

2015

The Children and Youth with Special Health Needs Program | Annual Report

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Minnesota
Department of Health
CHILDREN AND YOUTH WITH SPECIAL HEALTH NEEDS

Dear Reader,

It is my pleasure to present to you the Children & Youth with Special Health Needs (CYSHN) Program Annual Report. This report highlights program activities from the last year, and some projects currently underway for 2016. Much of our work has centered around parent engagement, community input, and building connections across systems - both internally and with partners.

Our work continues our mission to improve population health through building the capacity of all systems that serve families of children and youth with special health needs. As section manager, I am happy to share the wonderful work being done! We are now fully staffed, which has helped us meet important goals; we added an audiologist, new health informatics expert, and a birth defects epidemiologist with a focus on prevention.

I invite you to read more about the important work our section does to help us meet the Minnesota Department of Health's mission to protect, maintain, and improve the health of all Minnesotans.

We hope you enjoy reading our 2015 CYSHN Annual Report, and welcome any feedback you are willing to provide.

Sincerely,

A handwritten signature in cursive script that reads "Barb Dalbec".

Barb Dalbec
CYSHN Program Manager

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Abbreviations used in this report:

MDH = Minnesota Department of Health

CYSHN = Children & Youth with Special Health Needs

NCFU = Newborn & Child Follow-up Unit

BDMA = Birth Defects Monitoring & Analysis Unit

CBU = Capacity Building Unit

LPH = Local Public Health

MDE = Minnesota Department of Education

IEIC = Interagency Early Intervention Committee

MCH = Maternal and Child Health

DHS = Department of Human Services

ADA = Americans with Disabilities Act

Photos:

All photos are used with signed permission from the subjects, or owned by MDH.



One in every five Minnesota families with children has at least one child with a special health need. Estimates of children with special health needs in Minnesota range from 160,000 to 200,000.

Children and youth with special health needs are those who have, or who are at increased risk for, a chronic physical, developmental, behavioral, or emotional condition. They also require health and related services of a type or amount beyond that generally required.

This definition is purposely broad, inclusive, and not condition specific. It recognizes that all children and youth with special health needs, regardless of their condition, require a well-functioning, community-based system of resources to reach their full potential.

Who We Are

Visit our website to learn more about our section, and programs, and find additional resources.

health.state.mn.us/cyshn

Working together with statewide partners, the Children & Youth with Special Health Needs (CYSHN) section strives to reduce the number of children who have special health needs and assure that those children and youth with special health needs, and their families, are well supported in the communities they live in.

Programs impact this population's health through Assessment, Assurance, and Policy Development - the core functions of public health. By building the capacity of local public health, health care systems, and community organizations that serve children and youth with special health needs, the CYSHN section is working toward protecting, maintaining, and improving the lives of Minnesota children and youth with special health needs and their families every day.

This past year, our focus has been on four of the six core outcomes (bold below) put forth by the Health Resources and Services Administration - Maternal and Child Health Bureau¹:

- 1. Families of children with special health care needs (CSHCN) partner in decision-making regarding their child's health;**
- 2. CSHCN receive coordinated, ongoing, comprehensive care within a medical home;**
3. Families of CSHCN have adequate private and/or public insurance to pay for needed services;
- 4. Children are screened early and continuously for special health care needs;**
- 5. Community-based services are organized so families can use them easily;**
- 6. Youth with special health care needs receive the services necessary to make transitions to adult health care.**



¹U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The National Survey of Children with Special Health Care Needs Chartbook 2009–2010. Rockville, Maryland: U.S. Department of Health and Human Services, 2013.



Creating and utilizing parent partnerships

Parents and families are often the main advocate, connection to networks, and source of strength and support (financially, emotionally, and developmentally) for children and youth with special health needs (CYSHN). As our program works to serve this population, family perspective is essential to ensure that program development and service delivery is effective and tailored to meet the needs of the CYSHN population.

This year, we increased our effort to reach and involve parents and families. Five new members were added to the CYSHN Parent Work Group (nine members total), increasing diversity across backgrounds, experiences, and geographic area. Additionally, a Family Involvement Coordinator was hired to lead the effort of bringing parent perspective to our program. Program staff and parents were involved in defining the continued expansion of the Work Group's role.

In March, program staff and Work Group members met to exchange ideas for working together, areas of special interest, and to orient the parents to the structure of MDH and the work of the individual CYSHN program units. The shared enthusiasm was very encouraging!

So far, we have utilized the unique perspective of parents from the group in grant preparation, as well as throughout the Title V needs assessment planning, development and writing. A few parents from the work group helped to update some birth defects education materials (see page 16), sent to new parents with a child identified with a condition. Over time, the group has become connected with community stakeholders, enabling an ongoing bridge across systems and services that directly impact the health and wellbeing of CYSHN.

We hope to maintain the sustainability of the work group through continued demonstration of the value of parental insight. The significance of each parent's experience and voice is evident, and the two-way learning process for program staff supports a responsive system.

Mapping Care Coordination for CYSHN and their families



The CYSHN program brought together almost 100 people from across the state, in five regional locations, to understand the strengths and weakness of the systems and programs that serve children and youth with special health needs. Care coordination was the key focus because evidence indicates effective care coordination services can decrease overlap, conflict, confusion, and costs – leading to optimal care.

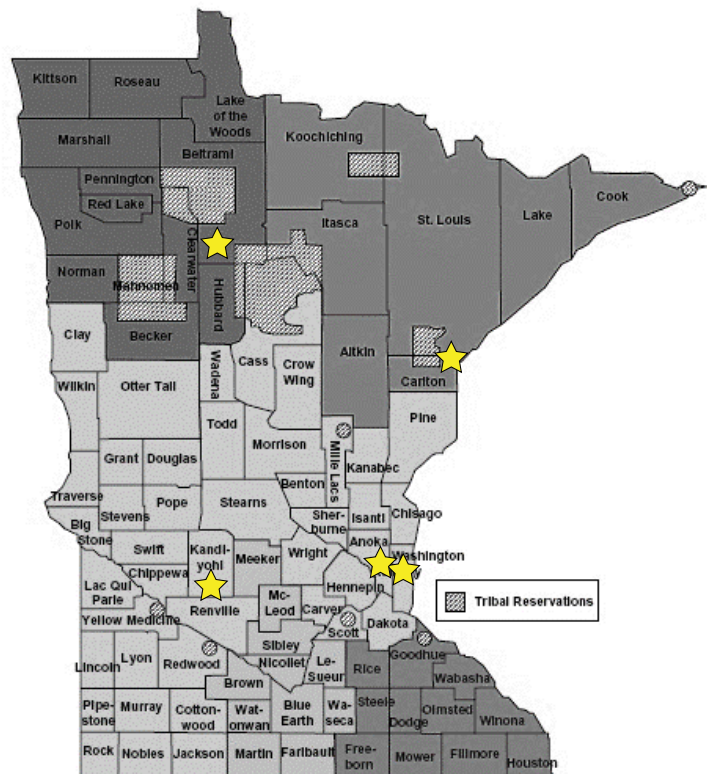
When care coordination is effective and parents and their children are supported and cared for, a great deal of stress and frustration is removed and parents have more quality time with their children.

Updates and more information are available on our website:

www.health.state.mn.us/divs/cfh/program/cyshn/integration

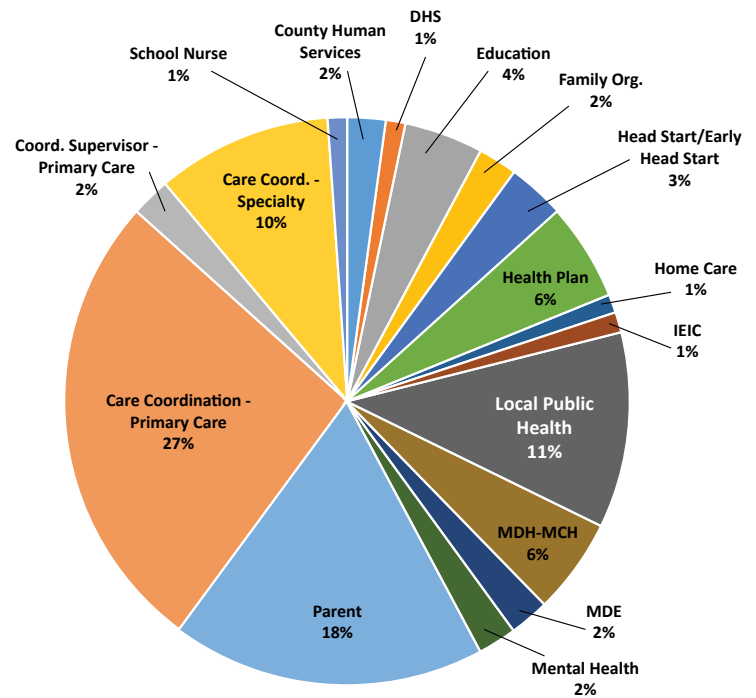
Care coordination mapping assessment meetings were held in the following locations (see map below):

- Northeast Minnesota – Duluth
- Northwest Minnesota – Bemidji
- Southwest/South Central Minnesota – Willmar
- East Metro Area
- West Metro Area



The meetings brought families, providers, and agency staff together (see chart, right) to complete mapping assessments that achieved the following outcomes:

- Gained a mutual understanding of the complexity of care coordination
- Identified opportunities and challenges in coordinating care for CYSHN
- Completed individual systems support maps identifying roles, responsibilities, needs, resources, and wishes involved in coordinating care
- Developed an individual action plan by each participant on ways they can improve how they practice care coordination
- Developed a regional systems framework in delivery of care coordination based on experiences from different parts of the state
- Developed a state action plan for systems improvement in each region



Who Attended Coordination Mapping Meetings

We partnered with Gillette Children’s Hospital to test, evaluate and plan for the spread of successful care coordination model(s) for CYSHN. The overarching goal was to determine successful care coordination models to decrease fragmentation, coordinate care across specialty as well as community resources, and increase positive outcomes across the lifespan for CYSHN and their families. In the second year of this grant, Gillette partnered with MDH and the University of Minnesota - Twin Cities to publish an article on lessons learned. The article describes models of pediatric care coordination within a child’s health care home using tailored care coordinator roles and functions. Publishing lessons learned will facilitate the spread of effective models to other areas of the state.

Cady, R., Looman, W., Lindeke, L., LaPlante, B., Lundeen, B., Seeley, A., Kautto, M. (September 30, 2015). *Pediatric Care Coordination: Lessons Learned and Future Priorities*. OJIN: The Online Journal of Issues in Nursing; Vol. 20 No. 3.

Effective Models of Pediatric Care Coordination



Transition Grant

Recommended Health Care Transition Timeline by Age

12

Youth & family made aware of the transition policy

14

Initiate health care transition planning

16

Prepare youth & parents for adult model of care & discuss

18

Transition to adult model of care

18-22

Transfer to adult medical home and/or specialists

23-26

Integrate young adults into adult care



According to the most recent data, only 47.1% of Minnesota's youth with special health needs (ages 12-17) receive the services necessary to make the transition to adult life². This shift includes moving from pediatric to adult health care, and opportunities for work, higher education, and independence.

In October, 2013, we partnered with Family Voices of Minnesota (FVM) to work with four Health Care Homes to develop transition planning models for youth with special health needs.

- Hennepin County Medical Center (HCMC) - Minneapolis
- HealthPartners Clinics, Como and White Bear - St. Paul
- CentraCare Clinic - St. Cloud
- Essentia Health Clinic - Duluth

Each of the four clinics formed a transition team with two or more parent partners; two teams had youth helping to develop the model and edit the tools to meet their needs. All clinics incorporated the Six Core Elements of Health Care Transition developed by The National Health Care Transition Center (NHCTC).

Over 135 youth were transitioned to adult health care over the two-year period, and a transition tool kit posted on the FVM website was accessed by health care providers over 500 times in the first six months. With spread to additional health care providers, Minnesota will be on track to meet our 2017 Olmstead goal of increasing the number of youth who successfully transition to adult health care by 10%.

The grant team was selected to present at the Association of Maternal and Child Health Programs (AMCHP) conference in January 2016.

²Data Resource Center for Child and Adolescent Health. (2015). 2009/10 National Survey of Children with Special Health Care Needs. Retrieved from: <http://www.childhealthdata.org/browse/survey/results?q=1616&r=25>

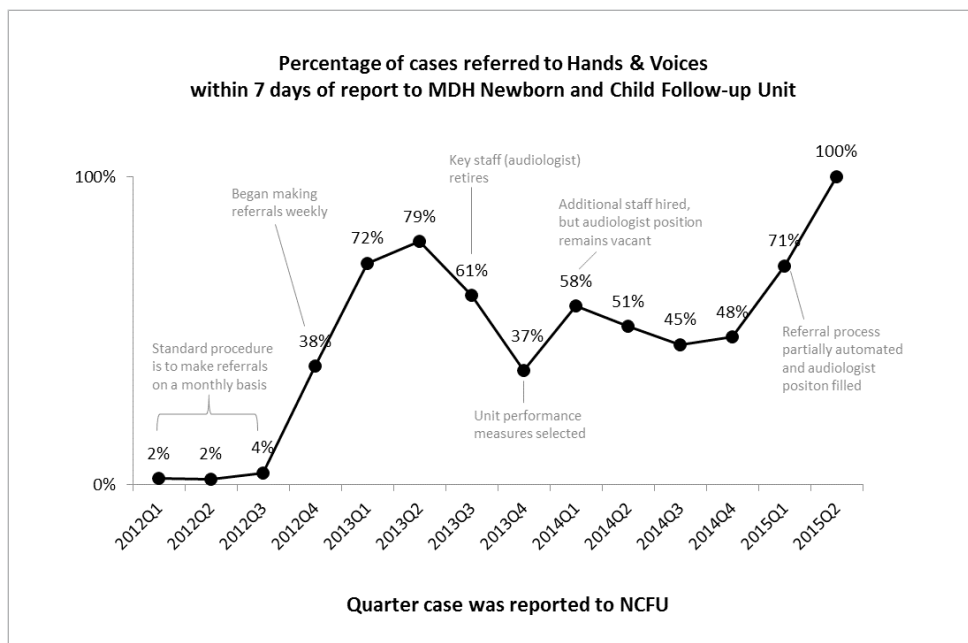
The Early Hearing Detection and Intervention (EHDI) program helps infants who do not pass their newborn screening hearing test. It is very important for infants to receive more hearing testing; EHDI helps to make sure this testing takes place. The EHDI program also helps families of children with hearing loss connect with educational, social, and community resources. Evidence supports that the earlier families are connected, the better the outcomes for their children.

Near the end of 2012, we changed our process for making referrals to Minnesota Hands and Voices (MHV), a partner organization that provides services and resources to families of a child who is deaf or hard of hearing. Before, we made referrals monthly, but have now started making referrals weekly*. We saw large improvements in timeliness for many months, but in August 2013 our audiologist who had a primary role in the notification process retired, leaving the program short staffed. In December 2013, we hired a Health Program Representative who was able to relieve some of the burden from the vacant audiologist position, and we saw some improvement. In 2014 we began to use Results Based Accountability (RBA)** to track our performance on this process. The information was used to come up with some ideas for improvement. Seeing how the lack of an audiologist had impacted our performance gave our management team justification for filling the vacant audiologist position. We automated a part of the notification process and hired an audiologist in January 2015, and saw substantial performance improvement see graph below). By June 2015, we had reached our target of 100% of referrals made to Hands and Voices within one week.

EHDI Hands and Voices RBA

* Timely connection to MHV has been a goal of the MN EHDI program since 2010.

** Results Based Accountability (RBA) is a data-driven, decision-making framework used by all MN state agencies to critically examine the quantity and quality of the services provided to customers, as well as the impacts and effects of those activities.



This graphs shows the time line with respective events that influenced the number of referrals made.

Improving Communication

Staff provide long-term coordination and connection to resources for children born with a condition on the Newborn Screening panel; hearing loss, critical congenital heart diseases, and disorders found through bloodspot tests. For our nurses working with families who are living with one of the 50 rare “bloodspot conditions”, it has become more difficult to connect with health care providers, and the families.

In an effort to improve connections and communication, NCFU staff explored new ways to communicate with primary and specialty care providers, children, and their families in a meaningful way:

- An infographic was developed for health care providers to enhance their understanding of our work with children and families, and to raise awareness of our program as a resource for providers and families. The infographic (next page, bottom) describes the processes and services offered.
- A Facebook group was established for parents or primary caregivers of children living with Congenital Adrenal Hyperplasia (CAH). This was the first independent Facebook group managed by MDH. The group provides a safe, easily accessible outlet to share information, ask questions, post photos, and find support group events. A second Facebook group was recently established for families living with fatty acid oxidation disorders and organic acidemias (FAOD/OA).
- In an effort to establish and strengthen staff relationships with providers, we identified mutual staff and specialty provider goals and objectives. This led to the development and implementation of a specialty provider post-visit survey.
- Finally, an infographic was developed for families who receive follow-up from NCFU (next page, top). The infographic shows the process and services offered by the unit. It will help families know what to expect, and will improve the rate of parents who answer our calls. It will be sent through the mail, along with the introductory letter currently being used.

“It was fascinating to see the information that CYSHN program staff provide to families.”

“It was truly beneficial to meet staff and get educated regarding the long term follow up done through MDH.”

- Health care providers; comments on post-visit survey

Next steps after diagnosis

There are so many things to think about after your baby is diagnosed with a health condition. The Children and Youth with Special Health Needs program at the Minnesota Department of Health (MDH) can help your family in a lot of ways.

START



Baby was born!

Your baby received Newborn Screening shortly after birth. The results showed a possible health condition.

Step 1

After your baby's health care provider diagnoses the condition, we are notified to offer follow-up to your family.



We can help link you to resources that may be helpful, such as financial, educational, and support services.



We help create opportunities for families to meet and share experiences and ask questions.



We can connect you to up-to-date information on your baby's condition and research opportunities, if you are interested.

Step 2

We will call you soon; This will take about 15 minutes. We do this to get to know you and your family better! That way we know which resources and services you might find helpful.

Step 3

We will keep in touch with you as your child grows and your needs change, and share things other families have found useful.



Sharing your journey helps improve programs and resources that also help other families. Thank you!

If you ever have any questions about our program or resources, feel free to call or email us!

Main Line: 651-201-3650 | Toll-free: 800-728-5420

Email: health.cysnhn@state.mn.us

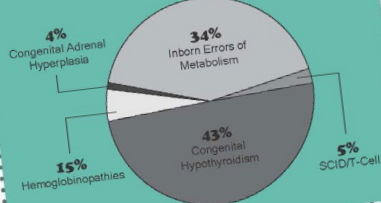
www.health.state.mn.us/cysnhn

Newborns in Minnesota are screened for hidden, rare conditions that can seriously affect lifelong health. Early identification and quality intervention are critical.

Newborn & Child Follow-up FOR BLOODSPOT CONDITIONS

MORE THAN 50 CONDITIONS

Percent of cases connected to Long-Term Follow-Up
Percentages sum to more than 100% because of rounding.



CONNECT FAMILIES TO RESOURCES

Public Health Nurses conduct assessments over the phone with families shortly after diagnosis and again 1 year later.

A "What You Need to Know" binder is sent to all families soon after diagnosis.

TRACKING & MONITORING

Goals for all children with a special health need:

- Receives coordinated, ongoing, comprehensive care within a medical home
- Well child care visits are up-to-date
- Receives developmental screening
- Has adequate private and/or public insurance to pay for services they need
- Receives medical management with appropriate specialists



FAMILY SUPPORT

Bringing parents of children with similar conditions together.

"When your child is born with a special health condition, you feel so alone. Through parent-to-parent match, I was able to connect with another family for support."

- Parent



COLLABORATIVE RESEARCH

MDH Long Term Follow-up staff work with federal agencies and state partners to define, study and publish key information regarding the long term follow-up goals of newborn screening, including care coordination, evidence-based management, continuous quality improvement and new knowledge discovery.



Children & Youth with Special Health Needs | 85 East 7th Place, Suite 220, PO Box 64882, St. Paul, MN 55164
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Evidence tells us that families who communicate early and effectively with their child's health care team are more likely to stay connected, assuring the best outcomes for children and youth with special health needs.

Culturally Appropriate Autism Awareness Month

[Read more:](#)

[Minnesota Medicine](#)

Addressing MMR Vaccine
Resistance in Minnesota's
Somali Community

By Lynn Bahta, RN, PHN,
and Asli Ashkir, RN, PHN,
MPH

Tusmo Times is read by
5,000 Somali families in
the Twin Cities metro
area. Somali TV programs
are viewed in Minneapolis
and Saint Paul. 7,000 So-
mali families view it when
on the air.



Educating communities is important and can be a useful public health tool when done correctly. When evidence based health information is delivered to a community or population using their trusted media channels, we can increase the probability that the community will not only see the information, but that they will pay attention to it. It is especially important to present it in a culturally appropriate manner, delivered, or supported by respected leaders in the community. Working in partnership with community leaders is a first step in understand and taking steps towards health equity.

Every year in April, Autism Awareness Month is celebrated nationally. For the first time, we facilitated an awareness media campaign focusing on the Somali community of Minnesota, using culturally and linguistically appropriate materials, media channels, and experts. Because the information was made available through community media channels, many families had the chance to access the education, understand what autism is, and the importance of early interventions. Some of the campaign items included:

- Autism Q & A fact sheets and advertisements (pictured above) in English and Somali and were published in a local newspaper, Tusmo Times, popular within the Somali community, and on the most popular Somali website, Hiiraan Online.
- Help Me Grow, a national child development organization, produced a video on child growth available in English and Somali. The video was posted to the Hiiraan Online website, and was played on Somali TV, a local TV channel that provides educational programs to different communities in Minnesota.
- An “Autism Q & A Live” TV show was a helpful collaboration with the East Africa Health project, Somali Parents Autism Network support group, and Somali TV.

Children with a chronic health condition have a lot to learn and to manage to help them lead healthy lives; this starts at a very early age. One of the conditions we provide long-term follow-up for is Congenital Adrenal Hyperplasia (CAH). For many years, parents and providers have requested information and support in explaining this condition and its medical management to children. Research has shown that disease specific children's books can help children better understand their condition. Such books can also help siblings, classmates, and peers understand what the disease means^{3,4}. While these books exist for diabetes, autism, childhood cancers, and many other conditions, no children's book existed for CAH.

In order to fill this gap, CYSHN staff collaborated with a multidisciplinary team of health care providers and families of children with CAH to develop a children's book titled, "I'm Growing with CAH!"

Using a children's book format highlights the importance of play as a learning tool for children and describes medical terms in developmentally appropriate ways. The book and activities help by involving the child in understanding why routines of medications, clinic visits, laboratory blood draws, medical alert jewelry and special treatment when they are sick is "their normal".



An evaluation of the book will be implemented in the beginning of 2016, to gather information about how the book is being used, and if it is meeting needs. Initial, informal responses from families have been very positive. You can read or download the book from our website: www.health.state.mn.us/cyshn

³Blaska, J. Children's literature that includes characters with disabilities or illnesses. *Disability Studies Quarterly*. 2004;24:1. <http://dsq-sds.org/article/view/854/1029>

⁴Ider-Puig R, Maksys A, Noestlinger C, et al. Using a children's book to prepare children and parents for elective ENT surgery: Results of a randomized clinical trial. *International Journal of Pediatric Otorhinolaryngology*. 2003;67:35-41

Children's book about growing up with CAH

What parents are saying:

"I can take this with me when I meet with Kenneth's preschool teacher. It will help me explain CAH to her!"

"This book will be great to read to Bradley's older sister so she can understand why he goes to the doctor so often and takes medication many times a day."

Update to Birth Defects Parent Packet

This information is sent to about 1,800 families each year, across the state of Minnesota.

Infants in Minnesota who are born with a birth defect are entered into a secure registry. We want to make sure that each of these families are aware of this registry, know what we do with their information, and their ability to de-identify their information (called “opting-out”).

Over time it became clear that the letter and information sent to parents was not meeting needs (next page, top image). Program staff heard from multiple parents over the phone or email, that the wording of the letter was not sensitive enough and left some unanswered questions.

Staff began the process to update the letter and information sent to parents. We met to discuss the content itself (what needed to be included, and what was missing), wording, and overall look and design. Comments from parents, a previous evaluation of the materials, and staff expertise were used.

After initial content was developed, design drafts were created and printed. A total of nine parents were asked to review the design drafts; four mothers of infants on the birth defects registry, and three mothers from the CYSHN Parent Work Group (see page 7). The reviewers represented both Metro and Greater Minnesota, different cultural backgrounds, and a range of knowledge on and experience with birth defects. Feedback on the different design options and information content were collected and used to create a final product (next page, bottom image).

We anticipate the revised materials will provide necessary information in a way that is well received, sensitive, and comprehensive. Staff will evaluate the effectiveness by the number of calls received after receipt of the materials and feedback from parents when available.

Next, we plan to review the materials sent to parents of an infant who has died, being especially sensitive in explaining how the program can have a positive impact for other families.

“I really appreciate how you took the time to reach out to us and get our opinion on the letter. It really means a lot. It is a tough letter to send out but I think the changes that you made on it already help significantly.”

- Parent Reviewer



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Birth Defects – What is Being Done in Minnesota?

What causes birth defects?

Little is known about the actual causes of birth defects. Approximately twenty percent of birth defects may be attributed to genetic factors. Ten percent are attributed to environmental factors, including drug or alcohol abuse, infections, or exposure to certain medications or other chemicals. The causes of the remaining seventy percent are currently unknown.

What is the Minnesota Birth Defects Program and what are its goals?

The Birth Defects Program is a new activity at the Minnesota Department of Health (MDH). This program gathers data about babies born each year with certain health conditions diagnosed within the first year of life. The mission of the program is to help children thrive, grow, and be as healthy as possible. The primary goals of the Birth Defects Program are to:

- Monitor incidence trends of birth defects to detect emerging health concerns and identify affected populations,
- Ensure appropriate services are provided to affected families,
- Prevent birth defects through targeted education,
- Educate physicians and the public regarding birth defects, and
- Stimulate research on risk factors, treatment, prevention, and the cure of birth defects.

How does the Birth Defects Program benefit Minnesota?

There are many programs in our state that may benefit children with birth defects and their families. Knowledge of the occurrence of birth defects will help MDH link families to the services they need. Better tracking of when and where birth defects occur and

potential links to risk factors will provide critical information that may help prevent birth defects in the future.

What if parents don't want MDH to have their personal identifying information?

Data privacy laws strictly protect the information that the Birth Defects Program gathers. If, for any reason, parents want to exclude their child from the system, they can fill out a form and the personal identifying information on that child will be removed. The Birth Defects Program will no longer contact you regarding services for that child. This does not eliminate the possibility that another program within MDH will contact you. They may have your information from another source.

Where can I get additional information?

The MDH maintains a website for birth defects information at the state level. It contains background information on current and past activities, an overview of the current advisory work group, fact sheets on medications that are known to cause birth defects, links to Minnesota statutes and other helpful websites. The web page is at:

<http://www.health.state.mn.us/birthdefects>

For more information about birth defects, or if you require this document in another format such as large print, Braille, or cassette tape, contact the Birth Defects Program at: 651-201-5000

September 2014
IC#141-1718
Family Fact Sheet/English-Spanish

Important Information for your Family

The information included here is important for your family because your baby was born with a health condition that we track in Minnesota. We hope the information in this packet will answer your questions so your family can grow and thrive!



Who we are

The Children and Youth with Special Health Needs program of the Minnesota Department of Health (MDH) made this folder for you. We work to provide positive health outcomes to better serve children and youth who have, or are at risk for, special health needs and their families throughout Minnesota.

For more information about the section, please visit: www.health.state.mn.us/cyshn

The health conditions we track

We keep track of about fifty conditions that babies can be born with. The conditions we track are generally referred to as congenital anomalies or more commonly, "birth defects". Sometimes these conditions are minor, but many are very serious. It is possible for babies to be born with more than one of these conditions. You can find the full list and more information about each condition on our website.

We understand that not everyone likes the term "birth defects"; we have chosen to use this term because it is commonly used and easy to understand.

We track conditions of the:

- Heart (Cardiac)
- Brain and spine (Central Nervous System)
- Chromosome
- Eye
- Ear (does not include hearing loss)
- Stomach, esophagus, intestine, and liver (Gastrointestinal)
- Genitals, urinary tract, and kidney (Genitourinary)
- Bones and muscles (Muscular Skeletal)
- Nose and mouth (Orofacial)



Why we track these conditions and what information is kept

We keep this information so we can watch for trends or high numbers that might be a concern. These patterns might help us identify causes and prevent these conditions for future births.

The information in the database is carefully protected; it is not public. We only provide information as "aggregate data" - this means that all numbers represent a population, not individuals. For example, we could report the percentage of babies born with cleft lip in Minnesota during the year 2015.

The database includes the following types of information:

- Date of birth
- Location of birth
- Specific birth condition(s) and how it was diagnosed
- Contact information
- Demographics of mother and baby (i.e. age, race, ethnicity)

How we can use this information:

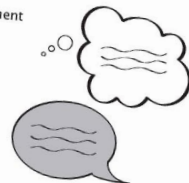
- Report how many babies were born with a condition and describe patterns
- Ask local public health (LPH) to contact you and help with resources
- Get in touch with your family to provide resources and other information
- Discuss complicated birth defects with medical specialists to accurately report the condition
- Partner with the Early Hearing
- Detection and Intervention program at MDH, for children at high risk of hearing loss
- Contact you about research opportunities, to see if you are interested in being involved
- Collaborate with researchers on approved projects

We will not use your information for any other reason!

Other departments who may also be contacting you

If you live in Minnesota, your local public health (LPH) department may contact you; this may be a city, county, or tribal health department. They can connect you to resources and services to help your family now, and as your baby grows. Your LPH department can answer questions you have related to financial help, early intervention, education, and more.

Other programs in MDH like hearing loss may also contact you if your baby also has another condition.



2015 Birth Defects Prevention Month

Every year in January we recognize Birth Defects Prevention Month (BDPM). During this month we bring attention to the known causes of birth defects, the way they impact lives and families, and ways to prevent them.

In the past, the theme has emphasized that birth defects are “Common, Costly, and Critical”. This year, National Birth Defects Prevention Network decided on the theme “Making healthy choices to prevent birth defects – Make a PACT for prevention”; PACT stands for Plan ahead, Avoid harmful substances, Choose a healthy lifestyle, and Talk to your health care provider.

Staff and partners were encouraged to spread the word throughout January in a variety of ways: tables with information in the lobby of buildings, posts to Facebook and Twitter, press releases to local media outlets, and small events. More information can be found on health.state.mn.us/BDPM.



Staff from CYSHN showing off their “PACT for Prevention”!

ADA 25th Anniversary Celebration

July 26, 2015 marked the anniversary of the passage of the Americans with Disability Act (ADA). A family event was held at the Minnesota History Center, with time for sharing, education, and socializing for families. We were proud to assist with promoting the event, and encouraged staff to attend to celebrate the profound impact this act has had on our population.

Through the 25th Anniversary activities, the Minnesota State Council on Disability and its project partners strive to:

- Encourage Minnesotans to recognize the importance of the disability community and culture.
- Help Minnesota employers gain greater understanding of the barriers to employment people with disabilities face, and the unique talents, strengths and abilities people with disabilities bring to the workplace.
- Share a more complete picture of the Americans with Disabilities Act with Minnesotans, and its 25-year impact on our community



Contact us:

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Children and Youth with Special Health Needs

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Email: health.cyshn@state.mn.us.

Visit us online: health.state.mn.us/cyshn

2016



Minnesota
Department *of* Health

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