, or roughly 960,000 adults identify as having a disability per 2019 data from the Behavioral Risk Factor Surveillance System (BRFSS). Additionally, per the National Survey of Children's Health in 2019, an estimated 222,000 children and youth in Minnesota (approximately 17.2%of children 0-17 years old) have a disability or a special health need. According to a case study done by The Commonwealth Fund, people with disabilities experience more difficulty accessing care, have higher emergency department utilization, and have higher rates of hospitalization compared to people without disabilities. The BRFSS also revealed that adults with disabilities are also more likely to be inactive, have hypertension, smoke, and have obesity, putting them at increased risk for adverse health outcomes.

Access to preventive health care and health promotion services is limited for people with disabilities. The COVID-19 pandemic has exacerbated disparities that people with disabilities face in accessing health care and health information per an article by the Johns Hopkins Bloomberg School of Public Health. The department previously was given funding by the Centers for Disease Control and Prevention (CDC) for five years to work on improving the health of people with mobility limitations and disabilities, however this federal funding is no longer available to Minnesota. Previous resources allowed the department the opportunity to adapt the National Diabetes Prevention Program to address the barriers that people with disabilities experience in healthcare access.
The COVID-19 pandemic resulted in major disruptions and challenges to the lives of persons with disabilities in areas such as transportation, technology, education, medical care, caregiver support and stress, mental health, accessibility to essential services, supports, testing and vaccinations, masking, housing, employment, and basic rights. The disabilities team, which was created during the pandemic response within the MDH COVID-19 incident command system, worked diligently to bring forward the needs of the community and create change where possible.

Proposal:

This recommendation will build on the momentum of the disabilities team to expand and nurture the relationships, collaborations, and infrastructure (both internally and externally) that have been created during the pandemic response to address the needs of people with disabilities. The goal is to reduce health disparities and improve the health of Minnesotans with disabilities by increasing availability and connection to accessible and appropriate preventive health care and evidence-based health promotion interventions and services across the state. This funding will allow MDH to address disability in three different ways.

First, MDH will invest in creating internal infrastructure through collaborative initiatives focused on integrating a disability equity lens across the agency through cross-agency work groups and community and agency-wide trainings to strengthen existing work and build connection across the agency. MDH will establish a community advisory committee comprised of community members and community stakeholders, including people with disabilities, trusted community organizations, and other stakeholders to guide overall efforts to reduce health disparities. The advisory committee will aim to increase availability and access to inclusive preventive health care service and evidence-based health promotion programs with the goal of reducing health disparities and improving the health of the disability community. The committee will build on the current Disability Advisory Committee that was created to address the needs of the disability community during the pandemic. The Minnesota Department of Human Services (DHS) will serve as a key partner in connecting the community with health needs through the Disability Hub MN (HUB), a statewide resource network that provides a wide variety of resources and guidance to people with disabilities. The HUB in not currently offering many resources around health and preventative healthcare access other than COVID-19 specific needs. This funding would allow the HUB to broaden their resources and trainings to include healthcare navigation in the first year. The Minnesota Olmstead Plan was created in 2015 to ensure that all people with disabilities in Minnesota have equal access to live full lives. An executive order by the governor in 2020 added that the Olmstead Subcabinet will engage communities with the greatest disparities in health outcomes for individuals with disabilities and work to identify and address barriers to equitable health outcomes. This plan as well as the 2020 Maternal and Child Health Needs Assessment and the department's work in creating inclusive chronic disease prevention programs will all continue to help inform the work moving forward.

Secondly, the need for community needs assessment data collection and health surveillance plan to inform and support efforts to eliminate health disparities associated with disabilities will be a key strategy; investment in data collection, collaboration, and evaluation of systems of care across the lifespan (infancy through adulthood) will inform and support efforts. Dedicated staff focused on continuous internal systems improvement and engagement with data-driven community-based activities to identify and address health care and preventive program needs is critical to reducing costs and improving health outcomes. Intentional community engagement as well as creating an internal system across the agency for a shared decision-making model to address disability efforts and data collection will play a large role in the success of this work. Collaborating across agencies, particularly with the Olmstead Implementation Office (OIO), to ensure agencies are collecting data needed to identify and address disparities, will strengthen the capacity for MDH to do this work.

Thirdly, MDH will establish systems to increase access to health care and fund data-driven, community-based activities to identify and address health care and preventive program needs among people with disabilities. MDH will offer community-based grants to support inclusive evidence-based chronic disease prevention and management services to address the identified gaps and disparities and implement policy, systems, and environmental changes to support sustainable inclusive practices in health care systems and community programs and initiatives. MDH has a strong partnership with DHS, allowing for collaboration to address the health disparities in the disability community.

Impact on Children and Families:

Although the likelihood of acquiring a disability tends to increase with age, approximately 2,000 children in Minnesota are born each year with a birth defect. One out of six children (149,000 ages zero to 21) receive special education services in Minnesota. One in five children (ages zero to 17) have a reported mental, emotional,

developmental, or behavioral challenge. This recommendation builds upon the department's programs and initiatives working to improve systems of care for children and youth with special health needs and their families.

Equity and Inclusion:

The proposed work for this funding will address the health inequities that have been exacerbated by the pandemic to the disability community. Disabilities affect community members from all racial and ethnic groups in Minnesota, yet the social and economic effects of living with a disability are not experienced equally across groups. According to a peer review in the *Research in Developmental Disabilities* journal, black, Indigenous, and other non-white individuals with disabilities face a double burden which appears to occur at the intersection of race/ethnicity and disability, whereby members of racial and ethnic minority groups who have a disability face greater health disparities and inequalities than do their peers without a disability. In Minnesota, disability disproportionately impacts Native Americans, African Americans, and older adults (age>65).

In the implementation of the work proposed, MDH will engage with people with disabilities from various communities, racial identities, ages, and locations (metro and greater Minnesota). MDH will also engage with health care agencies and community organizations that have immense experience and have built trust with the different communities most impacted. Multi-stakeholder engagement will inform how the work proposed will be implemented in ways that center people with disabilities and their families and ultimately address health needs in the various communities. The potential impact of this work is that MDH will be better equipped to work with people with disabilities among diverse communities across Minnesota in addressing the gaps in health outcomes and health care services.

Results:

MDH will implement mixed methodology to evaluate the approach, effectiveness, and impact of this multi-faceted project. The mixed methods evaluation approach will include but is not limited to: surveys, focus groups, and interviews with different stakeholders, such as MDH staff, partners organizations, and people with disabilities. MDH will build a more thorough evaluation and performance measure plan within the first six months with input from internal and external partners and will create additional alignment with the Healthy People 2030 objectives.

Type of Measure	***Measure Names***	***Current***	***Future***	***Dates***
Quantity	a. Number of trainings provided on disability inclusion within MDH and within work involving MDH	a. 2 trainings provided in 2020-2021	a. 4 trainings per year	FY 2021-2027
	b. Number of protocols/guidance document created for disability equity framework implementation	b. 2 guidance documents created in 2020-2021	b. Minimum of 3 guidance documents created for disability equity integration within MDH	
	c. Number of community-based organizations and external entities recruited and participating in partnership with MDH	c. 15 stakeholders engaged through ICS disability team and HPCD's prior work	c. Total of 30 stakeholders engaged through this work	

Quality	d. Increased collaboration with other relevant state agencies, healthcare agencies, and community organizations e. Increased engagement within MDH with people with disabilities to inform strategies and implementation process f. Established health surveillance plan with support from stakeholders g. Develop and conduct needs assessment h. Increased capacity within MDH and other partners through training and capacity building activities (including department wide framework in incorporating disability in health equity work) i. Increased access to inclusive healthcare and preventative services for chronic diseases though data-driven strategies	d-e. MDH will collect baseline data on this when the work starts. We will work with partners to create measurable goals f. No health surveillance plan currently exists g. No assessment conducted h. Roughly around 200 MDH staff have completed training on disability equity i. MDH will work with partners to determine baseline for this measure	d-e: Additional aligned efforts across MDH divisions, DHS, healthcare systems, and community organizations f. Established health surveillance g. Conduct needs assessment and create a summary report h. 25% of MDH staff trained on disability equity frameworks. MDH will engage with external partners to measure reach and impact of trainings i. Minimum of 2,000 people with disabilities reached through inclusive health care services	FY 2022 -2027
Results	i. Increase number of people with disabilities connected to <u>inclusive, preventive</u> healthcare services and chronic disease prevention programs j. Reduce disparities in health outcomes for people with PWD	i. In 2019 the Hub served almost 29,000 unique individuals j. MDH will collect baseline data based on health outcomes of interest for this project	i. Increase by at least 5,000 people with disabilities are connected to <u>inclusive, preventive</u> services through the Disability Hub j. MDH will consult with partners to identify health outcomes to measure	FY2022 - 2027

	k. Reduce disability-associated healthcare costs in Minnesota	k. 34% of MN's health care spending	k. MDH will consult with appropriate staff to determine goal	

Statutory Change(s):
None

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Drinking Water and Wastewater Advisory Council

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
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 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:

1. Identify and address stakeholder concerns in the water supply system and wastewater treatment facility classification, operation, and certification arenas.
2. Support the communities of Minnesota that rely on the water and wastewater treatment industries and competent professionals to keep them safe and healthy.
3. 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 general public (one being a representative of academia), and metro and outstate representation.

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	6/year	FY 2022 FY 2023

Statutory Change(s):

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

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Drug Overdose and Substance Abuse Prevention

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	5,042	5,042	5,042
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	5,042	5,042	5,042
FTEs	**0**	**4.0**	**4.0**	**4.0**

Recommendation:

The governor recommends an investment from the general fund for comprehensive funding to address the drug overdose epidemic by implementing three strategies: regional multidisciplinary overdose prevention teams to implement overdose prevention in local communities and local public health, enhance supportive services for the homeless who are at-risk of overdose by providing emergency and short-term housing subsidies through the Homeless Overdose Prevention Hub, and enhance employer resources to promote health and well-being of employees through the Recovery Friendly Workplace initiative. Of the total amount, $4,121,000 will be given outannually in grants and contracts to implement the strategies.

Rationale/Background:

Drug overdose deaths increased 27% from 2019 to 2020 (792 to 1,012 deaths) in Minnesota. African American Minnesotans are two times more likely to die of a drug overdose than white Minnesotans and American Indian Minnesotans are seven times more likely to die of a drug overdose than white Minnesotans. The highest drug overdose rates have moved to younger age groups. Other differences persist by gender and geography (urban, rural). In 2020, for every overdose death, there were 14 nonfatal overdoses treated in the hospital. This means that over 14,000 Minnesotans experienced a nonfatal overdose. In 2020, American Indian Minnesotans were nine times more likely and Black Minnesotans were three times more likely to experience a nonfatal overdose of unintentional or undetermined intent than white Minnesotans. All of this points to the need for 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 three strategies, regional multidisciplinary overdose prevention teams, Homeless Overdose Prevention Hub, Recovery Friendly Workplace, proposed are innovative, not currently funded by other sources, and would be synergistic in outcomes.

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

Proposal:

Strategy 1: Regional multidisciplinary overdose prevention teams consist of public health, public safety, health care, behavioral health, and education professionals working together to address the overdose crisis at the community level. Eight geographic regions in Minnesota (modeled after the EMS [emergency medical services] or local public health regions) will plan and implement drug overdose prevention projects. These teams will help

local communities identify priorities based on 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 potential settlement funds and achieve collective impact. MDH will provide community grants ($125,000 per region) to these priority communities to work as a coalition to implement overdose prevention strategies (i.e., school based - Kognito Friend2Friend substance use module social emotional learning in school; community based improving health equity – job training and housing; and harm reduction or diversion).

Strategy 2: Homeless Overdose Prevention Hub will enhance housing and supportive services for the homeless who are at-risk of overdose by providing emergency and short-term housing subsidies, and then access to mental health and substance abuse counseling and treatment, accompanied by job skills, mentoring, and other support services identified as we seek to turn the curve of the overdose epidemic. The goal of the Hub is to provide unsheltered, homeless persons who are at serious risk of overdose and infectious disease with a community space in which multiple service providers are able to provide 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 unsheltered are often most at risk. Community partners and organizations with robust street outreach teams and harm reduction services will collaborate on providing enhanced services to unsheltered persons. A primary objective is to provide access to transitional housing with low threshold requirements for people who experience chronic 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.

The second part of this strategy will fund (at $300,000 per year) the Resource Hub in South Minneapolis developed, tested, and implemented by the Native American Community Clinic. The Resource Hub provides connection and resources to those who are experiencing homelessness and living with OUD in the American Indian community in Minneapolis. The Resource Hub, using a whole health model, provides (1) housing and other social services; (2) linkage to medical, mental health and dental services through onsite nurse 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. The Community HUB Model was developed by Agency for Healthcare Research and Quality and has been used to connect at-risk individuals to health and social services and improve their health outcomes. Recently community resource hub for people to access fragmented service systems has been used by Minnesota Department of Education.

Strategy 3: Expand the MDH Minnesota Business Partnership Employer ToolKit to develop a recovery friendly workplace. MDH will build on the MDH Minnesota Business Partnership Employer Toolkit to more fully engage Minnesota businesses in battling the Opioid Epidemic and reducing the harms of substance abuse by working with Minnesota's current network of 13 Recovery Community Organizations throughout the state to develop a Minnesota version of a statewide Recovery Friendly Workplace program that has 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, we 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.

This employer toolkit will promote individual wellness by creating work environments that further mental and physical well-being of employees. The Recovery Friendly Workplace Initiative 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. This intervention will (1) train employers in evidence-based practices that demonstrably reduce substance misuse in the workplace ($321,000 grant to Minnesota Safety Council); (2) 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 (13 grants of $100,000 each [total $1,300,000] to the Recovery Community Organizations); (3) 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 ($350,000 for media buys and content development); and (4) 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 ($500,000 to local public health).

Four MDH staff will be required to support these strategies. They include one state program admin principal as content specialist for the strategies; one management analyst 1 for request for proposals, grant, contract, and invoice expertise; one communications specialist (planner senior) to focus on part 3 of Strategy 3; and one program evaluator for the three strategies (research analysis specialist senior).

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*. These strategies will reduce risk of overdose death, increase family stability and economic opportunities, reduce HIV risk behaviors, improve public order, and will help participants seek treatment for their substance abuse.

Equity and Inclusion:

American Indian and Black Minnesotans have disproportionately high rates of fatal and nonfatal overdoses. Disparities also exist by geography, income, and education level. The three 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, 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.

Results:

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quality	Implementation of evidence-based local overdose prevention policies and programs	No baseline established	10	12/31/2024
Results	Overdose deaths and rate per 100,000 population	1,012 deaths and 17.7 per 100,000 population	800 deaths and 14 per 100,000 population	December 2020; 12/31/2024
Results	Nonfatal overdoses and rate per 100,000	14,475 nonfatal overdoses and	11,000 and 192.8 per	December 2020;

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
		254/100,000 population	100,000 population	12/31/2024

Statutory Change(s):
New statute

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Engineering Plan Review Fees

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
State Government Special Revenue Fund				
Expenditures	0	0	0	0
Revenues	0	170	170	170
Net Fiscal Impact = (Expenditures – Revenues)	0	(170)	(170)	(170)
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The governor recommends increasing engineering plan review fees by 50% for nursing homes, hospitals, and other health care facility types to align with current costs and workload complexity. Fees increases range from a low of $15 for construction costs between $0 to $10,000 to a high of $2,400 for construction costs over $1.5 million. The complexity and number of plan review requests are increasing with the expansion and modernization of nursing homes and hospitals. Fees have not been increased in over a decade while plan designs have become more complex. Plan review fees vary based on the expected cost of the construction project; plan review fees in the lowest tiers do not even cover the staff time required to read the technical documents submitted as part of an emailed request and prepare the documents for review.

Rationale/Background:

The department is required to conduct engineering reviews for construction of new spaces in regulated health care facilities and for modifications to existing spaces. Based on time studies, actual expenses for the engineering plan review are $550,000 per year, while revenue collected is only $380,000. The current shortfall in the engineering budget must be covered with other resources. The complexity and number of plan review requests are increasing with the expansion and modernization of nursing homes and hospitals. Fees have not been increased in over a decade while plan designs have become more complex. Plan review fees vary based on the expected cost of the construction project; plan review fees in the lowest tiers do not even cover the staff time required to read the technical documents submitted as part of an emailed request and prepare the documents for review.

Proposal:

This proposal would enact a 50% increase across all categories of engineering plan review fees to cover current expenses and close the shortfall. Adjusting plan review fees will right-size the fee to the increasing complexity, volume, faster timelines of nursing home and hospital construction projects, and reflect the actual time required by professional engineering staff to review plans.

Impact on Children and Families:

Ensuring regulated facilities meet appropriate engineering standards helps protect Minnesotans in those facilities as well as those who love them.

Equity and Inclusion:

Equitable review of engineering plans will help create quality standards for all regulated facilities.

Results:

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quantity	Number of engineering plans reviewed per year	189	202	6/30/2023
Results	Engineering fee revenue sufficiently supports cost of work	No	Yes	6/30/2023

Statutory Change(s):

Minnesota Statutes, section 144.554

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Family Planning Special Projects

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	3,467	3,467	3,467
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	3,467	3,467	3,467
FTEs	**0**	**1.5**	**1.5**	**1.5**

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. These funds are essential to support continued statewide access to culturally appropriate, evidenced based family planning counseling and education, contraception services, preconception care, 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 U.S. reduce the incidence and impact of preterm and low birth rates, STIs, infertility, and cervical cancer. According to a peer-reviewed study by the Milkbank Quarterly, a multidisclipinary journal of population health and health policy, this investment saves the government billions of public dollars, equivalent to an estimated tax payer savings of $7.09 for every public dollar spent.

Family planning clinics, and the patients they serve, have been deeply impacted by COVID-19. Patients have deferred care, which decreased clinic revenues initially and will increase service demands in the long-run. Family planning clinics are on the front lines for COVID-19 education and testing and access to vaccines by providing accurate information and services to clients related to COVID-19. These clinics, embedded in their communities, are trusted resources that share culturally relevant information about vaccines from the Centers for Disease Control and Prevention.

In addition, many clinics have lost sources of funding due to changes to the federal Title X family planning program, which also supports pre-pregnancy and family planning services. The loss of $2,684,000 in Title X funding in Minnesota, impacts 53,569 patients who relied on Title X funded clinics in 31 locations across Minnesota. Eighty-three percent of these patients are at or below 250% of the federal poverty level.

COVID-19 exacerbated a concerning increase in STI rates in Minnesota, and in 2020, the rates of STIs reached near historic highs (33,252 cases). Many of these cases are among adolescents and young adults and one out of every three cases of chlamydia occurred in Greater Minnesota. Clinics faced supply shortages because COVID tests and STI tests require some of the same testing supplies. 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 state fiscal year in grants to clinics, 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 govern FPSP. Funding is distributed through a regional formula with a separate competitive awards process within each of eight regions. Cities, counties, tribal governments, 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 to un-emancipated minors in a school building.

Proposal:

This recommendation builds upon the current FPSP program and increases the funding for the FPSP grants to mitigate the service impacts of COVID-19 and meet the current needs of Minnesotans using state general funds. This additional funding would help to address the needs created by delayed care as a result of the COVID-19 pandemic and also to replace the loss of the Title X federal funds that many of the FPSP grantees previously received and relied upon to deliver services. MDH will distribute $3,160,000 in FY2023 and ongoing to current FPSP grantees according to the established Minnesota Rule 4700.2420, subpart 4C.

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 needs of many clients' delayed services due to COVID-19. In order to issue these grants, it requires funding for a 1.0 FTE grants specialist senior to execute award modifications, monitor grantee performance and spending, and compliance with grant requirements and state and federal regulations and a 0.5 Management Analyst 1 to handle invoice processing.

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. With the risk to pregnant people and infants due to a COVID-19 infection, planning a pregnancy allows for the family to have those close to them get vaccinated to reduce the risk of an adverse outcome related to COVID-19. 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 have 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 racial and ethnic populations 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, race, ethnicity, age, disabilities, 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 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 include rural Minnesotans, LGBTQ people, low income people, young adults, and Black, Indigenous and other communities of color. FPSP is governed by Statute and Rule which ensures that all family planning decisions are voluntary, noncoercive, offers a full range of options, with all decisions guided by the client. In SFY 2020, 53% of FPSP beneficiaries had incomes below 100% of the federal poverty guidelines, and 79% were below 200%. Eighty-six percent of FPSP beneficiaries who received a contraceptive method were 18 or older, with 61.3% between ages 18 and 29.

Results:
FPSP incorporates several strategies with strong existing evidence that will improve outcomes for Minnesotans. Long-acting reversible contraceptive methods are provided through FPSP grantees, and in 2020, 19% of FPSP clients voluntary selected one of these highly effective methods. Evidence suggests this strategy will result in increased used of contraception, reduced teen pregnancies, and reduced unintended pregnancies per the University of Wisconsin Population Health Institute. Reproductive life plans 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.

Type of Measure	***Name of Measure***	***Current***	***Future***	***Dates***
Quality	# of FPSP clients accessing counseled on reproductive life planning and contraceptive options (per state fiscal year)	25,604	44,864	FY 2020SFY 2025
Quantity	# of FPSP clients of childbearing age accessing who obtained a family planning method of their choice (per state fiscal year)	20,494	31,000	FY 2020-FY 2025
Results	Statewide cases of chlamydia decrease per state fiscal year	2,603	2,000	FY 2020-FY 2025

Statutory Change(s):
None

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Health Care Provider Directory

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	1,000	2,000	7,000
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	1,000	2,000	7,000
FTEs	**0**	**5.6**	**6.6**	**6.6**

Recommendation:

The governor recommends a general fund appropriation to develop, manage, and maintain a statewide shared heath care provider directory. This directory will be available to consumers, multiple state agencies (e.g., MDH, DHS, SEGIP, MNsure), as well as health plans and health systems serving Minnesotans. This will build upon the provider directory under development at DHS, will comply with federal and state rules and laws, and will create a single "source of truth" for health plans, providers, and consumers to identify health providers available to them based on their insurance coverage. It will also provide state agencies with a tool to manage compliance with the new federal No Surprises Act, monitor network adequacy and provider coverage across state-run programs for regulatory purposes, and monitor trends in provider contracting, type, network configurations and access over time.

Rationale/Background:

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. The new federal No Surprises Act requires every health plan and health provider to maintain a consumer-facing provider directory, and without a shared common directory, consumers will need to potentially navigate multiple directories to find the information they need.

Proposal:

This proposal includes three phases of development and implementation, as well as ongoing maintenance of the directory. In fiscal year 2023, the department will engage stakeholders to identify requirements for usability, information technology, decision-making processes, and operations. In fiscal year 2024 this work will progress to developing an implementation and sustainability plan. Technical development of the directory and consumer portal will begin in fiscal year 2025.

A shared statewide provider directory will greatly reduce redundant efforts currently in place with each health plan, health system, and state programs maintaining their own directories, resulting in more up-to-date, accurate

information and lower administrative costs for everyone involved. It will also be a transformational tool for consumers to help identify their provider options and avoid out-of-network fees by understanding which providers participate with their coverage.

This directory will have many stakeholders; as such, time is budgeted to ensure that all parties are thoroughly engaged and technical specifications align with each other and with emerging federal rules and regulations. The development process will identify and assess policy, operational, legal/regulatory and information technology requirements for the directory.

Impact on Children and Families:

This 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 participate with their coverage.

Equity and Inclusion:

This directory will 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.

Results:

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quality	Accuracy and comprehensiveness of provider information	Unknown	95% or greater accuracy	FY 2022 FY 2025
Quantity	Number/percent of providers registered	~90%	100%	FY 2022 FY 2025-26
Quantity	Number of consumers accessing the directory	Medicaid enrollees	All Minnesotans	FY 2022 FY 2026
Results	Number/percent of health plans participating with the directory	1 (DHS)	15 plans and growing	FY 2022 FY 2025-26

Statutory Change(s):

New statute

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Healthy Beginnings, Healthy Families

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	11,700	11,818	11,763
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	11,700	11,818	11,763
FTEs	**0**	**13.75**	**15.5**	**15.5**

Recommendation:

The governor recommends a general fund investment to address the significant disparities in early childhood outcomes and increase the number of children who are school ready through: establishing the Minnesota Collaborative to Prevent Infant Mortality; sustaining Help Me Connect; improving and increasing the reach of developmental and social-emotional screening and follow up/connection to services; and sustaining and expanding the Jail Model Practices Learning Community in Minnesota jails.

Rationale/Background:

The early years of a child's life are incredibly significant for later health and development. The brain grows quickly starting before birth and continues well into early childhood. Brain development depends on proper nutrition starting in pregnancy, environmental factors, and care that is nurturing and responsive to their needs. Parents and caregivers need support and the right resources in order to nurture their child's body and mind. Appropriate care for children, starting before birth and continuing through childhood, assures that the child's brain grows well and reaches its full potential.

Minnesota is home to roughly 423,100 children under the age of six of which about 30% 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.

Every family should have an equal opportunity to interact with a high-quality early childhood system that promotes healthy brain development, and assures the social, emotional, cognitive, and physical development and well-being of their children. Unfortunately, not all families have the same access to comprehensive early

[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

childhood services, the result of deeply entrenched systemic barriers, historical and current day discrimination and racism, and issues with quality and availability of services.

Preliminary data from Minnesota Vital Records, 2011-2019, shows African American/Black pregnant people and American Indian pregnant people die during pregnancy, delivery, or the year post-delivery at rates 1.8 times and 9.1 times higher respectively than non-Hispanic White people. American Indian pregnant people experience the lowest rates of prenatal care and the highest rates of giving birth prematurely to a baby with low birthweight in Minnesota. 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. Babies born before 37 weeks represent just under 10% of all births in Minnesota, but prematurity remains one of the top causes of infant mortality, representing 25% of all infant deaths. Persistent racial and ethnic inequalities contribute to the overall rates of premature birth. In 2018, Native American (14%) and Black (10%) women have higher rates of giving birth prematurely than white women (9%). In addition, approximately 1 in 10 women in Minnesota self-report experiencing postpartum depression. Providing postpartum support and care is crucial to ensuring the health of mothers and their babies. From 2016-2017, only 70% of Black children received one or more preventive healthcare visits. The rates for families who are uninsured are even lower, at 43% of children receiving one or more preventive visits during that period. Over the past 2 years, these rates have declined as families delay routine health care out of fear of contracting COVID-19 if they visit their health care provider. In Minnesota, 8.5% of children with special health needs did not receive needed health care compared to just 1% of those without special health care needs.

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. Developmental and social emotional screening is one tool to identify children early in life to assure school readiness. In Minnesota, developmental and social-emotional screening occurs in a variety of settings, which can lead to duplication of efforts and/or children not screened at all. According to the 2018/2019 National Survey for Children's Health, 57.5% of children in Minnesota ages 9-35 months received a developmental screening using a parent-completed screening tool in the past 12 months, compared to 36.4% of children in that age range nationwide. According to a report from Wilder Research an estimated 15% to 17% of Minnesota children under age six have developmental disabilities. However, only 4% of all children under age five were served by early intervention and early childhood special education services. Although a wide array of services is available to families of children and youth with developmental delays, families still experience many barriers when it comes to accessing services – particularly families from more diverse and rural communities. Minnesota has faced several obstacles to 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. Screening, prevention, or early intervention are important investments for long term outcomes. The return on investment is highest in the early years of life.

Children with incarcerated parents are at elevated risk for mental health problems and suicide attempts, substance abuse, and poor academic outcomes. 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. These adverse outcomes are due, at least in part, to the disruption in the parent-child relationship when a parent is incarcerated. There are systemic 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. Frequently, rural jails are challenged, having fewer available community and transportation to refer families to. And, compared to prisons, most jails have more restrictive visiting environments that were not designed with children in mind.

Proposal:

This recommendation creates a comprehensive, collaborative, multi-sector approach to address the myriad of factors that contribute to poor outcomes and the disparities that exist within Black, American Indian, non-white communities of color, and rural communities in Minnesota. A 1.0 FTE staff is needed to provide health leadership to this area for all the following components.

Minnesota Collaborative to Prevent Infant Mortality

MDH will establish a Minnesota Collaborative 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 Collaborative's activities will include community engagement, exchange of best practices, data management and advocacy. Success will be defined by the important infant health outcomes, driving infant mortality reduction, including extreme preterm birth, sleep-related infant death, and congenital malformations. Alongside the Collaborative, MDH will administer 31 infant mortality reduction catalyst grants to community organizations, Tribes and local public health entities who create data-driven roadmaps to improve maternal and infant outcomes among Black, American Indian and communities of color in Minnesota. These competitive grants will support multisectoral and upstream approaches, including social and environmental determinants of health. A Grants Specialist will provide planning, management and implementation of the grants to local agencies and a Management Analyst 1 will provide financial and administrative analysis and support for the grants. 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 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.

Fiscal components of the Minnesota Collaborative to Prevent Infant Mortality portion of the recommendation includes:

- 5.5 FTEs for staffing, including 1 Health Program Rep Principal as supervisor, 1 State Planning Director and 1 Tribal Liaison State Planning Director, 1 Epidemiologist Sr., 1 Grants Specialist, and 0.5 Management Analyst 1. These staff hold responsibility for coordinating the efforts of the Collaborative, 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 Collaborative and provide support to participants; convene an annual state perinatal health summit; provide technical assistance to grantees; and build an external dashboard on maternal and infant health data.
- Grant funding for 11 tribes, 5 American Indian servicing organizations (non-tribal) and 15 community-serving organizations for infant health
    - Total grant funding is $5,975,000 beginning in FY 2023 and annually thereafter.

Help Me Connect

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. Funding for the Help Me Connect (HMC) website is meeting a unique identified need to facilitate referral and access to community-based resources, which are culturally and ethnically appropriate. 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 on-line referral, service provision, and follow up communication system.

Fiscal components of the expansion of the Help Me Connect portion of the recommendation includes:

- 1.5 FTEs includes 1 State Admin Program Coordinator and 0.5 Student Worker. These staff hold responsibility to provide direction to and support the maintenance, implementation, and evaluation of the Help Me Connect website.
- IT software and contracts
- Contract for marketing
- Contract for interpreter services and navigator liaison

Universal Developmental and Social-Emotional Screening and Follow-up

Developmental screening is an essential population health indicator; screening identifies children in need of early intervention and/or further assessment, including vulnerable populations (poor, culturally and linguistically diverse, etc.) and provides connection to needed resources and services. This recommendation supports early childhood developmental and social-emotional screening and provides grant funding for follow-up/connection to services delivered through local public health departments and Tribal governments for families with children birth to 72 months of age.

Fiscal components of the Universal Developmental and Social-Emotional Screening and Follow-up portion of the recommendation includes:

- 6.0 FTEs including 1 FTE Supervisor, 1 FTE State Admin Program Coordinator, 2 FTE Health Program Rep Intermediate, 0.5 FTE Research Scientist 2 - Informatics, 1 FTE Grant Specialist, and 0.5 FTE Management Analyst 4. These staff hold responsibility 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 electronic screening system
- Grant funding for over 61 local public health agencies and 11 tribal nations for referral and follow-up

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).

Fiscal components of the expansion of the Model Jails project expansion portion of the recommendation include:

- 1.5 FTE including 1 Health Educator 2 and 0.5 Planner Intermediate. These staff hold responsibility to develop partnerships with county jails and support the implementation of a parent friendly practices, including implementation of a parent education curriculum, host a community of practice, and build partnerships to expand services and supports for justice involved families.
- Contract for support, training and evaluation of initiative
- Contract for evidence-based parenting education
- Grant funding for 15 jail sites
    - Grant funding for jail sites is $1,125,000 beginning in FY 2023 and annually thereafter.

Impact on Children and Families:

Overall funding for the Healthy Beginnings/Healthy Families recommendation would complement and provide opportunities for synergy in coordination of care and referral to a myriad of services that support a child's healthy start in life, including prenatal care, well-child visits, early childhood screening, referral and follow-up, and community-based solutions to infant and maternal mortality and developmental outcomes for children. Combined, the components of this recommendation will have demonstrated significant impact on improving 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 outcomes, including improved infant and maternal health outcomes, reduction in infant and maternal mortality, increased early childhood screening, referral and follow up rates, reduced reports of child maltreatment, family self-sufficiency, and increased school readiness.

Supporting cultural and community strengths build capacity for action and requires the commitment to developing authentic partnerships that lift 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.

Together, these efforts will move Minnesota forward in addressing the significant disparities in maternal and infant mortality, child development and school readiness, parenting support, and well child visits and follow-up. This work will support multi-sector partnerships and upstream approaches and includes addressing social and environmental determinants of health. This approach 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. 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 would help to address the health disparities that people experience by creating a more equitable investment in a multi-pronged, comprehensive early intervention approach to services that will have a multigenerational benefit to families, particularly those of color. Accomplishing this work will strengthen the fabric of families and community so essential to the wellbeing of children of color and American Indian children. It will also help secure Minnesota's future.

Results:

Minnesota Collaborative to Prevent Infant Mortality

Type of Measure	***Name of Measure***	***Current***	***Future***	***Dates***
Quantity	Number of Collaborative Meetings	0	6/year	FY 2021 FY 2023
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	MN Total: 3.84 White: 2.96 Black/African American: 6.32	FY 2016-2018 FY 2025-2027

		American Indian: 10.3	American Indian: 8.24	
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 2025-2027

Help Me Connect

Type of Measure	***Name of Measure***	***Current***	***Future***	***Dates***
Quantity	# of users accessing HMC (review of website analytics)	5,000/year	~ 50,000	Ongoing
Quality	Percentage of user survey results expressing high satisfaction after using HMC and high likelihood of returning to HMC in the future.	0	>75% with incremental growth	Ongoing
Quantity	Number of community organization requests to improve existing program listings.	10,000 current listings with ~200 requests to improve.	1,000 improvement requests	FY 2020 FY 2025
Quantity	Number of community organization requests to add new program listings.	10,000 current listings	15,000+	FY 2020 FY 2025
Quantity	Number of training and outreach events to early childhood professionals and navigators (health care, childcare, education, county staff)	50	50+	Annually
Quantity	# of family/child referral requests submitted through HMC.	0	25,000	FY 2020 FY 2025
Results	# of successful referral connections to services completed through HMC with confirmed enrollment.	0	20,000	FY 2020 FY 2025

Universal Electronic Developmental Screening

Type of Measure	***Name of Measure***	***Current***	***Future***	***Dates***
Quantity	Percent of children (9-36 months) who received parent-completed developmental screening	57.5%	65%	FY 2020 FY 2025

Quantity	% of children enrolled in the Follow-Along Program that completed at least one developmental/social-emotional screening electronically within the year	No baseline currently available	65%	FY 2020 FY 2025
Quantity	Number of electronic developmental screenings performed annually	No baseline currently available	35,000	FY 2020 FY 2025
Quantity	Number of electronic social-emotional screenings performed annually	No baseline currently available	20,000	FY 2020 FY 2025
Quantity	Number of providers who utilize electronic data platform	No baseline currently available	TBD	FY 2020 FY 2025
Quantity	Number of successful connections to resources/interventions for children with identified concerns on screening	No baseline currently available	TBD	FY 2020 FY 2025

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	12/30/24
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	12/30/24
Quality	Number of model practices that are implemented in partnering jails.	21	75 (including additional jails)	12/30/24
Results	Improved parent-child relationships and co-parenting relationships based on parent and co-parent surveys.	No baseline currently available	TBD	12/30/24

Statutory Change(s):
New statutes

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Home Visiting

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	126,700	210,501	313,599
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	126,700	210,501	313,599
FTEs	**0**	**41.75**	**59.25**	**79.25**

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. Currently, Minnesota is only serving approximately 10% of eligible families who would benefit from home visiting services. Universal short-term home visiting services to all children born in Minnesota will seek to serve 38,275 families in Year 1, 66,670 families in Year 2, and 103,414 families in Year 3, focusing on home visiting to priority populations (the homeless, incarcerated families, and children and youth with special health needs) and expansion of long-term home visiting to families. Over 90% 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. Up to 10% of requested funds will be used for grant monitoring, evaluation, training and technical assistance to implementing agencies as well as working collaboratively with other statewide programs that serve families.

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 during prenatal stages and continue up to when the child is five years old. These 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 evidence-based grant program is to build the capacity of nonprofits and community health boards to implement innovative and culturally appropriate evidence-based 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.

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. These families will be 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 recommendation seeks to address current gaps in services by expanding services to more families and creating greater flexibility to serve Minnesota's high priority populations. Home visiting service expansion will include funding for three tiers of home visiting designed to meet the needs of families in this challenging time: 1) regional pilots of universal short-term home visiting 2) long-term evidence-based home visiting programs across Minnesota, and 3) evidence-informed home visiting programs to serve priority populations. This three-tiered services approach will scale up services to more families over the three years, serving a total of 38,275 families in Year 1, 66,670 families in Year2, and 103,414 families in Year 3. The intentional scale up approach will allow agencies to build local capacity and infrastructure, to recruit and train a diverse home visiting workforce, and build essential referral networks within the early childhood system. These are critical elements to successful home visiting programs and expansion of services.

This home visiting initiative provides pregnant and parenting families with access to both short-term (2-5 visits) and/or long-term (1-3 years) home visiting services. It is anticipated that the cost of the initiative will increase over the three years as new families begin receiving services and as staffing and program capacity expand to cover the full state.

Each component of 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 are a total of $115,175,000 in fiscal year 2023, $191,350,000 in fiscal year 2024, and $285,090,000 in fiscal year 2025 and ongoing. Full-time equivalent staff at MDH are necessary for oversight and administration of the home visiting program expansion. 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. Other operating costs include information technology system upgrades for interoperability of electronic charting systems and benchmark tracking. MDH will also enter into contracts to evaluate universal and evidence-based home visiting services. Overall administrative costs are approximately 9.1% 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.

Results:

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Results	For families receiving home visiting services prenatally, percentage of infants who were breastfed any amount at 6 months of age	68%	70%	FY2021 FY2025
Results	For families receiving home visiting services prenatally, percentage of infants who were born preterm	14%	12%	FY2021 FY2025
Results	For children receiving home visiting services, percentage who are up to date on immunizations per CDC recommendations	No baseline	80%	FY2021 FY2025
Results	For families receiving home visiting services, increase the number of mothers receiving post-partum screening for depression within first three months	48%	55%	FY2021 FY2025
Results	For families receiving home visiting services, increase the number of children receiving developmental screenings	34%	55%	FY2021 FY2024
Quantity	Number of families receiving universal home visiting	<1000	40,000	FY2021 FY2023

Statutory Change(s):
None

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Lead Remediation in Schools and Childcare Settings

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	2,054	1,540	1,541
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	2,054	1,540	1,541
FTEs	**0**	**1.0**	**1.0**	**0.5**

Recommendation:

The governor recommends a general fund appropriation to establish a grant program for projects targeting reduction of lead in drinking water in public and private schools and childcare facilities. Expenditures in fiscal year 2023 include $1,600,000 in grants for schools and childcare settings to remediate plumbing and fixtures that are known to contain lead. Grant expenditures in fiscal year 2024 and beyond are reduced to $1,170,000 per fiscal year. There are approximately 8,000 childcare facilities and just under 2,500 educational facility buildings serving 845,000 students. Reductions in exposure to lead in water will improve the health and safety of Minnesota's children through enhanced brain development and lifetime productivity.

Rationale/Background:

The department is committed to reducing childhood lead exposure in schools and childcare facilities through testing and remediation of lead in plumbing and fixtures. There is no safe level of exposure to lead. Currently MDH has a federal Water Infrastructure Improvements for the Nation (WIIN) grant to offer free testing to eligible schools and childcare facilities. Childcare facilities are not required to test and are reluctant to participate due to the potential costs of remediation if lead is found. The WIIN grant does not provide funds for any remediation and excludes private schools.

Minnesota public and charter schools are required by Minnesota Statutes, section 121A.335 to test all fixtures used to provide water for consumption no less than once every five years. If a school finds lead, it must 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 ten-year facilities plan under Minnesota Statutes, section 123B.595. Private schools and childcare facilities do not have access to the 10-year facilities plan dollars.

Proposal:

MDH proposes to start a grant program that will allow public and private Minnesota schools and childcare facilities to meet eligibility requirements to apply for funds for projects that will result in reduction of lead in drinking water in schools and/or childcare facilities in disadvantaged communities. 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. Total grant awards will be $1,600,000 in fiscal year 2023 and $1,170,000 in fiscal year 2024 and each year thereafter.

The grant program is meant to test and remediate lead in drinking water in schools and childcare facilities. There are approximately 8,000 childcare facilities in Minnesota. There is no requirement for childcare facilities to test for lead in drinking water. There are 336 local education districts in Minnesota with just under 2,500 educational facility buildings serving 845,000 students. Schools are required to conduct testing at all drinking water taps used once every five years. The scoring criteria for grants will prioritize documentation of the lead hazard through testing, 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. One FTE staff will be needed to prepare and manage the grants, gather testing data, 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 childcare to ensure drinking water is safe for all Minnesotans.

Equity and Inclusion:

The same groups that are likely to be attending schools or childcare 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 childcare 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.

Results:

Establishing performance metrics to evaluate the results of this project will be important for transparency regarding the effectiveness of the grant. Since this program is a new program, the initial year would provide baseline data for the program. Over the following two fiscal years, 2024 – 2025, as school and childcare centers test for lead under state and federal statutes there will be more available information on the need for, and extent of, grant dollars. Outputs and outcomes expected to be achieved under the proposed program are described below. Outputs for this project include:

1) Decreasing the number of water fixtures, fountains, outlets, and/or plumbing that contain lead in Minnesota schools and/or childcare facilities associated with high levels of lead due to removal or replacement of these components.
2) Decreasing the number of Minnesota children drinking water from outlets that are known to have high levels of lead in the drinking water or contain known lead bearing components.
3) An increased number of schools or childcare facilities administrations, faculty, staff, and community members with information about reducing lead in drinking water achieved through outreach and education.

Outcomes for the project include:

1) An overall reduction in lead exposure and associated risk of exposure through the reduction of lead in drinking water in schools and childcare facilities.

2) An overall improvement in health outcomes in disadvantaged communities through increased efforts to remove sources of lead exposure.
3) An overall increase in public understanding of the health effects of lead exposure and increase in efforts towards the reduction of children's exposure to lead in drinking water in schools and childcare facilities.

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 (such as number of children/occupants impacted, number of fixtures replaced, changes to building management practices) to ensure that projects prioritize the reduction of lead exposure to children from drinking water. 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):
None

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Lead Service Line Inventory

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	4,029	4,029	140
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	4,029	4,029	140
FTEs	**0.0**	**2.0**	**2.0**	**1.0**

Recommendation:

The governor recommends a general fund appropriation to provide $3,750,000 annually in grants in both fiscal years 2023 and 2024 to community water systems to inventory the materials used for water service lines and include that inventory in a broader asset management plan. These grants will help the community water systems meet the draft 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 US EPA is currently in the process of soliciting public comment on a revision of the Safe Drinking Water Act proposed 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 proposal would 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 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. The inventory and asset management costs are expected to average about $10,000 per system. One engineering specialist and one FTE planner principal will be needed to develop, market, and administer the grant program.

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 provide general information about lead in drinking water as well as potential funding information if homeowners would like to replace their lead service line.

In addition, 2.0 FTEs of staff will be needed to provide technical assistance and grant administration in fiscal year 2023 and fiscal year 2024. 1.0 FTE staff will remain in fiscal year 2025 and beyond to maintain the database of lead service lines, provide technical assistance to community systems and the public users of the Infrastructure Transparency Tool and provide technical assistance for systems as they begin replacing LSLs.

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.

Results:

Since very few water systems currently have a complete service line inventory, every inventory conducted will provide a better picture of the lead service line replacement needs across the State of Minnesota. Community water systems will be able to meet the draft 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. 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.

Statutory Change(s):

None

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Legalizing Adult-Use Cannabis (Revised)

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	9,235	8,452	8,296
Transfers Out	0	716	0	0
SGSR Funds				
Expenditures	0	0	(3,424)	(3,424)
Revenue	0	(2,872)	(4,433)	(5,753)
Transfers Out	0	3,139	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	15,962	9,461	10,625
FTEs (New)	**0**	**15.0**	**14.5**	**14.25**

Recommendation:

The Governor recommends legalization of cannabis for adults in Minnesota, which will include a fiscal impact for the Department of Health. A new Cannabis Management Office would 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. Recommended funding at the Department of Health is for youth cannabis use prevention, education for pregnant and breastfeeding women about the health effects of cannabis use, data collection on cannabis use rates in Minnesota, and new standards for contaminants found in cannabis and related products.

Revisions: The Governor's recommendation released on January 26, 2022, did not include the revenue loss to the state government special revenue fund that would be credited to a dedicated account under the purview of the Cannabis Management Office.

Rationale/Background:

The governor's recommendation is similar to House File 600, legislation introduced in 2021 and considered in the 92nd Legislature.

Proposal:

The duties of the Office of Medical Cannabis would transfer to the new Cannabis Management Office. A transfer of staff and budget authority would occur on August 1, 2022, in fiscal year 2023. Health department budget authority in the general fund and state government special revenue fund would be permanently realigned to the new state agency. Beginning in fiscal year 2023, medical cannabis revenue would be credited to a dedicated account under the new office.

The Governor's recommendation includes general fund appropriations at MDH for youth cannabis use prevention at $4,611,000 per year, education for pregnant and breastfeeding women about the health effects of cannabis use at $3,324,000 per year, data collection on cannabis use rates in Minnesota at $399,000 in fiscal year 2023 ($333,000 in fiscal year 2024 and $278,000 in fiscal year 2025 and each year thereafter), and new standards for contaminants found in cannabis and related products at $901,000 in fiscal year 2023 ($965,000 in fiscal year 2024 and $ 864,000 in fiscal year 2025 and each year thereafter).

To account for the budget authority transition to the new agency, the department would transfer unspent appropriations and obligations to the new agency on August 1, 2022. Transfers out in fiscal year 2023 are an estimated at 11/12 of the base forecast. Under the recommendation, the health department's Health Improvement base in the general fund would be reduced by $781,000 in fiscal year 2024 and each year thereafter, and the health department's Health Improvement base would be reduced in the state government special fund by $3,424,000 in fiscal year 2024 and each year thereafter.

Statutory Change(s):

To be determined

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Supporting Long COVID Survivors and Monitoring Impact

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	2,669	3,706	3,706
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	2,669	3,706	3,706
FTEs	**0**	**4.0**	**7.0**	**7.0**

Recommendation:

The governor recommends an ongoing general fund investment to understand the impact of long COVID in Minnesota and partner with long COVID survivors and communities disproportionately impacted by it. The department will raise awareness of long COVID; develop statewide consensus guidelines 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; and provide grants to communities, long COVID survivor organizations, media and communications, long COVID survey contractors, and the Minnesota Electronic Health Record Consortium.

Rationale/Background:

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 Minnesotans. Currently, there is no widely accepted clinical definition nor much understanding of its prevalence among children, adults, individuals with pre-existing conditions, or those already disproportionately impacted by the COVID-19 pandemic. Symptoms can range from mild to debilitating. 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 affect all systems of the body: neurologic, cardiovascular, pulmonary, digestive, mental health, and numerous organs of the body. There is even evidence COVID-19 may destroy our insulin producing cells leading to diabetes. Long COVID affects healthy children and adults, often with more than one symptom. It compounds health issues for those 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. The most common symptoms include fatigue, joint pain, muscle pain, breathing problems, chest pain, coughing, headache, loss of taste and/or smell, digestive issues, and cognitive concerns such as memory loss 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. Estimates of these symptoms range from 2-77 % in adults and 1-87% in children, depending on the study. A conservative estimate is 10-20% of all Minnesotans infected with COVID-19 experience long COVID symptoms. As Minnesota nears 800,000 diagnosed COVID-19 cases since the beginning of the pandemic, this suggests 80,000 to 160,000 Minnesotans could already be impacted by long COVID. This could be higher when considering Minnesotans who were never tested for COVID-19 but were likely infected by SARS-CoV-2.

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. 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. There are currently no clinical guidelines for diagnosing, treating, or managing long COVID much less recommendations to insurers, employers, schools, and other sectors to support and accommodate those affected by long COVID.

There is a need to better understand its impact on Minnesotans with pre-existing chronic conditions and disabilities. There is a need to raise awareness about long COVID to support COVID-19 survivors experiencing these symptoms and to highlight the danger of being infected with COVID-19 at all. There is a need to develop consistent, statewide guidelines 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 experiencing long COVID symptoms. 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.

Currently, for fiscal year 2022 and 2023, MDH long COVID work is focused on understanding the impact of long COVID on Minnesotans through surveys and epidemiologic studies and designing 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 adequately 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 consensus for long COVID screening, diagnosis, treatment, care coordination, and follow-up recommendations** with long COVID survivors, high-risk communities and 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. These would be routinely updated as new clinical information arises.
2) **Convene and coordinate with Minnesota stakeholders** to co-develop recommendations, resources, and tools to 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 collection and reporting of information about the long COVID experience within these communities.

5) **Collaborate with the Minnesota Electronic Health Record Consortium (MEHRC)**, a partnership of over 11 health systems covering all of Minnesota, to establish an ongoing system to identify and monitor Minnesotans who present with long COVID symptoms, those who are diagnosed, what treatment and specialty care they receive, how often individuals require long COVID care, for how long, and how severe their symptoms may be. Collaborating with MEHRC 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. Since July 2020, MDH has been meeting with CDC long COVID staff and it has become clear that examining electronic medical records are needed to complement long COVID surveys and fully understand the current impact of long COVID in Minnesota and the United States and to track how this is being addressed within health systems as the pandemic continues.
6) **Sustain existing long COVID survey, epidemiologic studies, and communications efforts**.

The department will award competitive grants at $550,000 beginning in FY 2023 and each year thereafter for Minnesota long COVID stakeholder organizations and communities to co-design and co-implement all proposed activities. Additionally, we will create contracts for epidemiologic surveys, data collection, and studies.

Impact on Children and Families:

The recent surge of the SARS-CoV-2 Delta variant has seen increased infection rates among children, adolescents, and young adults. This includes increased hospitalization rates for these ages. This will lead to more children and families experiencing symptoms of long COVID. Lack of clear long COVID diagnosis and treatment guidelines 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 approximately 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, 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 studies 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 data collection, data 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.

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*	*Future*	*Dates*
Quality	Consensus long COVID diagnosis, treatment, and care coordination guidelines.	N/A	Recognized guidelines implemented	12/31/2024

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quality	Policies, resources, & tools to support long COVID survivors at home, school, work, and in their communities	N/A	Implemented in key sectors	12/31/2024
Quality	Policies, resources, & tools address health equity concerns	N/A	Implemented	12/31/2024
Quality	Ongoing long COVID surveillance system(s) for Minnesota	N/A	Accurate, valid, and sustainable system(s) implemented	12/31/2024
Quantity	Numbers reached with communications & awareness messaging	120,000	4,000,000 Minnesotans	12/31/2024
Quantity	Number of communication & awareness messaging designed to improve health equity	0	At least 30 deliverables/ products	12/31/2024
Results	Sociodemographic characteristics of Minnesotans with long COVID & over time	Not known	Dashboard, reports	12/31/2024
Results	Quality of care received by Minnesotans impacted with long COVID	Not known	Dashboard, reports	12/31/2024
Results	Impact of long COVID in BIPOC, rural, low income, and other communities disproportionately impacted by long COVID	Not known	Dashboard, reports	12/31/2024

Statutory Change(s):
New statute

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Medical Cannabis Patient Fees Reduction (New)

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
SGSR Funds				
Expenditures	0	4	0	0
Revenues	0	(5,610)	(7,165)	(8,720)
Net Fiscal Impact = (Expenditures – Revenues)	0	5,614	7,165	8,720
FTEs	**0**	**0**	**0**	**0**

Request:

The Governor recommends a reduction to the current annual patient fees from $200 (for non-Medical Assistance enrollees) or $50 (for those on Medical Assistance) per year to $40 per year for all patients beginning in fiscal year 2023. This proposal aligns the fee amount to be more in line with other states' fees. Although the requested fee revenue will reduce the overall revenue collections, the activity will still be in balance as current revenue projections are expected to be greater than expenditures.

Rationale/Background:

Medical cannabis currently provides therapeutic benefit for nearly 30,000 Minnesota patients. With dried raw cannabis authorized under current law as of March 1, 2022, patient enrollment is estimated to grow to 66,000 patients in fiscal year 2023, 99,000 patients in fiscal year 2024, and 132,000 patients in fiscal year 2025. Minnesota's annual patient enrollment fee is the highest in the nation. Price is consistently cited by patients as a barrier to program participation. Reducing the annual fee would greatly benefit patients and reduce the price barrier for them. Costs to patients are substantial–in addition to the annual enrollment fee, patients also have the costs of the health care visit to become certified and costs of their medicine. Reducing the annual fee would greatly benefit patients and reduce the price barrier for them, making the program more accessible.

Proposal:

The recommendation reduces current annual patient fees from $200 (for non-Medical Assistance enrollees) or $50 (for those on Medical Assistance) per year to $40 per year for all patients beginning in fiscal year 2023. There is a one-time, $4,000 information technology cost in fiscal year 2023 to update the department's patient registry for the new fee.

The medical cannabis earnings group has historically over recovered in the state government special revenue fund. The requested fee revenue reduction more closely aligns future expenditure and revenue in fiscal year 2023, and it is greater than anticipated expenditures in fiscal year 2024 and thereafter should the forecast growth in the number of patients materialize.

Projected Medical Cannabis Departmental Earnings in the State Government Special Revenue Fund (SGSR), Fiscal Years 2023 to 2025 (dollars in thousands)

Description	FY 2023	FY 2024	FY 2025

Expenditure			
Medical Cannabis Base	3,424	3,424	3,424
Change	4	0	0
Revised Expenditure	**3,428**	**3,424**	**3,424**
Revenue			
Current Law Projection	8,723	11,598	14,473
Change	(5,610)	(7,165)	(8,720)
Revised Revenue Projection	**3,113**	**4,433**	**5,753**
SGSR Cost (Savings)	**315**	**(1,009)**	**(2,329)**

Impact on Children and Families:

The medical cannabis program certifies patients that are very sick and have complex health histories. Medical cannabis is not covered by insurance, therefore all costs for the medicine are out of pocket for patients. One way we can impact patient costs is to lower the annual enrollment fee for patients. This will reduce one of the economic barriers to participation in the program.

Equity and Inclusion:

Approximately half of currently certified patients in the medical cannabis program are considered low income and receive medical assistance. Reducing the annual enrollment fee for patients will reduce one of the economic barriers to patients in the program.

Results:

Lowering the patient fees will substantially reduce barriers to participation in our program.

IT Related Proposals:

The cost to implement a change to the patient register is $4,000.

Statutory Change(s):

MS 152.35

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Medical Education and Research Cost Fund Administration

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures				
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0.7**	**0.7**	**0.7**

Recommendation:

The governor recommends a redirection of $150,000 in the general fund base appropriation for Medical Education and Research Costs (MERC) formula distribution, to support management of the program. The MERC fund was established in 1999 (Minnesota Statutes, section 62J.692) and is administered by MDH. The purpose of the MERC grant program is to support a robust healthcare workforce in Minnesota by providing funding to clinical training sites that train specific healthcare professions. Currently, the program is allowed to use $150,000 from the tobacco tax for administrative costs. This is no longer adequate to fund the staffing and technology required to administer this program.

Rationale/Background:

The MERC fund distributes $59 million in grants to Minnesota's clinical training facilities each year, with a formula that allows $150,000 for the department to administer the grants. This allocation for administrative costs has not increased since the program's inception in 1999. The amount available for MERC formula distribution includes $57 million from the MERC fund and appropriations in the general fund and health care access fund. In the Laws of 2014, chapter 71, the legislature provided a $1 million general fund appropriation as part of the deparment's ongoing base for the MERC formula distribution. In the Laws of 2016, chapter 189, the legislature provided a $1 million health care access fund appropriation as part of the deparment's ongoing base for the MERC formula distribution.

When originally funded more than 20 years ago, the program did not envision, or include funding for, technology to support an online application portal and analytics to replace an inefficient paper-based process. Workforce shortages, especially in primary care and rural areas, require more expert analysis of the costs of clinical training by provider type and location in order to focus efforts in areas of need within the state.

The current appropriation covers the cost of one full-time equivalent staff to administer the program, and does not support IT or other associated expenses, including data analysis to increase clinical training of health care providers.

Proposal:

The proposal redirects a portion of the MDH general fund base for MERC formula distribution, allowing the department to use $150,000 for administration annually beginning in fiscal year 2023. Funding the request through existing general fund appropriation would result in a dollar-for-dollar reduction of funds distributed, but would not impact the federal Medicaid match. The proposed increase in the portion of funds allocated for

administrative costs would provide funds for maintaining and enhancing the application portal for online data submission. It will also cover the costs of staff time to analyze costs across sectors and professions, which will help MDH better use and target resources to promote preceptorship and improved clinical training, especially in the areas of primary care among the underserved and in rural areas.

Impact on Children and Families:

The MERC program supports clinical training at facilities that provide services to patients receiving Medical Assistance, including children and families. It also helps to ensure a strong pediatric workforce by supporting the training of a range of pediatric providers.

Equity and Inclusion:

The MERC program supports clinical training at facilities that provide services to patients on medical assistance and encourages clinical training and preceptorship in facilities with a diverse patient population. Such training will help ensure health care providers gain skills in working in diverse settings and improves access to culturally competent and concordant care, which is related to better clinical outcomes for patients.

Results:

The department will analyze portal data which we will use to support training in primary care in rural areas and urban underserved communities. We will analyze data to compare costs of clinical training and preceptorships to determine options for future revisions of the program and to inform other programs that encourage clinical training and preceptorship.

Statutory Change(s):

None

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Mercury in Skin Lightening Grants

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	300	300	300
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	300	300	300
FTEs	**0**	**1**	**1**	**1**

Recommendation:

The governor recommends a general fund appropriation to reinstitute the Mercury in Skin Lightening Products grants program that was authorized with a one-time appropriation in 2019. The appropriation will be used to manage the grant program, track mercury testing results, and prepare public health education materials. Expenditures include $150,000 in grants to complete the work. Materials will focus on the potential exposure to mercury from skin lightening products; the dangers of exposure to mercury through dermal absorption, inhalation, hand-to-mouth contact, and through contact with individuals who have used these skin lightening products; the signs and symptoms of mercury poisoning; the health effects of mercury poisoning, including the permanent effects on the central nervous system and kidneys; the dangers of using these products or being exposed to these products during pregnancy and breastfeeding to the mother and to the infant; knowing how to identify products that contain mercury; and proper disposal of the product if the product contains mercury.

Rationale/Background:

The dangers of mercury and other harmful chemicals in skin lightening products have been well documented and are known to primarily impact the central nervous system and kidneys, yet this issue persists in some Minnesota BIPOC and immigrant communities. The department is aware of at least a dozen cases or mercury poisoning related to skin lightening product use in recent years (including one that was the subject of a 2020 Health Alert). Increasing public awareness and education on the health dangers associated with using skin lightening products that contain mercury that are manufactured in other countries and brought into the United States and sold illegally online or in stores remains a critical need.

Proposal:

The department requests reinstating the Skin Lightening Products Public Awareness and Education Grant program, first authorized by the 2019 legislature. In 2019, four grants were awarded, with much valuable work being done in this area (see: Skin Lightening Products Public Awareness and Education Grant (state.mn.us)). Reinstituting the grants will allow the department to educate impacted communities about:

- Potential exposure to mercury from skin lightening products
- The dangers of exposure to mercury through dermal absorption, inhalation, hand-to-mouth contact, and through contact with individuals who have used these skin lightening products
- The signs and symptoms of mercury poisoning

- The health effects of mercury poisoning, including the permanent effects on the central nervous system and kidneys
- The dangers of using these products or being exposed to these products during pregnancy and breastfeeding to the mother and to the infant
- Knowing how to identify products that contain mercury
- Proper disposal of the product if the product contains mercury

MDH also recommends requiring that the results of mercury testing of human urine, serum or other human body tissues in a Minnesota citizen be reported to MDH by the testing laboratory and/or the attending physician. One FTE staff would be funded by this proposal to evaluate grant applicants, assist grantees with communication development and distribution, and track and report on data submitted by testing laboratories and physicians.

Impact on Children and Families:

Children, including fetuses and infants, are most susceptible to the negative health impacts of mercury exposure, primarily effects on the central nervous system and kidneys. They are also likely to be exposed if their mothers use these products, through skin contact and residues left in the home environment.

Equity and Inclusion:

This issue affects our BIPOC and immigrant communities almost exclusively, making it a key health equity concern.

Results:

By educating the public about the dangers of mercury, people will have less exposure to this harmful chemical and will have the deleterious effects. The department will be able to track mercury poisoning incidents through the required tracking system.

Statutory Change(s):

New statute

Health

Supplemental Budget Change Item FY 2022-23

Change Item Title: No Surprises Act Enforcement

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	964	763	757
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	**0**	964	763	757
FTEs	**0**	**3.4**	**3.4**	**3.4**

Recommendation:

The governor recommends a general fund appropriation to implement state-based enforcement of the newly enacted federal No Surprises Act. This proposal expands the authority of the department to enforce federal No Surprises Act provisions for health plans the department regulates as well as providers and facilities. Enforcement includes reviewing health plan and provider compliance, investigating consumer complaints, and coordinating and working 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.

Rationale/Background:

This proposal supports enforcement authority and related resources needed for the department to implement the federal No Surprises Act, passed as part of the federal Consolidated Appropriations Act of 2021, 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 exception is for employer-sponsored health plans governed by ERISA, where the federal government remains responsible for enforcement.

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 regulatory structures.

Proposal:

The department requests authority, staffing and IT resources to implement and enforce the federal No Surprises Act, which became effective January 1, 2022. This critical work to protect consumers will support the management of: consumer complaints regarding provider, facility or health plan surprise billing issues; complaints between health plans and providers regarding reimbursements and coverage policy, including out-of-network payment requirements established in the Act; conducting random and complaint-based audits of correct

implementation of payment policy defined in the Act; and ensuring new consumer transparency and notification requirements are met.

Initial costs will include developing or purchasing an IT application to manage complaints and appeals, with lower ongoing maintenance and updating costs in subsequent years. Costs for staff attendance at trainings associated with implementing the new federal regulations are expected to be higher in the in the first two years of implementation.

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.

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.

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.

Statutory Change(s):

None

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Opioid Overdose Prevention and HIV Prevention for People Experiencing Homelessness

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures		1,129	1,129	1,129
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	1,129	1,129	1,129
FTEs	**0**	**1**	**1**	**1**

Recommendation: The governor recommends a general fund investment to expand access to harm reduction services and improve linkages to care to prevent drug overdoses, HIV/AIDS, hepatitis, and other infectious diseases for high-risk populations, including those experiencing homelessness or housing instability. This investment includes funds for maintaining existing and establishing new syringe services programs. Funds would be used to cover startup costs, coordination with homeless outreach and housing providers, coordination with existing infectious disease care providers, and traditional syringe services programs.

Rationale/Background:

In 2020, MDH declared an HIV outbreak for Hennepin and Ramsey counties: this is the first HIV outbreak in Minnesota since the start of the HIV/AIDS epidemic in the 1980s. The outbreak is centered around newly diagnosed cases of HIV among people who inject drugs (PWID) and among individuals who have stayed or spent time in homeless encampments in the metro area. The outbreak is believed to have originated in December

2018 within a homeless encampment in Minneapolis. In 2021, MDH declared a separate outbreak in the Duluth area, which is also ongoing and just over 1/3 of the individuals impacted in the Duluth outbreak reported experiencing homelessness or unstable housing. There are currently 85 cases linked to the outbreak in Hennepin and Ramsey Counties and 19 linked to the outbreak in the Duluth area

Homelessness can increase needle-sharing and transactional sex, making people more vulnerable to acquiring HIV and other drug-related infectious diseases (like Hepatitis C). A recent Hennepin County analysis found that 57 of the 85 people included in its outbreak (62.4%) have a record in the county's Homeless Management Information System, indicating that they are either currently or formerly homeless. 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.

In addition to the HIV outbreaks, injection drug use has also been increasing significantly in Minnesota. The Department of Human Services estimated a 300% increase in injection drug use in Minnesota between 2007-2017. In 2020, there were 1,008 fatal drug overdoses in the state: a 27% increase from 2019. Like the HIV outbreaks, the rise in drug overdoses is also closely associated with homelessness. An analysis by the Minnesota

Drug Overdose and Substance Abuse Pilot Surveillance System (MNDOSA) of health systems in Northeast Minnesota found that 29% of patients with emergency department visits for drug overdoses were experiencing homelessness.

Fully addressing the intersection of homelessness, injection drug use, and infectious disease requires a comprehensive plan that includes significant investments in low-barrier shelter, supportive housing, and treatment options. Expanding access to harm-reduction services, practical strategies aimed at reducing negative consequences associated with drug use, is a critical first step that can show immediate results in preventing infectious disease and death. Syringe Services Programs (SSPs), a type of harm reduction service, are an evidence-based practice that greatly reduces the transmission of HIV and other bloodborne pathogens, prevents drug overdoses, and improves care coordination and access to housing and benefits. SSPs are community-based prevention programs that provide a range of services to reduce the harms associated with drug use and prevent HIV and hepatitis infectious. Services include (1) linkage to substance use disorder treatment; (2) access to and disposal of sterile syringes and injection equipment; (3) vaccination, testing, and linkage to care and treatment for infectious diseases; and (4) education about overdose prevention and in some cases, access to medication that can reverse an overdose. SSP staff are often the only people with trusting relationships with people who inject drugs, they provide lifesaving services, and offer a critical access point for connections to treatment and housing.

SSPs have been linked to a 42-66% reduction in the transmission of HIV. They reduce health care costs by preventing HIV and HCV and other infections associated with using drugs. The estimated lifetime cost of treating one person living with HIV is near $450,000. A 12-week course of treatment for Hepatis C for one patient can cost between $50,000-$90,000. Hospitalization in the US due to substance- use related infections alone costs over $700 million annually. (CDC)

A CDC study found that SSPs do not increase either drug use or crime. In fact, people who inject drugs (PWID) who utilize SSPs are five times more likely to access treatment for a substance use disorder, and nearly three times more likely to reduce or stop injecting drugs. SSPs have been shown to reduce needle-stick injuries among law enforcement officers by 66% (Centers for Disease Control, 2019).

SSP funding has not kept pace with the increased demand for sterile syringes and other services and current grantees regularly exhaust their funds or are forced to curtail services before the end of their program year. In the first six months of 2021, MDH-supported SSPs distributed almost as many sterile syringes (952,392) as they did in all of 2020 (1,162,789). Increased funding would enable SSPs to purchase sufficient supplies to meet clients' needs throughout the year. Additional funding could also expand the network of SSPs grantees to include low-barrier shelters and other trusted providers that are currently serving people experiencing homelessness and people who inject drugs. Increased funding that supports existing SSPS and new SSPs could also support the use of innovative practices such as telehealth, mobile medicine/harm reduction services, and home visits to better serve people experiencing homelessness or who have other barriers to accessing services in a traditional clinic model. Funding the above activities has the potential to end the HIV outbreaks in Minnesota and reduce drug overdose deaths.

Proposal:

This proposal is part of the Minnesota Interagency Council on Homelessness's (MICH) request for transformational investments related to housing instability and homelessness. The One Minnesota plan recognizes housing stability as a foundation of success for improving health outcomes and eliminating racial disparities. This proposal complements the investments proposed by other agencies by providing lifesaving supports to people experiencing homelessness and helping connect people to treatment, shelter, and permanent housing.

The department is requesting a general fund appropriation to expand harm reduction services and linkages to care for people in high-risk groups, including those experiencing homelessness or housing instability. An estimated $360,000/year would go to six existing Syringe Services Programs (SSPs). An additional $600,000 per year would go to expanding the network of SSPs to include low-barrier shelters and other programs serving people experiencing homelessness and outreach programs currently operating without state support. The remaining funds would support 1.0 FTE for a Senior Health Program Representative to oversee the grantee selection process and provide grant management.

MDH currently funds six SSPs, five covering the Metro and one covering the Duluth area: Indigenous People's Task Force, Rainbow Health, Native American Community Clinic, NorthPoint Health and Wellness, Ramsey County Clinic 555, and Rural AIDS Action Network. Each grantee receives approximately $100,000 per year from MDH. SSPs offer sterile syringes and supplies, safe disposal of used needles, Hepatitis C Virus and HIV testing and linkage to care, condom distribution, Naloxone kits and training to prevent overdoses, and referrals to medical, mental, and sexual health services. They also provide education about infectious disease and drug overdose prevention.

In addition to the six SSPs that MDH currently funds, there are at least seven other organizations currently offering, or wanting to offer, similar services without state funding. This proposal would allow MDH to enter into three-year grant agreements for $200,000/year with up to three new organizations to better support and expand their work. Preference would be given to organizations with demonstrated effectiveness in reaching and engaging people experiencing homelessness and people who inject drugs and who are capable of testing promising initiatives to increase access to harm reduction services and improve linkages to care for HIV/AIDS and substance use disorders. This could include using telehealth technology, Pre-Exposure Prophylaxis (PrEP), and HIV treatment leading to viral suppression; using a mobile model to provide supplies and services to homeless individuals; and the inclusion of social workers and nurse case managers as part of a multidisciplinary HIV Prevention and Primary Care team. Funding would be used to cover startup costs, coordination with homeless outreach and housing providers, coordination with existing infectious disease care providers and traditional SSP activities.

As trusted providers, SSPs are uniquely positioned to help PWID find or maintain housing stability. Unfortunately, SSPs' work is often not coordinated with homeless outreach and coordinated entry teams or with Ryan White programs offering housing assistance for people living with HIV/AIDS. Thus, the people who work most closely with homeless PWID do not have the connections they need to help them find appropriate shelter or housing options. With the proposed additional funding, new and existing grantees could provide additional staffing support to improve coordination with homelessness and Ryan White service providers to improve housing stability for their clients. MDH would seek to pilot the integration of SSPs into at-least one low-barrier shelter program. It would also work with MICH to offer additional training and technical assistance to SSPs to support linkages between harm-reduction services and homeless outreach, shelter and housing programs.

New and existing grantees would be supported by a full-time Senior Health Program Representative (1.0 FTE). This position would support the amendments to existing contracts and the selection process for new grantees. They would also be the primary point of contact for grantees; ensure that grantees were complying with all MDH requirements; promoting a community of learning between grantees; and sharing information with the broader set of stakeholders affected by the HIV outbreaks and the rise in Drug-Related Infectious Diseases.

Impact on Children and Families:

Homelessness impacts families and youth disproportionately. Half of all people experiencing homelessness statewide were in families (3,214) or unaccompanied youth under 25 (746)**.** HIV and drug overdoses also affect Minnesota children and families:

- 164 people living with HIV in Minnesota gave birth from 2018-2020 (none of the babies were subsequently diagnosed with HIV)
- 46 adolescents and young adults (ages 13-24) were newly diagnosed with HIV in Minnesota in 2020
- Syringe sharing is more common among young people. In the U.S., 48% of youth ages 18-24 who inject drugs report sharing syringes, increasing their risk of contracting an infectious disease such as HIV and hepatitis C.
- Among people with HIV, youth aged 18 to 24 years reported higher levels of skipped doses of HIV medicine, missed medical visits, and experienced homelessness. (CDC 2018)

Equity and Inclusion:

The housing stability goal of the One Minnesota plan recognizes how housing stability is the foundation of success for critical goals from improving education and health outcomes, to eliminating racial disparities, to building and maintaining a strong workforce. Indigenous communities and people of color remain vastly over-represented among those experiencing homelessness. Most people (62%) counted in the statewide homeless Point-in-Time count in 2020 identified as Black, Indigenous, or People of Color. African Americans remain the plurality (42%) of those counted. Systematic racist policies and practices created and continue to fuel the inequities in who experiences homelessness. The transformational and targeted investments we are proposing will cement this Administration's commitments to housing, racial, and health justice for people experiencing homelessness.

The same racial and ethnic disparities are apparent in Minnesota's HIV and drug overdose cases. Nearly 70% of new HIV cases in Minnesota in the last year were among people from communities of color. Both of the HIV outbreaks in Minnesota disproportionately impact American Indian and Black communities:

- Hennepin/Ramsey outbreak – 43% white, NH, 26% American Indian, 12% Black
- Duluth area outbreak- 44% American Indian, 56% white
- Almost 30% of people included in the Hennepin/Ramsey HIV outbreak are American Indian and Americans Indians are 50-200 times more likely to be part of the outbreak than other racial or ethnic groups. American Indians are also seven times more likely to die from a drug overdose than white, non-Hispanic persons.

Results:

Type of Measure	***Name of Measure***	***All of 2020***	***Jan-June 2021***	***Future***	***Dates***
Quantity	Syringes Distributed by MDH IDPEC-funded SSPs	1,162,789	952,392	Increase by 50%	2023
Quantity	Number of naloxone doses distributed to participants by 6 MDH funded SSPs	31,163	26,156	Increase by 20%	2023
Quantity	Overdose reversals reported by SSP participants to SSPs (number reported is likely MUCH lower than actual number as this is based on PWID voluntarily reporting at SSPs sites)	947	499	Increase by 20%	2023
Quantity	Rapid HIV tests conducted by MDH IDEPC-funded SSPs	538	345	Increase by 30%	2023
Quantity	Rapid Hepatitis HCV tests conducted by MDH-funded SSPs	217	111	Increase by 30%	2023
Results	90% of MDH funded SSP participants who have a	87%	Data for 2021 not	90%	2023

Type of Measure	*Name of Measure*	*All of 2020*	*Jan-June 2021*	*Future*	*Dates*
	confirmed positive test for HIV are linked to care within 30 days		yet available		
	90% of MDH funded SSP participants who have a reactive rapid HCV test are linked to confirmatory testing within 30 days.	Data not available	Data not available	90%	2023
	MDH-funded SSPs refer participants (upon request) to care providers (HIV, PrEP, MAT, primary care) who are familiar with needs of people who inject drugs and people experiencing homelessness and are known to provide compassionate, destigmatizing care to these individuals	Active referral list shared with MDH by each grantee.	Active referral list shared with MDH by each grantee.	Active referral list shared with MDH by each grantee.	2023

Statutory Change(s):
None

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Public Health System Transformation (New)

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	23,531	23,531	23,531
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	23,531	23,531	23,531
FTEs	**0**	**11**	**11**	**11**

Request:

The Governor recommends $23,531,000 from the general fund an ongoing 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, $21,000,000 will be provided in grants to local public health and tribes and $1,000,000 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 preparing to do 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. 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: $20 million for local health departments to fulfill foundational public health responsibilities.
- Funding to Tribal Governments: $1 million for tribal health departments to fulfill foundational public health responsibilities.
- Office of American Indian Health: 1 FTE manager and 3 FTE staff to support the development and maintenance of tribal public health infrastructure.
- MDH staff to support local and tribal health departments: 7 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: $1 million 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 had the ability to 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; engage with populations most impacted by health inequities; examine and fix their own practices for bias; diversify their workforce; and inform 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.

Results:

Type of Measure	***Name of Measure***	***Current***	***Future***	***Dates***
Quantity	# of local and tribal health departments with a plan for public health transformation	0	80%	2021-2023
Quality	% of health departments satisfied with support provide by MDH	NA	80%	2021-2023

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Results	% of MN's population served by a local health department that meets national standards	51%	100%	2021-2027

Statutory Change(s):
Minnesota Statutes, sections

- 145A.131 Local Public Health Grant.
- 145A.14 Special Grants, Subd. 2a. Tribal governments

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Revitalize Health Care Workforce

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
Health Care Access Fund				
Expenditures	0	22,000	22,000	22,000
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	22,000	22,000	22,000
FTEs	**0**	**8**	**8**	**8**

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 supplements the infrastructure and experience of the Office of Rural Health and Primary Care to direct funding to Minnesota's communities in a comprehensive and equitable way.

This request includes the following components:

Rural Training Tracks and Rural Clinicals
$6,580,000 to support rural clinical training opportunities to grow our primary care workforce, including 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
$425,000 to 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.

International Immigrant Medical Graduate (IIMG) Training
$430,000 to provide short-term 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
$12,565,000 in additional funding 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 to provide increased assistance for facilities that take on training for new health care provider types or additional trainees.

Mental Health Supervision

$2,000,000 in funding for grants to assist psychologists, social workers, marriage and family therapists, and clinical counselors needing supervised hours to become licensed in paying for those supervised hours, with a focus on practitioners from BIPOC and other under-represented populations and practitioners who are treating low-income patients or providing treatment in a community clinic.

Rationale/Background:
The dominant theme in the pandemic recovery has been labor shortages across all sectors at a time when hiring demand was already at an all-time high and projected to get worse. The health care sector has been uniquely challenged – hospitals, 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 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 family medicine residency rural training track programs in greater Minnesota and one psychiatry residency rural training track program. Each rural track would train two residents, ensuring a continuous primary care physician pipeline in 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 shorter-term 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 limited by CMS rules and restrictions. As a result, it does not have the ability to support some 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 Supervision
Behavioral health providers (new graduates and incumbents) seeking licensure need up to 200 hours of one-to-one supervised practice. Currently, there are limited-to-no financial supports available to either the supervisee or the supervisor to complete this requirement. In many cases, supervisors charge supervisees to provide

supervision, which places a financial burden on the supervisees, a barrier which disproportionately impacts BIPOC and other under-represented communities who have disproportionally dropped out of the system before reaching licensure. Thousands of behavioral health providers choose to forego this step and as a result do not get licensed because of the unaffordability of existing clinical training system.

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. This request includes the following components:

Rural Training Tracks and Rural Clinicals
$6,580,000 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 medical residents, two in each program on an on-going basis. By fiscal year 2027, each site will be training 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 35 physician assistant students in 10 sites; 45 nurse practitioner students in 10 sites; 100 mental health students in 50 sites; and fund three 12-month, rural fellowships for oral health providers.

Workforce Research
$425,000 to 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.

Immigrant International Medical Graduate (*IIMG) Training*
$430,000 to provide short-term clinical training opportunities 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
$12,565,000 in additional funding to support for health care facilities training approximately 1,062 additional primary care providers that do not currently qualify for the MERC program.

Mental Health Supervision
$2,000,000 in funding for grants to assist 350 psychologists, social workers, marriage and family therapists, and clinical counselors needing supervised hours to become licensed to pay for those supervised hours. The focus will be on practitioners from BIPOC and other under-represented populations and practitioners who are treating low-income patients or providing treatment in a community clinic.

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 such as rural family medicine physicians, nurse practitioners, physician assistants, and dental providers. Increasing the number of rural physicians and physicians from the BIPOC and other under-represented communities will improve access to culturally competent primary care for children and families living in rural and underserved communities.

Equity and Inclusion:

Inadequate access to health is an equity issue. This proposal 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. Development of rural training tracks with greater

emphasis on health equity and population health needs will yield primary care practitioners skilled and empathetic to the real needs of the people they serve and address disparities in rural care availability.

Results:

Type of Measure	*Name of Measure*	*Current*	*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;	2021 July 2025 first RTT matriculates into program
Quantity	Increase in number of studies and reports yielding useful analysis of workforce needs and solutions (*Workforce research*)		2 per year	2021 2022
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*)		15 IIMGs in training	2021
Results	Ability to use Minnesota-specific workforce research in developing health care policies that are responsive to state needs. (*Workforce research*)			2021 2022 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.		In 2 years, 150 new rural-ready providers with rural training experiences	2021 2024 and beyond

Statutory Change(s):

To be determined

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Safety Improvements for Long-Term Care Facilities

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	5,500	$8,200	0
Revenues	0	0	0	0
Other				
Expenditures	0			
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	5,500	$8,200	0
FTEs	**0**	**4.0**	**6.0**	**0**

Recommendation:

The governor recommends a general fund appropriation to establish a temporary grant program that would provide support to MDH-licensed long-term care facilities for improvements to physical environment, investments in technology, and other activities to increase safety of residents and staff. The funding will be used to reduce risk of transmission of COVID-19 or other infectious respiratory conditions, and to reduce social isolation of residents in these facilities. The department will issue grants to facilities in fiscal years 2023 and 2024.

Rationale/Background:

Recent data illustrates the ways in which physical environment can relate to risk factors and infectious disease outbreaks such as covid. The physical environment in long-term care (LTC) facilities can be a contributing factor in covid outbreak risk for LTC settings; many skilled nursing homes, assisted living settings, or facilities previously registered as housing with services establishments have very old physical plants built in the 1960s and 1970s. There are also equity issues for smaller providers having fewer financial resources than larger, corporate-owned settings.

Proposal:

This proposal would create a temporary competitive process for MDH-licensed LTC facilities (including skilled nursing facilities and assisted living facilities) to apply for grants to be used for projects to reduce the risk of COVID transmission. Eligible projects could include personal protective equipment for visitors, residents, and staff; physical environment improvements to reduce shared spaces or improve air flow; pandemic visiting rooms; or electronic communication tools to address social isolation while also keeping medically vulnerable residents safe.

Funding includes staff for program administration to ensure appropriate oversight of the dollars and to run a fair and competitive process that complies with all State requirements. MDH anticipates 10 grants averaging $1,250,000 each, for a grand total of $12,500,000 over two years, with a range of grant sizes to allow for flexibility and responsiveness to facility needs.

Impact on Children and Families:

Identifying methods to ensure 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:
Not all facilities have the funds to undertake safety improvements. Providing additional avenues to boost protections against COVID-19 helps more Minnesotans stay healthy and avoid additional health concerns while receiving care.

Results:

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quantity	Number of projects	0	10	2024 2025
Quantity	Number of residents affected	0	3,500	2024 2025
Quantity	Number of residents in rural areas affected	0	35% of total	2024 2025

Statutory Change(s):
None

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: School Health

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	837	3,462	3,287
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	837	3,462	3,287
FTEs	**0**	**5.0**	**6.0**	**6.0**

Recommendation:
The governor recommends a general fund investment to provide competitive grants to expand health education and services to existing or new school-based health clinics (SBHC) and schools statewide to meet the health needs of students K-12. Additionally, funds will be available to integrate oral health services into school settings. These grants will support schools in their response to physical, dental, mental, and behavioral health needs of their students. Funds will be used to establish partnerships between schools and community health organizations, such as a community health center, hospital, or local health departments. This work would be in collaboration with the Minnesota Department of Education (MDE) to align with their Full-Service Community Schools and Wrap Around Services. Of the total appropriation $2,250,000 annually will be given in grants beginning in fiscal year 2024.

Rationale/Background:

Schools have direct contact with young people aged 5 to 18 years, for about 6 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 can grow to be healthy and successful adults.

However, there needs to be a greater alignment, integration, and collaboration between health and education to improve the overall health of a student. Engaging community and diverse partners offer important opportunities for school improvements that will advance educational attainment and healthy development for students.

Children and adolescents benefit from access to high quality medical, dental, 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, social emotional learning, coping skills, and overall mental health. As a result of COVID-19, childhood vaccination rates decreased. As of August 2021, 67.7 percent of 13-year-olds in Minnesota completed their 7th grade Tdap/MenACWY vaccine series compared with 70.2 percent in 2019.

Currently, there are 25 school-based health clinics (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. 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

In addition to the SHBC model, additional support for students with complex health conditions and the integration of dental education and hygiene services is necessary to fully meet the health needs of students.

Proposal:

The Minnesota Department of Health proposes to 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. To better serve students, this proposal intends to unify the best practices of the Whole School, Whole Community, Whole Child (WSCC) and school-based health center (SBHC) models. Under this proposal, MDH will coordinate and implement three inter-related grant programs to improve the health and well-being of all students:

- MDH will provide $1,0000,000 annually 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 young people are presenting in direct response to COVID-19 disruptions to everyday life.
- MDH will provide $1,000,000 annually in competitive grants to schools, oral health providers and other community groups to build capacity and infrastructure to establish, expand or strengthen oral health services into school settings.
- MDH will provide $250,000 annually in competitive grants to local public health and schools using the evidence-based Whole School, Whole Community, Whole Child (WSCC) model to increase alignment, integration and collaboration between public health and education sectors to improve each child's cognitive, physical, oral, social, and emotional development.

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, and the health care providers. The locally determined programs will be imbedded in the school culture, woven into relationships with teachers, administrators, and allied service providers such as school counselors, social workers and school nurses. The intention is to support schools on educating students while health care organizations provide whole-child wellness care in the same place. To achieve these locally driven approaches, across the School Health Initiative, MDH will:

- Establish an advisory board consisting of community representatives, parents, youth, School Based Health Alliance, and family organizations, to provide planning and oversight.
- Align and coordinate with MDE's approach to integrating full-service and/or wrap around services into school districts.
- Promote child-centered approach using the best practices of the SBHCs and WSCC models.
- Provide clinical and mental health services through an onsite school-based health center by a qualified health provider at no cost to students.

- Increase access to oral health education and services, including establishing a school dental hygiene clinic, providing preventive services such as sealants and fluoride application, integrating oral health safety measures into physical activity, and establishing dental homes through referrals.

The proposal includes a 6.0 FTE staff to implement this initiative, including two health program representatives senior and one planner principal state to plan, seek community input, and coordinate the initiative across the state and local levels. These positions will oversee the grantees and provide technical assistance and training where needed to meet the needs of the grant as outlined in the grantees workplans. A 1.0 FTE supervisor will provide oversight to the school health portfolio to improve the department's collaboration and coordination with MDE, school districts, and school health services. 2.0 FTE grants specialist senior positions will execute the grant agreements, monitor expenditures, and ensure compliance with terms of the three grant programs detailed above.

Impact on Children and Families:

Public health and education serve the same children, often in the same settings and needs greater alignment that includes, integration and collaboration between education and health professionals to improve each child's cognitive, physical, oral, social, and emotional development. There is a gap in engaging family and community who serve as a critical linkage for supporting and reinforcing healthy behaviors in multiple settings, at home, in school, in out-of-school programs, and in the community. There is fragmentation, duplication of services and need for a streamlined system for service delivery that is cost effective.

This proposal intends to strengthen and expand the health promotion and health care delivery activities in schools using both the SBHC and WSCC models which are evidence-based approaches for delivering health education, care and support to children and adolescents through coordinated and child-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 SBHCs or WSCC models efficiently and cost-effectively addresses health inequities like access to mental health support, oral health care, vaccines, vision care, and other essential medical care for children and youth in Minnesota. Minnesota has a variety of successful working models of SBHCs and WSCC, which partner health care providers with schools or entire districts educating 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.

Results:

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quantity	Number of students served by grantee SBHCs	9,000	11,250	FY2020 - FY 2025
Result	Increased number of high-risk schools served using evidence-based oral health models	62	125 (50% increase)	FY 2025
Quality	Percentage of students reporting their health needs were met at the clinic (student satisfaction survey)	No baseline	75%	FY 2025
Result	Percentage of students screened with a positive depression screening will decrease	60%	50%	FY2020 - FY 2025
Result	Increased number of students receiving dental sealants, fluoride varnish, oral health education	Dental sealant: 2,394 Fluoride varnish: 5,857 Oral health education: 10,241	Dental sealant: 5,000 Fluoride varnish: 10,000 Oral health education: 20, 000	FY2020 - FY2025

Statutory Change(s):

None

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Sentinel Event Reviews for Police-Involved Deadly Encounters

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	494	494	494
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	494	494	494
FTEs	**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. Multidisciplinary committees will meet twice 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 overtaken not only Minnesota but the United States as a whole, 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, scheduled for release in fiscal year 2022, identified 135 civilian deaths that resulted from encounters with law enforcement during the years 2016-2020.[1] Deaths that occur during encounters between law enforcement and civilians are tragic but preventable. While traditional responses to these incidents approach them from a reactive, blaming, and individualistic lens, the public health approach 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, including maternal mortality, motor vehicle collisions, and drug overdose deaths. Law enforcement-involved

[1] Cole, C. (2021, June 14). *Quantifying Police-Involved Deadly Force Encounters (PIDFE) in Minnesota* [Conference presentation]. Council of State and Territorial Epidemiologists 2021 Annual Conference, Pittsburgh, PA, United States.

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 DPS, Department of Human Services (DHS), Department of Human Rights (DHR), 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 a semi-annual report of cases reviewed with key findings, recommendations, impact, and outcomes from the sentinel event reviews to the chairs of the policy and finance committees in the House and Senate with jurisdiction over public safety issues. 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.

This project will require a project coordinator, an epidemiologist, and a review facilitator. These staff members will establish the review structure and process, collect and analyze data, engage extra-agency partners, facilitate semi-annual 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 can emerge as 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 is likely to 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. Minnesotans of color have voiced this for decades and MDH's own investigation into encounters that took place in the state from 2016 – 2020 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 the majority of people killed in law enforcement-involved deadly force encounters are adults, the issue does indirectly and directly affect children. Of the 135 law enforcement-involved deadly force encounter deaths that MDH identified from 2016 to 2020, six occurred to Minnesotans under the age of 18, the youngest of whom was 13. These tragedies can 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 incidents 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 135 law enforcement-involved deadly force encounters deaths occurring in the state from 2016–2020 found that Black, African, and African American Minnesotans were 4.14 times more likely to die in an encounter with law enforcement than white Minnesotans. American Indians and Alaska Natives were 5.86 times more likely to die of a law enforcement-involved deadly force encounters 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.

Results:

Type of Measure	***Name of Measure***	***Current***	***Future***	***Dates***
Quantity	Number of sentinel event reviews held annually	0	2	March and September, yearly beginning 2023
Quantity	Number of semi-annual reports presented to legislature and public	0	2	August and February, annually beginning 2023
Quality	Percentage of known law enforcement-involved deadly force encounters deaths reviewed <1 year post-incident	0%	80%	2020 2023-2027

Type of Measure	*Name of Measure*	*Current*	*Future*	*Dates*
Quality	Percentage of review committee recommendations that have resulted in policy change or changes to organizational practices	0%	50%	2020 2023-2027
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)	0.25 per 100,000 population using a floating average from 2023 – 2027	2016-2020 2023-2027
Results	Quantifiable reduction in racial and ethnic disparities in law enforcement-involved deadly force encounters incidence rates in Minnesota	Relative Risk of 5.9 for American Indian and Alaska Native population. Relative risk of 4.1 for Black, African, or African American population	Relative risk of 3.0 for American Indian and 2.0 for Black, African, or African American population	2023-2027

Statutory Change(s):
To be determined

Health

FY 2022-23 Supplemental Budget Change Item

Change Item Title: Trauma System Fee Adjustment

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	61	61	61
Revenues	0	(354)	(354)	(354)
State Government Special Revenue Fund				
Expenditures	0	430	430	430
Revenues	0	430	430	430
Net Fiscal Impact = (Expenditures – Revenues)	0	415	415	415
FTEs	**0**	**2.43**	**2.43**	**2.43**

Recommendation:

The governor recommends an increase to hospital license fees and aligning appropriations from the general fund and the state government special revenue fund to designate trauma hospitals and ensure an effective statewide trauma system. The proposal supports the staff and technical resources needed to maintain trauma designations according to industry standards. The proposal will ensure the department is able to continue to designate trauma hospitals at the required frequency following industry standards and ensure 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:

Traumatic injury is the leading cause of death for people between the ages of 1 and 44, and the third leading cause of death overall. Currently, 99% 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.

The number of institutions seeking this designation has grown, and as of 2021, there were 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. In the 2021-2022 Departmental Earnings Report, Trauma system revenues were projected as $354,000 per year and expenditures were $428,000. Information technology, personnel, and other costs have increased over the past two decades.

Proposal:

The recommendation 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 $1,150 base fee and an additional $15- per-bed fee. The state government special revenue fund appropriation will be used to support clinical and professional staff and the infrastructure necessary to designate roughly 50 trauma hospitals per year, 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 an 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 of $61,000 per year, to support staff to conduct analysis necessary to optimize clinical care, such as general surgery and emergency medical services, modify system requirements based on outcomes, meet all reporting requirements, reduce healthcare costs (e.g., eliminate multiple, unnecessary and/or delayed transfers, and repeat diagnostic testing), work with other state and industry partners to address longstanding structural concerns with, and access to, rural emergency medical service, 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 communities. It is the leading cause of death in ages 1-44. 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 one of the most important means to ensure children, families, and all Minnesotans have the best chance to survive and rehabilitate from sudden trauma, no matter where it occurs in the state.

Equity and Inclusion:

Minnesota has one of the most inclusive trauma 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.

Results: (paragraph and/or table)

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 percent of Minnesotans live within 60 minutes of a trauma hospital.
- 76 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.

Statutory Change(s):
Minnesota Statutes, sections 144A and 144.602 to 144.608