ADDRESSING INFANT MORTALITY AMONG U. S. BORN AFRICAN AMERICAN WOMEN IN MINNESOTA

Recommendations for Improving Family Home Visiting Programming in Minnesota

Community Voices and Solutions (CVAS)

September 2015

Background

These recommendations were prepared as part of the Community Voices and Solutions (CVAS) report to the Minnesota Department of Health (MDH) Center for Health Equity (CHE) in September 2015, in fulfillment of MDH's requirements to the Office of Minority Health (OMH) and the State Partnership Grant to Improve Minority Health.[1]

From 2010-2013, MDH received a grant from OMH to improve the availability, utility and efficacy of health disparities and health outcomes data for Minnesota's communities of color, with a focus on improving the consistency and quality of racial/ethnic health data collection and mobilizing key stakeholder groups in African American communities to partner with MDH to take action on infant mortality.

MDH was awarded another grant under the same OMH initiative from 2013-2015. The purpose of the MDH grant was to identify, address and prevent health inequities through the reduction of infant deaths and the improvement of the identification and dissemination of health inequities in Minnesota. Specifically, it addressed the high rate of U.S. born African American infant mortality through a health equity lens. The first goal was to improve birth outcomes and eliminate disparities in infant mortality among African Americans, and the second goal was to improve the documentation of health status of populations of color and American Indians health using a health equity lens. Efforts were focused on building community capacity and action by increasing key stakeholders' knowledge of evidence-based maternal child health and family home visiting (FHV) models of care and social determinants of health (SDOH).

About Community Voices and Solutions (CVAS)

The Community Voices and Solutions (CVAS) was the advisory group for MDH's State Partnership Grant program. The group was comprised of community members who had knowledge of and experience working in the African American community. CVAS provided guidance and advice to MDH in the planning, implementation, and evaluation of this program.

CVAS dated back to MDH's State Partnership Grant to Improve Minority Health Grant for 2010-2013. At the time, MDH identified several barriers to developing successful strategies to address health disparities. Among these barriers was the lack of data on health status, behaviors, and health care access for communities of color, as well as the lack of mutual, ongoing relationships between state-level agencies and programs and the communities with whom they work. Although MDH maintained a number of workgroups and advisory panels on which community members participated, opportunities for meaningful input into programs and priorities were often limited. This in turn limited MDH staff's awareness of the data and programmatic needs of communities and the most effective ways to meet those needs. Around

[1] CVAS Project Coordinator Theresa Evans-Ross prepared the report in collaboration with other CVAS members and MDH.

the same time, in December 2010, the Twin Cities-based Stairstep Foundation, with funding from MDH's Office of Minority and Multicultural Health (OMMH), conducted a study that examined the issue of infant mortality among African Americans in the Twin Cities area. An environmental scan that included 16 Metro area African American churches was conducted to identify the extent of the problem, gather perceptions about the contributing factors, and find solutions from the community's perspective. The findings from that report, *Addressing Infant Mortality among African Americans: An Urgent Matter*, provided the foundation for forming a community partnership to begin planning and implementing a plan to address infant mortality in these communities, which later became known as the CVAS Advisory Committee. CVAS's charge was to look into the causes of, and recommend solutions to, the infant mortality crisis in Minnesota's African American community.

The CVAS partnership brought together professionals from Twin Cities' organizations that provided services to African Americans, community representatives, and MDH staff from OMMH, Minnesota Center for Health Statistics (MCHS), and Maternal and Child Health (MCH) division. It included representatives from health clinics, social service agencies, schools, local health departments, professional associations, and community-based and nonprofit organizations in the Twin Cities. Many of the CVAS members had longstanding and significant roles in improving the health of African Americans in Minnesota.

Highlights of CVAS's work throughout the 2010-2013 grant period include:

- Formed partnerships with community agencies to improve quality care coordination for pregnant women, for example, the Minnesota SIDS Center, Community Health Workers Alliance, and Minnesota Home Visiting Nurses Association
- Participated in facilitated discussions on the life course perspective and models to assess women's health throughout the life span
- Explored and strengthened members' understanding of the critical role of fathers and their involvement in African American families
- Identified and discussed strategies to address social and economic inequities that contribute to infant mortality in the African American community
- In coordination with MDH, hosted an African American infant mortality forum attended by over 100 participants where they learned about infant mortality statistics, existing programs and evidence-based strategies, and provided input into future directions, next steps, and priorities for action for MDH

CVAS had a brief hiatus from 2013-2015 due to several staffing changes at MDH and among the project staff, but was reconvened in the summer of 2015. MDH hired a Project Coordinator who in turn recruited five community members from diverse professional backgrounds.[2] The six new

[2] CVAS members received minimal stipends paid out of the grant.

community members, in addition to three other MDH staff, formed the new CVAS, and held its first full meeting in April 2015.

The 2015 CVAS accomplished the following:

- Held weekly in-person meetings with MDH and community groups working on infant mortality.
- Met with MDH PRAMS staff to review and discuss the 2016 Pregnancy Risk Assessment Monitoring System (PRAMS) 2016 African American Data Book to understand the process used to gather the data, provide input into the how this reference material could be more useful to the community, and to plan the agenda for two community sharing sessions.[3] [4]
- Co-hosted with MDH a community sharing meeting where participants reviewed MDH's PRAMS) 2016 African American Data Book for usefulness to the community.
- Co-hosted with MDH two community co-learning sessions where participants learned about the root causes of infant mortality in the African American community and discussed solutions to infant mortality disparities.
- Developed recommendations for improving FHV programming among African Americans in Minnesota

CVAS members from 2010-2013 and in 2015 can be found at the end of this document.

Infant Mortality in Minnesota's African American Community

Reducing infant mortality has been a statewide public health goal and priority for MDH. MDH has always provided statewide leadership and works in partnership with many internal and external groups and organizations to achieve its infant mortality reduction goal. There have been many outstanding and innovative efforts to reduce infant mortality in Minnesota, both at the statewide level and the community level. One example is Minnesota Milestones, a 30-year plan first introduced in 1991 and identifies infant mortality as an important barometer of population health and monitors its performance among 70 progress indicators. Another example is the Eliminating Health Disparities Initiative (EHDI), a joint long-term policy initiative of the Minnesota Legislature and MDH, enacted in 2001, and established a goal of a 50 percent

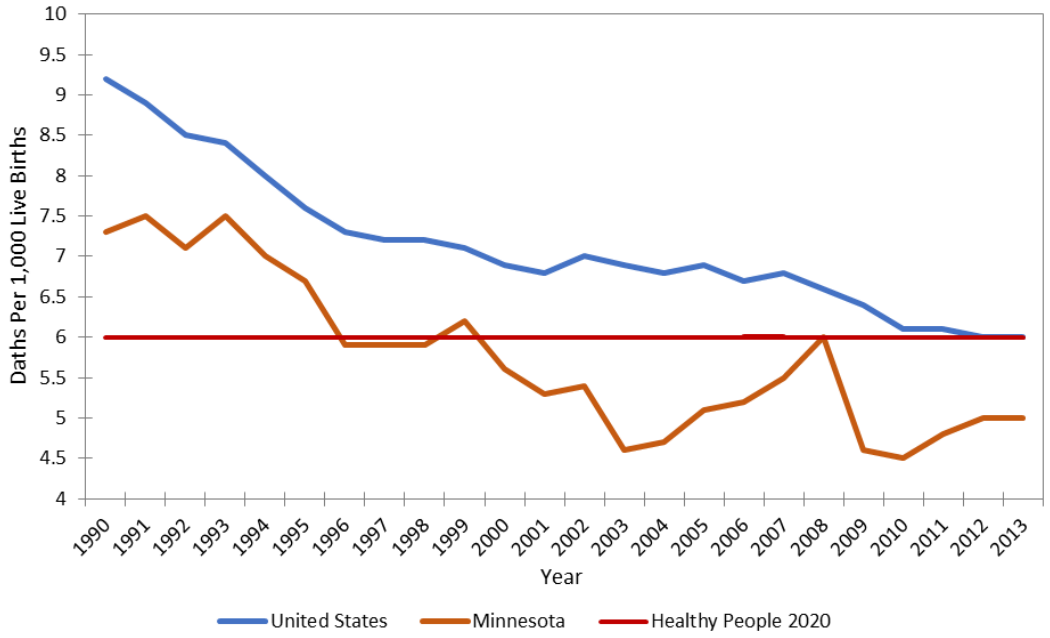
[3] The Pregnancy Risk Assessment Monitoring System (PRAMS) is a surveillance project between the MDH and the U.S. Centers for Disease Control and Prevention (CDC) that began in 1987. Minnesota PRAMS is an important part of MDH's surveillance activities, with the goal of improving the health of mothers and infants by reducing adverse outcomes such as infant mortality and morbidity. PRAMS administers a population–based survey designed to collect information on maternal behaviors and experiences before, during and after a woman's pregnancy. Each month, approximately 200 mothers are randomly selected from the state's file of birth certificates of babies born in the preceding two to four months, and are surveyed by mail or by telephone.

[4] Developed by MDH's Maternal and Child Health Section and specifically highlights data on African American women from the Minnesota PRAMS 2009-2010, the most recent years for which data are available. It is still undergoing review and not yet publicly available.

reduction in the infant mortality rate between communities of color and American Indians as compared to Whites by 2010.[5]

Minnesota has one of the lowest infant mortality rates in the country. Figure 1 shows that from 1990-2013, Minnesota's infant mortality rates have stayed below the U.S. rate. Minnesota met the Healthy People 2020 goal of 6.0 deaths per 1,000 births earlier and has sustained it over a longer period, while the nation as a whole met it only recently in 2012. The chart also shows that the state has experienced more and larger decreases in the rate over this period compared to the U.S.

Figure 1. Infant Mortality rates for the U.S. and Minnesota, 1990-2013.



Source: CDC National Vital Statistics Reports, Vol. 64, No. 9, August 6, 2015. Retrieved on December 2015 from http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_09.pdf

Despite overall gains in reducing infant mortality, racial and ethnic disparities in infant mortality rates persist in Minnesota. Table 1 shows that racial/ethnic disparities in infant mortality still exist and have improved very little between 2003-2007 and 2009-2013, and in fact has worsened among Hispanics. It also shows that African American and American Indian babies are more than twice as likely to die as White babies before their first birthday.

[5] Minnesota Department of Health (March 2015). *Infant mortality reduction plan for Minnesota: Part I*. Retrieved from http://www.health.state.mn.us/divs/cfh/program/infantmortality/content/document/pdf/infantmortality.pdf

Table 1. Infant mortality rates by race/ethnicity: Minnesota and United States, 2011-2013 (Rate per 1,000 Births)

	2003-2007			2009-2013		
Race/Ethnicity	Infant Mortality Rate	Disparity Ratio	Disparity Difference	Infant Mortality Rate	Disparity Ratio	Disparity Difference
African American	9.6	2.2	5.2	8.5	2.1	4.4
American Indian	10.7	2.4	6.3	9.6	2.3	5.5
Asian	4.7	1.1	0.3	4.4	1.1	0.3
Hispanic[+]	4.3	1.0	-0.1	5.3	1.3	1.2
White	4.4			4.1		

[+]Hispanic can be any race
Disparity Ratio = Population of Color Rate/White Rate
Disparity Difference = Population of Color Rate – White Rate

Source: Minnesota Department of Health, Center for Health Statistics

The causes of infant mortality vary by population: sleep-related causes, such as sudden infant death syndrome or SIDS, are a primary source of infant deaths in the American Indian community, while **prematurity is the leading cause of death among African-Americans**. Birth defects are the main source of infant deaths in the Asian, Hispanic, and White populations.

In Minnesota, as in the U.S., approximately 67 percent of infant deaths occur in the neonatal period (the first month of life), with the remaining deaths occurring during the postneonatal period (from one month to the end of the first year of life). Deaths occurring in the neonatal period are due mostly to problems with the pregnancy or health of the infant, such as preterm delivery, birth defects or low birthweight. Infant deaths occurring in the postneonatal period are more likely to be the result of social and environmental factors such as sudden infant death syndrome (SIDS), exposure to cigarette smoke, or problems with access to health care.

The timing of infant deaths also varies by population. Table 3 shows that in Minnesota from 2009-2013, the **neonatal infant mortality rate was about twice the postneonatal rate for African Americans**, Hispanics, and Whites, and was almost four times for Asians. For American Indians, the postneonatal death rate was only slightly higher than the neonatal death rate. **African Americans have the highest rate of neonatal deaths than any other population**, suggesting that successful program interventions for this population should be focused on factors that cause prematurity such as those that affect the woman's health during pregnancy.

Table 3. Infant mortality rate by time of death and race/ethnicity, Minnesota 2009-2013 (Rate per 1,000 Births)

	African American	American Indian	Asian	Hispanic[+]	White
Neonatal (<28 days)	5.7	4.6	3.5	3.5	2.8
Postneonatal (28 to 364 days)	2.8	4.9	0.9	1.8	1.3

[+]Hispanic can be any race

Source: Minnesota Department of Health, Center for Health Statistics

One such factor is smoking. For all races/ethnicities, the **infant mortality rate is higher among women who smoked during pregnancy** (Table 4). This rate was more than twice the rate among non-smoking African American and Hispanic mothers.

Table 4. Infant mortality rates by smoking status during pregnancy, Minnesota 2009-2013 (Rate per 1,000 Births)

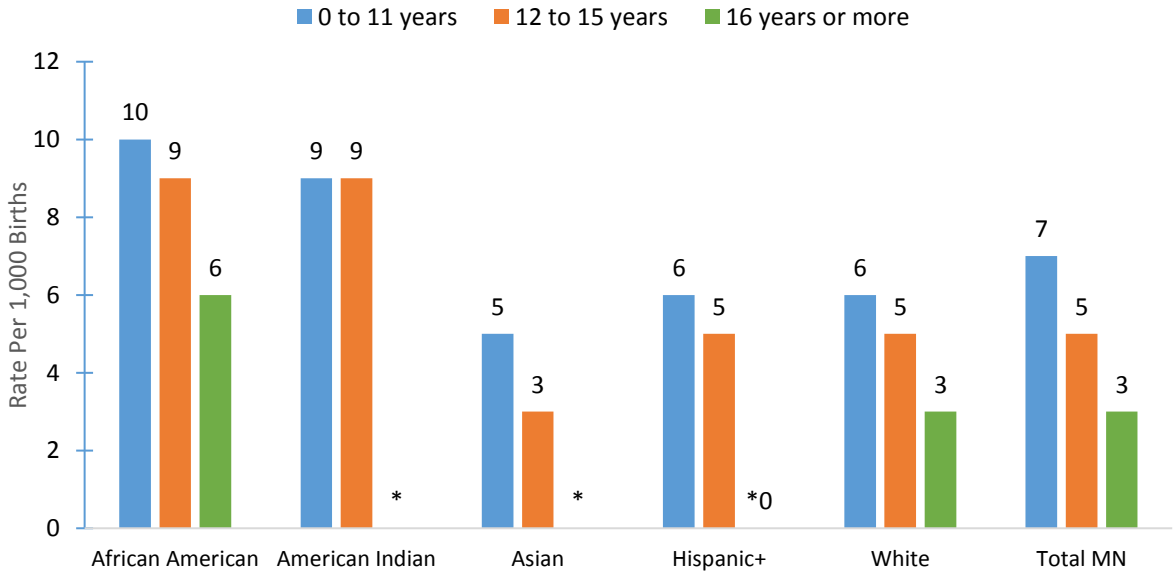
Smoking Status during Pregnancy	African American	American Indian	Asian	Hispanic[+]	White
Smoked	16.1	12.5	8.0	13.1	7.2
Did Not Smoke	7.7	7.4	4.3	4.9	3.6

[+]Hispanic can be any race

Source: Minnesota Department of Health, Center for Health Statistics

Another factor that affects birth outcomes is the mother's education. Figure 2 shows that across all races and ethnicities, the infant mortality rate declines as the mother's education level increases.

Figure 2. Infant mortality rate by maternal education and race/ethnicity, Minnesota 2008-2012



[+]Hispanic can be any race

Source: Minnesota Department of Health, Center for Health Statistics

But education does not seem to afford African American women as much advantage as it does women of other race. For instance, Figure 2 shows that the mortality rate for infants born to well-educated African American women, those who had 16 or more years of education, is the same as the rate for infants born to Hispanic and White women with less education (6 per 1,000 births).

Looking at it from a different angle, babies born to well-educated African American mothers are twice as likely to die before turning a year old compared to babies born to White and Hispanic mothers with the same level of education (rate of 6.0 versus 3.0).

Racism and stress have received increased attention. Research studies point to the relationship between chronic physiologic stress brought about by experiences of racial discrimination throughout one's lifetime and their cumulative effect on the body's nervous, endocrine and immune systems that is manifested during pregnancy.

These are only a few of the socio-economic and environmental factors that impact birth outcomes in the African American community.

Infant Mortality among U.S. Born African American Women in Minnesota

The African American population in Minnesota has become increasingly diverse. In 1990, 4.7 percent of all births to African American women were to women born outside the United States; by 2010, nearly half of these births were to foreign-born women, with the majority from Somalia, Ethiopia, Kenya and Liberia.

U.S. born African Americans in Minnesota experience persistent disparities in health outcomes, most of them with roots in inequities created by racism (slavery, Jim Crow "separate but equal" laws, segregation, unemployment, social exclusions, and harsh punishment for social infractions) and discrimination (redlining, predatory lending). Data show that U.S. born African Americans have fewer opportunities for health due to fewer educational opportunities, higher unemployment rates, lower rates of home ownership, and higher rates of homelessness and food scarcity that impact their health outcomes.

This historical inequity in opportunities seems to be borne out by the data. Table 5 shows that the African American infant mortality rate is more than twice the rate for Whites in Minnesota, and three times the White rate when looking only at U.S. born African Americans.

Table 5. Infant mortality rates among U.S. born and All African Americans, Minnesota 2009-2013 (Rate per 1,000 Births)

	U.S. Born African American	All African American
Infant mortality rate	11.7	8.5
Infant mortality disparity ratio (African American rate/White rate)	2.9	2.1

[+]Hispanic can be any race

Source: Minnesota Department of Health, Center for Health Statistics

Minnesota's Family Home Visiting (FHV) Programs

Minnesota Statute 145A.17 Family Home Visiting Programs Subdivision 1 established the following program goals for the Minnesota FHV Program:

- Foster healthy beginnings
- Improve pregnancy outcomes
- Promote school readiness
- Prevent child abuse and neglect
- Reduce juvenile delinquency
- Promote positive parenting and resiliency in children
- Promote family health and collaboration

Minnesota's Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program has chosen to implement two home visiting models from among those approved for selection by the U.S. Health Resources and Services Administration: Healthy Families America (HFA) and Nurse-Family Partnership (NFP). These models were selected based on the following criteria: opportunity to maximize the state's existing federal grant focused on the NFP, addition of the HFA with the NFP model to give the flexibility to serve more families, the strength of the NFP and HFA programs' evidence, and MDH capacity to support program expansion, including data collection.

In addition to sites offering HFA and/or NFP, Minnesota's local public health system offers a range of FHV programs including those that are: in various stages of applying to become a HFA and/or NFP implementing agency, exploring evidence-based models and implementing evidence-based practices, implementing locally-developed promising practice FHV models, and seeking formal designation as an evidence-based model by national experts.

The need for home visiting in Minnesota is undeniable, if maternal and child health statistics are an indication. For example:

- 8.4 percent of single term births were preterm (2012)
- 3.9 percent of pregnant women received inadequate or no prenatal care (2012)
- The birth rate for teens 15-17 years was 9.1 per 1,000, and it was 36.1 per 1,000 for 18-19 year olds (2010-2012)
- 33 percent of births were to unmarried mothers
- 7.9 percent of the mothers giving birth had a low education level (2012)
- 70,000 children under 5 years of age were living in poverty (2011)[6]

The program has served thousands of families across the state. Total enrollment in all of Minnesota's FHV programs was 30,809 families in 2011 and 27,420 families in 2012 (Table 5). The decrease in clients served is likely due to a number of factors such as an improvement in

[6] MDH Family Home Visiting Program Overview. Retrieved January 2016 from: http://www.health.state.mn.us/divs/cfh/program/fhv/index.cfm

data quality due to a more standard-based data collection and greater clarity in state reporting requirements, and an increase in the use of evidence-based models which has led to a move from short-term to longer-term more intensive visiting to address the complex needs of higher risk families.

Table 6. Number of clients enrolled in all FHV programs, Minnesota, 2011 and 2012.

	2011	2012
Primary caregivers	11,391	9,872
Prenatal clients	4,072	4,217
Infants and children	15,046	13,341
Total Enrollment	**30,809**	**27,420**

Source: Minnesota Department of Health Family Home Visiting Program. 2014 Report to the Legislature. Retrieved January 2016 from: http://www.health.state.mn.us/divs/cfh/program/fhv/content/document/pdf/legrept.pdf

CVAS reviewed evidence-based home visiting program models supported by the MDH FHV program as well as other evidence-based models with cultural components for adaptation. In its review, CVAS focused on key components that meet the needs of U.S. born African American women and children in Minnesota, including their cultural relevance for families from diverse backgrounds. These models include the two models implemented by Minnesota, Healthy Families America (HFA) and Nurse-Family Partnership (NFP), and also Federal Healthy Start, Mixed Provider, JJ Way, and Family Spirit.

1. **Healthy Families America (HFA**) is a nationally recognized evidence-based home visiting program model designed to work with overburdened families who are at-risk for adverse childhood experiences, including child maltreatment. It is the primary home visiting model best equipped to work with families who may have histories of trauma, intimate partner violence, mental health, and/or substance abuse issues. HFA services begin prenatally or right after the birth of a baby and are offered voluntarily, intensively and over the long-term (3 to 5 years after the birth of the baby). HFA's program goals are to:
    - Build and sustain community partnerships to systematically engage overburdened families in home visiting services prenatally or at birth
    - Cultivate and strengthen nurturing parent-child relationships
    - Promote healthy childhood growth and development
    - Enhance family functioning by reducing risk and building protective factors

2. **Nurse Family Partnership (NFP)** is an evidence-based, community health program that helps transform the lives of vulnerable mothers pregnant with their first child. Each mother served by NFP is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits that continue through her child's second birthday. NFP's program goals are to:

- Improve pregnancy outcomes by helping women engage in good preventive health practices, including thorough prenatal care from their healthcare providers, improving their diets and reducing their use of cigarettes, alcohol and illegal substances
- Improve child health and development by helping parents provide responsible and competent care
- Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.

3. **The Federal Healthy Start Program** has built its history and a substantial track record on serving vulnerable residents whose health and health care have been marginalized by virtue of race, gender, health status, economic status, and/or geography. Federal Healthy Start offers a unique delivery system of health and social services to pregnant and parenting (interconceptional) women while simultaneously providing Maternal and Child Health (MCH) home visiting promising practices that implement standardized core services developed by the Maternal and Child Health Bureau (MCHB). As a network rooted in the local community, federal Healthy Start has the keen ability to absorb other practice models within its overall service structure. Research conducted with the initial 15 federal demonstration Healthy Start projects with women screened during a five-month period in 1995 and 1996 showed that the federal cohort of Healthy Start projects were more successful in enrolling high risk women into case management using outreach models and lay Community Health Workers at community-based locations than clinical and WIC models.[7] A vast majority of the federal Healthy Start programs use a foundational model of home visitation that includes mixed provider types.

4. **Mixed Provider Model of Care** is a unique model of home visitation that employs a mixed team of professional and paraprofessional staff such as registered nurses, social workers, counselors, case managers, and lay workers (Community Health Workers, doulas) in the delivery of home visitation services. The mixed provider team works together in delivering services to at-risk women at any stage of her perinatal health and reproductive life and their families, including male involvement components. The mixed provider model takes place not only within participant families' homes but other locales within a specific target community (clinics, schools, churches, community centers, multifamily housing complexes, etc.). Using lay workers, from the community from which they identify and share through language, socio-economic status, race/ethnicity, and life experiences as part of the provider team for home visitation, helps to engage and strengthen individual and family involvement in the home visit, which in turn improves pregnancy outcomes and infant health. The mixed provider model used by the federal Healthy Start cohort addresses not only the medical

[7] Federal Health Start: McCormick M.C., Deal L.W., Devaney B.L., Chu D., Moreno L., and Raykovich K.T. The impact on clients of a community-based infant mortality reduction program: The National Healthy Start Program survey of postpartum women. *Am J Public Health*. 2001; 91:1975-1977. Retrieved January 2016 from: http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.91.12.1975

conditions and health issues of at-risk perinatal women but also their stressors of everyday life.

5. **The JJ Way** is a midwifery model of maternal care to eliminate racial and class disparities in perinatal health and improve birth outcomes for all infants. Realizing that the midwifery model could help improve birth outcomes for all babies, midwife Jennie Joseph (JJ), a British trained midwife who practices in Florida and her birth center team worked to create a midwifery-based model that was culturally relevant and accessible to women of color and low-income women, mostly African American and Hispanic women. The key objectives for this practice are for pregnancies to reach a gestation of 37 weeks or greater and for newborns to have a birth weight of 5 lbs. 8 ounces (2500 grams) or greater. The first adaptation of this model is the use of a team approach. The JJ Way® staff believes that increasing a woman's social capital (though prenatal bonding between mother and baby, and also with the father, siblings, extended family, friends, and clinic team members) increases the likelihood of positive birth outcomes. In a 2007 study of The JJ Way® conducted with 100 women enrolled at The Birth Place clinic in Winter Garden, Florida, there were no premature or low birth weight babies born to African American or Hispanic women in the study.[8] The JJ Way® program provides:

    - *Easy access to evidence-based prenatal care.* No patient is turned away
    - *Connections.* Prenatal bonding of mother, father, family and friends is encouraged
    - *Knowledge.* Culturally relevant educational messages are shared throughout the child-bearing experience
    - *Empowerment.* Patients and their families take responsibility for their own care
    - *Choice of delivery site*. Patients may deliver at the birth center or hospital
    - *Practitioner training, education and consultation*

6. **Family Spirit** is an evidence-based and culturally tailored home-visiting intervention delivered by Native American paraprofessionals as a core strategy to support young Native parents from pregnancy to 3 years post-partum. Parents gain knowledge and skills to achieve optimum development for their preschool age children across the domains of physical, cognitive, social-emotional, language learning and self-help. Family Spirit is currently the largest, most rigorous and only evidence-based home visiting program designed specifically for Native American families. Family Spirit's program goals are:

    - Increase parenting knowledge and skills
    - Address maternal psychosocial risks that could interfere with positive child-rearing (e.g., drug and alcohol use, depression, low education and employment, domestic violence)

[8] Of the 84 who remained in the program and delivered a live birth, 29.4% self-identified as African American and 16.5% as Hispanic. From: JJ Way cost savings [PDF document]. Retrieved January 2016 from the Commonsense Childbirth website: http://www.commonsensechildbirth.org/wp-content/uploads/2011/05/JJ-Way-Cost-Savings-.pdf

- Promote optimal physical, cognitive, social/emotional development for children from ages 0-3
- Prepare children for early school success
- Ensure children get recommended well-child visits and health care
- Link families to community services that address specific needs
- Promote parents' and children's life skills and behavioral outcomes across the lifespan

CVAS Recommendations for Improving Minnesota's Family Home Visiting (FHV) Program

CVAS's review of the models of care provided information about their effectiveness and offered important insights into program development as well as implementation that were useful in developing the recommendations to improve home visiting for African American communities in Minnesota.

Effective home visiting programs are those that respond to the unique needs of each individual family, build on family strengths, and work to build the capacity and self-sufficiency of families they serve. Quality programs recognize and appreciate the cultural basis of parenting and avoid stereotyping. Families are more likely to engage in services that are culturally and linguistically appropriate. Culture is essential in addressing a person's health and wellbeing. Several components must be considered when developing a home visiting model of care that is evidence-based and culturally tailored to the unique needs of African Americans:

1. **Meet participants where they are.** This means providing the services and support based on their individual circumstances, their priorities and their strengths. It must take into account the challenges they are facing (e.g., transportation barriers) but also what participants themselves can contribute (e.g., tapping into the family as a nexus of strength or involving family members in child-rearing).
2. **Include cultural/community components.** Cultural components that could be incorporated into programs for the African American community include: traditional parenting/nurturing practices, cultural teachings/worldviews, family structure (e.g., elder caregivers, extended family), African American life skills development, cultural lesson modules (illustrative designs, scenarios, activities), and community resources (e.g., African American cultural programs)
3. Creating and adapting a model of care must **include the engagement of the African American community.** Institutions such as black churches and African American-led organizations work closely with families and know of their challenges and circumstances and assets (see 1 and 2 above) which must be taken into consideration in creating and adapting models of care.

CVAS recommends creating and/or adapting an effective evidence-based practice model of care with components specific to the cultural needs of the African American community in

Minnesota, and using a mixed provider model that is a combination of Community Health Workers, doulas, midwives, Registered Nurses, and social workers to provide the home visits and other wraparound services.

The overarching theme that arose from CVAS's work, meetings and group discussions, and community sharing and co-learning sessions was the significant value in recognizing the strengths inherent in African American communities that have contributed to their survival and growth despite overt and structural inequality and racism. These cultural strengths can be an important basis for building, sustaining, and moving the community towards greater health equity. At the same time, Minnesota's efforts to reduce the infant mortality rate and poor birth outcomes among U.S. born African American women must be strengthened to increase and broaden the understanding of health equity issues, and must be accompanied by learning from community-based organizations and diversifying leadership and staff of organizations and institutions that serve the African American community**.** The current infant mortality crisis in Minnesota signals the need to pay close attention to the conditions that impact the quality of life of African Americans, particularly the psychosocial factors that pose as risks for poor birth outcomes.

An African American FHV Model with a cultural and holistic component is a priority recommendation for improvement of FHV programming in Hennepin County for African American women. An evidence-based FHV model must be developed or adapted and implemented in partnership with the African American community. The Federal Healthy Start Mixed Provider Model of care has proven to work to improve the quality of care among individuals most disadvantaged or at- risk areas, and served by federal Healthy Start programming. It is an important point of care to utilize individuals who resonate with the community and reflect the culture of that community as a method of building trust.

The recruitment, training and placement of Community Health Workers, doulas, patient navigators and other health paraprofessionals who have authentic community relationships, are culturally competent, and reflect the community being served, must be promoted and accelerated. They can help women overcome barriers to care.

MDH must allocate funding for creating or adapting an evidence-based model of care curriculum that is specific to the unique circumstances of African American communities in Minnesota. For example, adapting a cultural curriculum or model of care such as Family Spirit or The JJ Way.

Other recommendations include:

- Advance efforts to strengthen the mother's support system (father/partner, family, friends, other pregnant women, surrogate grandmothers and sisters)
- Continue to rigorously examine the conditions that have produced the rise in infant deaths among African Americans in Minnesota to enable the development of interventions that effectively prevent these outcomes. Address these conditions as a State civil rights issue.

- ❖ Continue to provide funding for comprehensive culturally sensitive, race- and gender-specific research and interventions explicitly designed to respond to the current crisis of infant mortality in U.S. born African Americans. These programs must be community-based and include a focus on expectant fathers.
- ❖ Advance the MDH FHV program's focus on the development of trainings and protocols, as well as identifying resources that will support and advance continually monitored and assessed training and delivery practice of all home visitors.
- ❖ The MDH FHV program must employ professional and managerial staff reflective of all communities of color in Minnesota, specifically the African American community. Position descriptions and hiring practices must demonstrate the value of authentic relationships that are inclusive of African American representation in the workforce. MDH must lead by example to ensure the trust of the community and community partners.
- ❖ Increase health literacy by involving members of the target population - including persons with limited health literacy - in planning, developing, implementing, disseminating, and evaluating health and safety information. Apply proven health literacy design principles and standards to health information and services. For example, studies have shown that picture-based instructions promote better understanding of how to take medication and decrease medication errors among patients.
- ❖ Support community action and awareness programs that help to reduce infant mortality. An example is the **Twin Cities-based African American Babies Coalition**, a group of community stakeholders that educates the public in a culturally relevant and accessible about the effect of traumatic experiences (toxic stress) that can short-circuit a child's brain development.
- ❖ Expand Minnesota's state funded Fetal and Infant Mortality Review (IMR) process to include specific recommendations for system changes that lead to improved data organization and translation to reduce disparities in communities at greatest risk.[9]
- ❖ Agency-wide, MDH must continue to increase understanding of the root causes of infant mortality among African Americans in Minnesota through education and dialogues with the community. Hold learning sessions, trainings, workshops, forums or conferences on race and equity with community partners that include viewing and discussion of videos such as *Race - The Power of an Illusion*.[10] Consider developing a training module with community partners that examines the life course theory, how it is congruent with African American culture and concepts of resiliency, and how these concepts can be used to address health disparities and improve birth outcomes.

[9] IMR is an action-oriented, collaborative activity involving community partners and health professionals that involves reviewing cases of infant death. The results of the review help families and communities understand the factors behind infant deaths, who are then connected to appropriate community resources so they can develop culturally-appropriate strategies for reducing the risks of infant death.

[10] Race – The Power of an Illusion is a 2003 three-party documentary produced by California Newsreel that tackles race in society, science and history.

Specific Recommendations on Community Engagement

- Expand and continue to develop and maintain strong authentic community engagement partnerships that utilize the expertise of individual community members and community organization in advocating and addressing infant mortality disparities among African Americans in Minnesota
- Community engagement grant projects must include the expertise of community members, MDH and MDH FHV staff and leadership reflective of the community served.
- MDH and Hennepin County FHV community engagement partnerships must be transparent in all aspects of the process, including planning, implementation, evaluation, reporting, and emphasizes the value of co-authorship.
- When grant writing is done for reducing infant mortality among U.S. born African Americans and other health disparities there must be sufficient resources for engagement work. Support should include funding for on-going sustainable project implementation in the community, technical assistance, and evaluation. Support should be prioritized for innovative, culturally and holistically connected projects that are led by community-based organizations and skilled community members and professionals trusted by the communities they serve.
- Sustain the CVAS Advisory Committee's community-led project work. This should include expanding committee membership, include community work and the design of a web-based site to provide greater impact and serve as a community point of information exchange/center for community and faith-based organizations, community members, MDH and other stakeholders. The site will include FHV messages for at-risk areas, a community infant mortality educational toolkit on effective evidence-based/ best practices, culturally specific and holistic intervention models of care and services, co-learning session schedules for infant mortality and racial equity workshops, CVAS advisory meetings/membership, and other materials and information regarding infant mortality, health disparities and undoing systemic racism.
- MDH grant funding to sustain CVAS project work should also include producing a video for the community, stakeholders, legislature, professionals and others. The video will be used for training purposes, education and information of all CVAS work done to date.

Policy Recommendations

- Efforts to address the root causes of health inequities must address policies and systems in sectors other than health, and health and equity considerations must be incorporated in all policies. The health community - public health agencies, health funders, community-based organizations, health care professionals, researchers and practitioners – must broaden its reach by engaging and partnering with individuals and organizations in sectors such as education, housing, transportation, and criminal justice.
- A lesson that can be gleaned from the 25-year history of the Healthy Start Initiative is that low birth weight and fetal/infant morbidity in disadvantaged communities such as in African

American communities can be reduced. It is therefore essential that government support, especially in terms of financial infusion, be maintained and increased to support federal Healthy Start programs the persistent health disparities suffered by African Americans right from birth are reduced.

- Regulatory boards or bodies must build cultural and linguistic proficiency, competence, and awareness into specific requirements for licensure, accreditation, and certification of health care professionals.
- MDH must require the use of community-based standards to measure quality of service/performance.
- MDH must provide additional funding opportunities for Minnesota communities facing the greatest risk for infant mortality and health professionals to have continued constructive dialogues/forums/co-learning sessions on race and racism, and to explore how racism has shaped the personal and collective experiences of many in the Minnesota. In so doing, individuals can explore opportunities for healing from racial wounds, while engaging in a broader dialogue that allows the state to move beyond its racial conflicts. Include engagement with a variety of news media to advance Minnesota's understanding of how race continues to shape life experiences in the state.
- Build and strengthen networks with community and faith-based organizations, social service agencies, and nontraditional partners—such as foster care services, poison control centers, and literacy service providers— to deliver health and safety information to different points in the community

Community Voices and Solutions Advisory Group, 2010-2013

Name	Title	Organization
Alfred Babington Johnson	CEO	Stair Step Foundation
Mary Jo Chippendale	Supervisor	MDH, Maternal and Child Health
Mitchell Davis	Health and Wellness Director	Minneapolis Urban League
Dorii Gbolo	Executive Director	Open Cities Community Health Center
Clarence Jones	Director of Community Outreach	South Side Community Health Center
Marianne Keuhn	State Director - Programs & Public Policy	March of Dimes
Shirlynn LaChapelle	Nurse	Minnesota Black Nurses Association
Beverly Propes	Public Health Nurse	Minneapolis Public Schools
Akhmiri Sekhr-Ra	Project Director	Cultural Wellness Center
Shennika Sudduth	Family Support Service Manager	Model Cities
Janet Thimke	Infant Mortality Advisor	MDH, Maternal and Child Health
Angela Watts	Project Director	Twin Cities Healthy Start
José Gonzalez	Director	MDH, OMMH
Babette Jamison	African American Health Coordinator	MDH, OMMH
Melanie Peterson-Hickey	Research Scientist	MDH, Center for Health Statistics
David Stroud	Supervisor	MDH, Center for Health Statistics

Community Voices and Solutions Advisory Group, 2015

Name	Title	Organization
Trena Allbritton	Public health nurse	NorthPoint Health and Wellness Center
Rhonda Chakolis	Pharmacist (PharmD)	CVS Pharmacy
Marcus Edorh	Statistical analyst	General Mills Corporation
Theresa Evans-Ross	Independent consultant	Community member
Jackie Whitmore	Family services coordinator	Urban Ventures
Xiaoying Chen	Community Engagement Planner	MDH, OMMH
Kim Edelman	Epidemiologist Senior	MDH, Center for Health Statistics
Mia Robillos	Research Scientist	MDH, Center for Health Statistics