Eliminating Health Disparities Initiative: Infant Mortality Grants Fiscal Year 2022

Report to the Minnesota Legislature 2022
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Minnesota Department of Health
Center for Health Equity
P.O. Box 64975, St. Paul, MN 55164-0975
(651) 201-5813
https://www.health.state.mn.us/communities/equity/ehdi/index.html

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Executive Summary

The Eliminating Health Disparities Initiative (EHDI) is a grant program within the Minnesota Department of Health (MDH) Center for Health Equity (CHE). Established in 2001 by the Minnesota Legislature (Minnesota Statute 145.928), EHDI was designed to strengthen local control and decision-making in communities across the state towards elimination of health disparities.

EHDI provides funds to close the gap in the health status of Africans/African Americans, American Indians, Asian/Pacific Islanders, and Hispanics/Latine in Minnesota compared to whites in eight priority health areas: Breast and Cervical Cancer Screening, Diabetes, Heart Disease & Stroke, HIV/AIDS and Sexually Transmitted Infections, Immunizations for Adults and Children, Teen Pregnancy Prevention, Unintentional Injury and Violence, and Infant Mortality.

This report covers EHDI activities during the state fiscal year 2022 (FY22) (July 1, 2021, to June 30, 2022), the third year of EHDI's current four-year grant cycle, of the two infant mortality grantees: American Indian Family Center (AIFC) and Minnesota Indian Women's Resource Center (MIWRC). Together, they provide services to American Indians residing in Hennepin, Ramsey, Dakota, and Washington counties. Aside from targeting individual-level changes (such as increasing or improving awareness, knowledge, behavior, or skill), their programs focus on broader social determinants of health, such as changing policies, systems, or environments to address the root causes of inequities.

For the third year in a row, the grantees have had to adapt their programming in response to the COVID-19 pandemic. Many in-person activities resumed, while still taking precautions to ensure the safety of participants, staff, and partners. Despite all the challenges that COVID presented, in FY22 AIFC's and MIWRC's combined efforts included 113,028 interactions with people to increase awareness around infant mortality, 256 people reached in efforts to increase access to healthcare, 107 participants in targeted prevention activities such as parent education, and 40 people involved in tailored intervention services, such as mental health counseling. These are duplicated numbers, as some people were reached in more than one way.

EHDI legislation requires that MDH report how the infant mortality grantees use their grant funds and the amount expended for each use. In FY 22, the two grantees spent 76% of funding on salaries and fringe, 4% on contractual services, 9% on supplies, 2% on other expenses, 9% on indirect expenses, and 1% on travel.

EHDI is only one of many statewide efforts to reduce infant mortality rates. By empowering community-based organizations to develop and implement strategies that build on community strengths, EHDI enables grantees to make important contributions to the elimination of infant mortality disparities in communities most impacted by health inequities. With continued support from the state, they can create more and longer-lasting changes at the individual, community, institutional, and system levels.

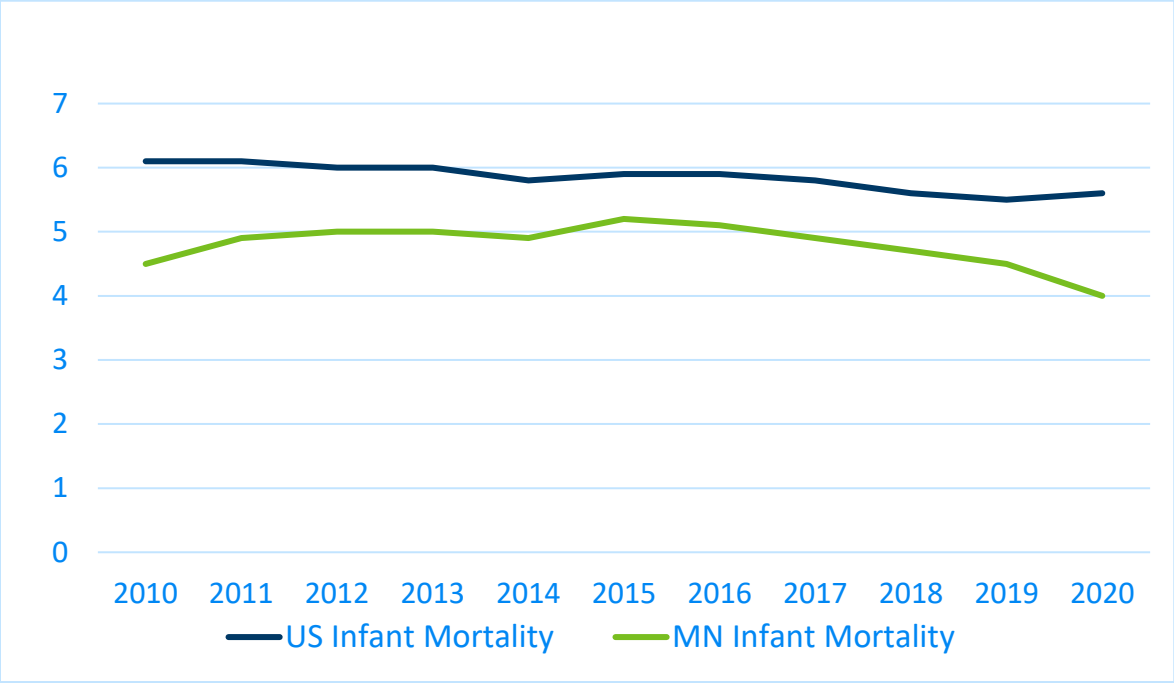
I. Infant Mortality in Minnesota

Infant Mortality Rates and Disparities

Infant mortality is defined as the death of an infant before his or her first birthday. The infant mortality rate is measured in terms of the number of infant deaths per 1,000 live births. It is considered a key indicator of maternal and child health, as well as overall societal health. According to the U.S. Centers for Disease Control and Prevention (CDC), the infant mortality rate in Minnesota in 2020 was a 4% decline from the previous year, from 4.6 infant deaths per 1,000 live births in 2019 to 4.2 infant deaths per 1,000 live births in 2020.[1] This means that for every 1,000 infants that were born alive in Minnesota in 2020, four died before their first birthday.

The infant mortality rate in the U.S. exhibited a declining trend from 2010 to 2020 (Figure 1). Minnesota rates were lower than those for the U.S. during these years, and in 2020 reached its lowest rate at 4.13 after peaking in 2015 at 5.17.

Figure. 1. Infant Mortality Rates, U.S. and Minnesota, 2010-2020

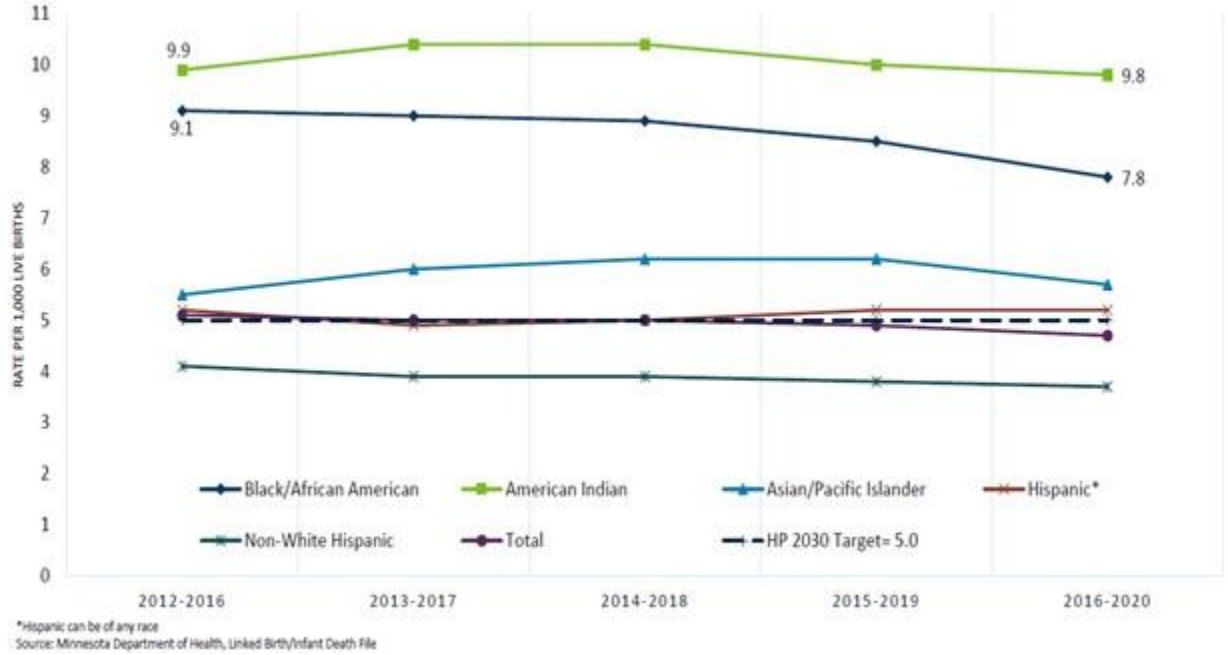


Source: Minnesota Center for Health Statistics.

[1] Ely, D. M., & Driscoll, A. K. (2021). Infant Mortality in the United States, 2019: Data From the Period Linked Birth/Infant Death File. National Vital Statistics Reports: From the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, 70(14), 1-18

However, the declining infant mortality rates mask significant disparities. Figure 2 shows that in Minnesota for the periods 2012-2016 to 2016-2020, the rates of infant mortality among American Indians (9.8), Black/African American (7.8), Asian/Pacific Islander (5.7) and Hispanics (5.2) are higher than the rate for non-Hispanic whites (3.7). This means that compared to white babies, American Indian and Black/African American babies are more than twice as likely to die before reaching their first birthday. The infant mortality rates for Hispanics and Asian/Pacific Islanders also show an upward trend.

Figure. 2. Infant Mortality Rates (five-year rolling averages) by Maternal Race/Ethnicity, Minnesota, 2012-2016 to 2016-2020



Based on 2016-2020 Minnesota data, the leading causes of infant deaths in Minnesota are prematurity (33.1% of all infant deaths), congenital anomaly or birth defect (25.3%), other perinatal conditions (14.7%), and sudden infant death syndrome or sudden unexpected infant death (SIDS/SUID) (11.5%)[2]. These causes vary by population. Prematurity is the leading cause of infant deaths for babies born to Black/African American, Asian/Pacific Islander, and Hispanic mothers, while SIDS/SUID the leading causes of infant deaths for babies born to American Indian mothers.

Infant mortality rates also vary by maternal characteristics, behaviors, and access to health care, as well as social, economic, and environmental determinants of health (SDOH). Policies and programs give rise to the living and working conditions that can pose risks to the health of the mother and baby, leading to diminished opportunities for a healthy future.

For example, disparities are observed when variables such as mother's nativity, age, smoking status, and education are factored in.

[2] MDH Linked Birth-Infant Death in Minnesota Resident Period Data File, 2022.

- Infant mortality rates are higher for U.S.-born compared to foreign-born African American, Asian/Pacific Islander, and Hispanic women compared to whites, due to the immigrant effect; that is, they retain the advantages of healthier lifestyles and food they were used to in their home countries when they move to the U.S.
- Infant mortality rates are higher among women who smoke, but compared to white smokers they are more than double for smokers in communities of color and American Indian communities.
- Teen moms experience higher infant mortality rates than older women, and those from EHDI populations are also more likely to live in poverty and have less access to adequate health care.
- Infant mortality rates are generally higher among women with fewer years of education. By race/ethnicity, however, it is striking that rates are still higher among African American and American Indian women even if they have received more years of education than white women.

Statewide Infant Mortality Reduction Plan

MDH released the Infant Mortality Reduction Plan for Minnesota: Part 1 (PDF) in March of 2015. The document serves as a "call-to-action" to address the persistent racial and ethnic disparities in infant mortality and poor birth outcomes in the state. The plan was developed with input from a diverse group of community and professional stakeholders to identify the sources of infant mortality disparities and to gather their perspectives on changes the state could make in systems, policies, and practices to improve birth outcomes. It lists seven recommendations to reduce infant mortality:

1. Improve health equity and address the social determinants of health that most significantly impact disparities in birth outcomes.
2. Reduce the rate of Sudden Unexpected Infant Deaths (SUID), which includes SIDS and sleep-related infant deaths in Minnesota.
3. Assure a comprehensive statewide system that monitors infant mortality.
4. Provide comprehensive, culturally appropriate, coordinated health care to all women during the preconception, pregnancy, and post-partum period.
5. Reduce the rate of preterm births in Minnesota.
6. Improve the rate of pregnancies that are planned, including reducing the rate of teen pregnancies.
7. Establish an ongoing task force of stakeholders to oversee implementation of recommendations and action steps.

EHDI is only one of many statewide efforts to reduce infant mortality rates. This report demonstrates how EHDI infant mortality grantees contribute to the implementation of Recommendations 1, 2, 4, and 5 of the Infant Mortality Reduction Plan (EHDI awards separate teen pregnancy prevention grants that contribute to recommendation 6). With continued support from the state, EHDI grantee efforts can make important contributions to the elimination of disparities in infant mortality in Minnesota.

II. The Center for Health Equity and EHDI

The mission of MDH is to protect, maintain, and improve the health of all Minnesotans. The elimination of health disparities and achievement of health equity are agency-wide goals. Achieving optimal health for all Minnesotans requires creating an environment in which everyone has access to what they need to be healthy.

The Center for Health Equity (CHE) provides leadership for MDH's efforts to advance health equity. The Eliminating Health Disparities Initiative (EHDI) is a grant program within CHE. It was established by the Minnesota Legislature in 2001 (Minnesota Statute 145.928 in Appendix A) in response to mounting evidence that disparities in health outcomes between Minnesota's white residents and residents from populations of color and American Indian communities were distressingly wide and on a clear trajectory to grow even wider. EHDI provides funds to close the gap in the health status of Africans/African Americans, American Indians, Asian/Pacific Islanders, and Hispanics/Latine in Minnesota compared to whites in eight priority health areas: Breast and Cervical Cancer Screening, Diabetes, Heart Disease and Stroke, HIV/AIDS and Sexually Transmitted Infections, Immunizations for Adults and Children, Teen Pregnancy Prevention, Unintentional Injury and Violence, and Infant Mortality. The legislature added prenatal care as a ninth priority health area during the 2019 legislative session with no specific appropriation to this priority health area.

The initiative was designed to strengthen local control and decision-making in communities across the state toward the elimination of these disparities in the four priority populations. Funding sources for the grant are state General Funds and federal Temporary Assistance to Needy Families or TANF funds (only Teen Pregnancy Prevention grantees receive TANF funds). Even though Minnesota ranks high in terms of general health status compared to other states, the state has some of the worst racial/ethnic health disparities between groups in the nation.

III. EHDI Infant Mortality Grants

Information in this section was obtained from annual reports submitted by grantees covering the reporting period July 1, 2021, through June 30, 2022 (FY 22).

Fiscal Year 2022 Overview

In FY 22, two organizations received EHDI funding to implement infant mortality programs: American Indian Family Center and Minnesota Indian Women's Resource Center. They served primarily American Indians in Ramsey, Dakota, and Washington counties (see Appendix B). These organizations are funded for the current grantee cycle of FY 20-23 and serve families and infants through their Wakanyeja Kin Wakan Pi or Our Children Are Sacred and Parenting Skills Education programs.

The infant mortality grantees were awarded a total of $347,183 for FY22. Information on how grantees expended these funds is provided on page 9. Grantees worked to address health disparities beyond providing programs that target individual-level changes (such as awareness, knowledge, behavior, or skill). They also focused on broader social determinants of health, such as changing policies, systems, or environments to address the root causes of inequities. Grantee activities at the individual, organization, community, and system levels are shown on page 10.

The infant mortality grantees reached community members in several ways: they provided them with targeted prevention and tailored intervention services, engaged them in efforts to build organizational and community capacity to improve access to culturally relevant health care services, and built community awareness through education. Details on reach methods and numbers reached are provided on pages 12-13.

EHDI grantees, like the rest of the world, are still adapting to the repercussions of the COVID-19 pandemic. They continued to engage with participants virtually while also creating safety protocols to ensure the well-being of staff and community members as they transition to in-person engagement. Meanwhile, these frontline organizations also provided basic needs and ensured community members were equipped with the

latest COVID-19 information. Grantees were proud to report that these were accomplished despite the emergencies and immense pressures created by the COVID-19 pandemic.

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Use of Grant Funds

EHDI legislation requires that MDH's infant mortality report include information on specific uses of grant funds and the amount expended for each use. Table 1 shows how the two infant mortality grantees used their EHDI funding in FY 22.

Table 1: All Uses of Grant and Total Funds Awarded to Infant Mortality Grantees, Fiscal Year 2022.

	Salaries and Fringe	Contractual Services	Travel	Supplies	Indirect	Other	Total Spent	Total Awarded
AIFC	$98,289	$7,300	$1,817	$24,218	$14,254	$773	$146,651	$178,171
MIWRC	$132,937	$3,961		$4,734	$12,716	$3,810	$158,158	$169,012
Total	$231,226	$11,261	$1,817	$28,952	$26,970	$4,583	$304,809	$347,183
% of Total Spent	75.9%	3.7%	0.6%	9.5%	8.8%	1.5%		

Grantees spent 76% of funding on salaries and fringe, 4% on contractual services, 9% on supplies, 2% on other expenses, 9% on indirect expenses, and 1% on travel.

Travel expenses include mileage reimbursement for staff travel to meet clients and paying for Uber trips for client travel. Supplies expenses include office supplies such as postage, mailing, program supplies, communication costs, office furniture, evaluation expenses, and others. Finally, other expenses include program incentives, food for events, necessity items for clients such as household and hygiene items, and others (Table 1).

Appropriation Retained for Administrative Purposes

Grants are allocated through the EHDI RFP selection process, and MDH does not retain funds for administrative and associated expenses. The total amount of funds appropriated for these grants is allocated to community grantees.

Objectives, Level of Change, and Activities

In response to community and stakeholder feedback and based on the EHDI philosophy that all work must be community-driven, the EHDI program allow grantees to expand programming to go beyond targeting individual-level changes (such as awareness, knowledge, behavior or skill) to focus on broader social determinants of health, such as changing policies, systems or environments that address the root causes of inequities. Beginning in the FY20-FY23 grant cycle, EHDI allowed applicants to choose to work within one or more levels of change to address one or more of the PHAs. The three levels of change are:

Level 1: **Health Promotion/Direct Service**: Providing education or direct services to individuals

Level 2: **Organizational/Institutional Change**: Changing organizational or institutional policies or changing the way a system in an organization or institution works.

Level 3: **Root Causes/Conditions for Health:** Participating in or leading efforts that target specific social and economic conditions for health (also known as the social determinants of health) to address the root causes of health disparities.

The two grantees funded to address infant mortality identified intended objectives and corresponding strategies at all three levels of change.

Objectives and Activities

American Indian Family Center

- Objective 1: Reduce risk factors that can lead to infant mortality and increase protective factors to prevent infant mortality (Level 1).
    - Provide weekly parent-education to mother's and father's utilizing the Positive Indian Parenting curriculum.
    - Host Community Baby Shower to celebrate and welcome new babies and parents.
    - Mentor parents who need support while implementing new skills as a parent
    - Provide training for participants to provide mentorship to other mothers/families.
    - Provide support and access to an American Indian Early Childhood Family Education (ECFE) Class
    - Screen and assess needs through a holistic intake process to identify care plan goals
    - Provide support and resources for chemical dependency support and Fetal Alcohol screenings
    - Provide therapeutic Life Coaching
    - Conduct culturally sensitive home visits
    - Host workshops and community activities/events
    - Provide additional support and resources to families as needed
- Objective 2A: Build the capacity of service providers to provide culturally specific health services to American Indian women (Level 2).
    - Navigate the health and human services systems to aid in building the capacity of service providers to provide culturally specific health services to American Indian women. Increase access to primary care through culturally competent outreach and enrollment strategies.
- Objective 2B: Build the capacity of local social service organizations to provide culturally specific health services to American Indian women (Level 2)
    - Provide training to other state, local, and non-profit organizations around Positive Indian Parenting and the use of culturally specific curriculum.
    - Develop partnerships with health and community organizations to work collaboratively to review and discuss cultural curriculum and service delivery models
    - Participate in coalitions, planning meetings and councils at local, county, and state levels

Minnesota Indian Women's Resource Center

- Objective 1A: Reduce Native maternal-child morbidity/mortality (including Infant Mortality) and the unintentional violence and injury associated with Child Protection involvement (Level 1)
    - Provide family case management
    - Provide individual and group parenting education
    - Provide direct client assistance

- Conduct Indigenous Breastfeeding Counselor Program training
- Conduct Indigenous Safe Sleep Promotion training

- Objective 1B: Increase the amount of effective, culturally appropriate parenting program model knowledge available to entities seeking to reduce Native maternal-child morbidity/mortality and avoid or reduce the unintentional violence and injury associated with Child Protection involvement (Level 1)
    - Evaluate the Life Skills Parenting program using a "decolonizing data" approach
    - Objective 2A: Increase dominant-culture institutions' understanding of the historical roots of Native American/Alaska Native health disparities so that they can better address disparities via effective policy changes (Level 2) Conduct Historical Trauma training
- Objective 3A: Increase the capacity of MIWRC to advocate on behalf of urban Native American families for policies that support breastfeeding (Level 3).
    - Get involved in the Minnesota Breastfeeding Coalition and with partners, With Partners, advocate specifically for policy goals that will improve breastfeeding rates for Indigenous families in Minnesota.

Shared Measurement System

A shared measurement system (SMS is a system of tracking, measuring, and reporting on the collective or shared reach and outcomes common across grantees within a priority health area. EHDI first implemented an SMS in FY18, marking a critical first step in better understanding the collective impact of the EHDI program. Since then, changes to EHDI's SMS have included more detail required in annual reporting for reporting program reach and seeking ways to understand better and assess outcomes within and across populations achieved through EHDI. The SMS is now being implemented with the second cohort of grantees. However, the COVID-19 pandemic has dramatically impacted the expansion and adaptations significantly. Data reported here still needs to catch up on the many meaningful ways grantees are tracking changes in the health of their participants, which is evident from individual evaluation reports. Nonetheless, this section provides a picture of grantees' impact within and across target populations and priority health areas.

Program Reach

Reach categories aim to broadly capture the variety of strategies EHDI grantees employ within their priority health areas. These reporting categories were first used in FY20, replacing direct and indirect contacts, based on a qualitative analysis of the shared work grantees engaged in before and during the COVID-19 crisis. Output categories from grantee evaluation plans were summarized into four categories as part of the EHDI SMS:- growing awareness, ensuring access, targeted prevention, and tailored intervention. *Growing awareness* and *ensuring access* correspond to the idea of indirect contact in that the strategies and activities undertaken in these categories in and of themselves may not be sufficient to change health conditions or disparities, but they are necessary due to the unequal access created by current social conditions. *Targeted prevention* and *tailored intervention* strategies are often promising or evidence-based strategies that aim to directly influence protective or risk factors for specific health conditions in both holistic and targeted ways. Definitions of the strategies grantees use to reach their target populations include:

1. **Growing Awareness** of health issues, and of solutions available through EHDI funded programs or other available resources. For example, they engage in media campaigns, host, and attend health fairs, and build community buy-in to advocate for policies that promote well-being.

2. **Ensuring Access** to culturally relevant health services for people and families by providing transportation, translation, insurance enrollment, service referrals or other wrap-around services that help stabilize and address needs that prevent them from prioritizing health. EHDI grantees also train and coordinate among institutional and policy partners to help them provide services that are culturally relevant and holistic so that community members have trust their needs will be addressed.
3. **Providing Targeted Prevention** through individualized and/or group programming for prevention or wellness purposes to people who are at high risk or already at borderline for developing a health condition. For example, people attend nutrition education or exercise classes, receive immunizations, or have a mammogram or other screening. People also learn about strategies for preventing unintended pregnancies and avoiding HIV/AIDS and STIs.
4. **Providing Tailored Intervention**s such as disease management and containment services for people with underlying health conditions. For example, grantees may employ Community Health Workers who help people regularly monitor blood pressure and cholesterol levels or offer diabetes management classes. Grantees also provide safety and wellness interventions for people who have caused or survived violence.

In FY22, EHDI infant mortality grantees reached American Indian community members in all four ways described above. They had approximately 113,028 interactions with people via social media campaigns, cultural and traditional practices ceremonies, and other outreach strategies (growing awareness); they provided wrap around services to families, referrals or training on providing culturally relevant services to 256 people (ensuring access); 107 people participated in targeted prevention activities such as new moms creating contextualized and tailored safe sleep and breastfeeding plans, and 40 people with diagnosed mental health or educational intervention needs received tailored intervention services (Table 3).

Table 3. Number of People reached by EHDI Infant Mortality Grantees by strategy, Fiscal Year 2022

Reach Strategy	# American Indians Reached
Growing Awareness	113,028
Ensuring Access	256
Targeted Prevention	107
Tailored Intervention	40

Specific examples of activities within each strategy area are:

- Growing awareness: social media campaigns; training on historical trauma, traditional foods and medicines; community baby showers; and individual and group education to raise awareness about the importance of infant mortality risks and prevention measures.
- Ensuring access: training non-Native providers and government entities in understanding the impact of historical trauma and promoting policy changes that will positively impact Native families.
- Targeted prevention: screenings, education sessions that address safe sleep, breastfeeding, and car seat safety.

- Tailored intervention: caregivers of infants are referred to in-house mental health counseling if screening identifies the need for further services.

Evaluation

EHDI grantees are required to evaluate their programs, including developing a logic model and an evaluation plan. Beyond reporting on populations reached through specific strategies, EHDI grantees are typically required to evaluate their programs, including developing a logic model and an evaluation plan. Beyond annual reporting on shared measures, such as populations reached through specific strategies and individual counts, EHDI grantees have the option to report findings from their own evaluations. These evaluations are envisioned to increase evidence for the community-based solutions grantees develop to address health disparities. The COVID-19 pandemic put significant pressure on grantees to prioritize community needs and provide them with COVID-19 resources and information. For this reason, the standard expectations for evaluation have been waived since FY20 in reporting other program outcomes, which limited the available evaluation data.

Infant mortality grantees did report specific outputs that resulted from their activities, such as the number of participants or recipients of services, events held, or products created. For example, AIFC hosted 46 parent education sessions, and MIWRC provided historical trauma training to 17 adults and 8 children. The two organizations also collaborated to increase access to primary care through culturally competent outreach and enrollment strategies.

Stories of Success in FY22

In their FY22 annual report, the infant mortality grantees shared program highlights amidst the challenging work of adapting to COVID-19 and the corresponding emergent community needs.

American Indian Family Center (AIFC)

"This year has been great for our Parent Mentor Program - Soogizin Dodem - in that the participants are starting to feel more confident in their ability to lead other parents in the community. Many have taken leadership over leading discussions with the group and have discussed meeting outside of the group with program participants as their own support group. Our EHDI staff have been encouraging them to do so and we are excited to see where they take it and how far they have come over the last two years. Our Men's and Women's group have also received many referrals from outside sources and in-house and continue to work with our wrap-around service model to support each program participant to the best of our ability. The Men's program supported the building of a Traditional Sweat Lodge in the fall of 2021. Our Men's Outreach Specialist began developing a relationship with Belwin Nature Conservancy in early 2021, and over time gained access to land where programs are able to access Sweat Lodge and other Traditional Ceremonies. These ceremonies support not only the OAI group, but also WKWP, Soogizin Dodem, and other programming at AIFC."

Minnesota Indian Women's Resource Center

"Key accomplishments have been in recruitment, collaboration, curriculum development, and outreach. Recruitment- we receive both county and self-referrals, each family that seeks our services and enters the program we see as a success since we are able to assist them at every capacity to help them achieve their parenting goals. Collaboration- This is beneficial for both clients and the agency to bring in community consultants to educate us all. This also allows for relationships between organizations to develop. Curriculum development- Gifts From The Sacred Circle is the curriculum that we follow, it is a culturally specific parenting skills guidebook. Assignments are either written or a discussion depending on the clients preferred learning

method. Outreach- Community events and word of mouth from our clients has helped spread recognition to the community of our services at MIWRC, this has been a successful method."

COVID-19 Impact

Because of ongoing COVID-19, both agencies have transitioned to hybrid programming. While virtual programs continue, staff are also working to create protocols for safe transition to in-person programming, prioritizing staff and community well-being, and fulfilling basic needs. Many families engaged through grantee programming have been personally affected by COVID-19 by having a relative or neighbor get sick. Many in the community are homeless and are more vulnerable on the street. Many in the community do not have access to vehicles and this makes shopping and access to essential needs additionally difficult. Many of the people with whom grantees engaged, regardless of geographic location, experience barriers to accessing remote or virtual services due to lack of internet access or technology devices. Additionally, the American Indian community in the Twin Cities metro area has seen an increase in the number and size of public encampments of unhoused community members.

Potential Cost Savings

The work of EHDI infant mortality grantees can lead to potential health care cost savings for the state. Both grantees implemented parenting education programs which have been demonstrated in the literature to generate cost savings, societal benefits, and economic benefits. In the short term this could mean cost savings from prevented hospitalizations, and in the long term this could include taxpayer savings from a reduced need for remedial social and education programs; reduced child maltreatment, child developmental delays, school failure, and criminal activity; and increased productivity from a better prepared workforce. One study found that the United States would save $13 billion per year and prevent an excess of 911 deaths if 90% of families breastfeed exclusively for 6 months.[3] Another study calculated a return on investment of $31 for every $1 spent on parent education programs that teach prevention of infant sleep-related deaths and incapacitating injuries to infants from motor vehicle accidents.[4]

IV. Conclusions

The Minnesota Legislature established EHDI in 2001 to close the gap in the health status of Africans/African Americans, American Indians, Asian/Pacific Islanders, and Hispanics/Latine in Minnesota compared to whites in eight priority health areas, including infant mortality. EHDI is grounded in the philosophy that community issues require community solutions. By empowering community-based organizations to develop health improvement strategies that build on community strengths, community members are more likely to be reached, engaged, and impacted.

U.S. infant mortality rates have been gradually declining in the last few decades, reaching their lowest between 2015 and 2020. In Minnesota, infant mortality rates have exhibited a similar downward trend. Additionally, Minnesota's infant mortality rates are generally lower than the national rate and most states. Despite this seemingly rosy picture for the state, the health gaps between whites and populations of color and American Indians remain. If Minnesota is to advance health equity, the state must pay attention to inequities

[3]US. Department of Health and Human Services. (2011). Breastfeeding: Surgeon General's Call to Action Fact Sheet. https://www.hhs.gov/surgeongeneral/reports-and-publications/breastfeeding/factsheet/index.html
[4]Minnesota Department of Health. (2020). Infant Mortality. Source: Minnesota Center for Health Statistics. https://data.web.health.state.mn.us/infant_mortality

in social and economic factors which are the key contributors to health disparities and are what need to change. The EHDI infant mortality grantees are doing just that.

Information gathered from infant mortality grantees in FY 22 indicate that EHDI is making significant contributions towards the goal of reducing infant mortality disparities. The two infant mortality grantees are serving one of the populations most impacted by infant mortality disparities, American Indians. Through strategies of growing awareness grantees reached 113,029 people; 256 people received services or training aimed at ensuring access to culturally relevant healthcare; 107 people participated in targeted prevention activities, and 40 people with diagnosed or identified health conditions received tailored intervention services. They provide services to American Indians residing in Ramsey, Dakota, and Washington counties. Grantees have reported these accomplishments despite the extreme challenges posed by COVID-19.

Strategies they employ include increasing health care access, providing culturally specific outreach and care coordination, trainings, workshops, and community events to honor and support their participants and to increase awareness of infant mortality; providing health and social services and referrals to improve the health of mothers, babies, and children; increased organizational capacity to serve their priority populations. They are utilizing community assets and strengths by implementing culturally responsive practices, for example, incorporating cultural elements into their programming.

EHDI, in partnership with MDH and the Minnesota State Legislature, is committed to making an impact on infant mortality disparities and inequities through the efforts of grantees. This work is a worthy and critical investment in the current and future health of Minnesotans.

APPENDIX A. EHDI Legislation

MINNESOTA STATUTES 2020 145.928

Subdivision 1. Goal; establishment. It is the goal of the state to decrease the disparities in infant mortality rates and adult and child immunization rates for American Indians and populations of color, as compared with rates for whites. To do so and to achieve other measurable outcomes, the commissioner of health shall establish a program to close the gap in the health status of American Indians and populations of color as compared with whites in the following priority areas: infant mortality, access to and utilization of high-quality prenatal care, breast and cervical cancer screening, HIV/AIDS and sexually transmitted infections, adult and child immunizations, cardiovascular disease, diabetes, and accidental injuries and violence.

Subd. 2.State-community partnerships; plan. The commissioner, in partnership with culturally based community organizations; the Indian Affairs Council under section 3.922; the Minnesota Council on Latine Affairs under section 15.0145; the Council for Minnesotans of African Heritage under section 15.0145; the Council on Asian-Pacific Minnesotans under section 15.0145; community health boards as defined in section 145A.02; and tribal governments, shall develop and implement a comprehensive, coordinated plan to reduce health disparities in the health disparity priority areas identified in subdivision 1.

Subd. 3.Measurable outcomes. The commissioner, in consultation with the community partners listed in subdivision 2, shall establish measurable outcomes to achieve the goal specified in subdivision 1 and to determine the effectiveness of the grants and other activities funded under this section in reducing health disparities in the priority areas identified in subdivision 1. The development of measurable outcomes must be completed before any funds are distributed under this section.

Subd. 4.Statewide assessment. The commissioner shall enhance current data tools to ensure a statewide assessment of the risk behaviors associated with the health disparity priority areas identified in subdivision 1. The statewide assessment must be used to establish a baseline to measure the effect of activities funded under this section. To the extent feasible, the commissioner shall conduct the assessment so that the results may be compared to national data.

Subd. 5.Technical assistance. The commissioner shall provide the necessary expertise to grant applicants to ensure that submitted proposals are likely to be successful in reducing the health disparities identified in subdivision 1. The commissioner shall provide grant recipients with guidance and training on best or most promising strategies to use to reduce the health disparities identified in subdivision 1. The commissioner shall also assist grant recipients in the development of materials and procedures to evaluate local community activities.

Subd. 6.Process. (a) The commissioner, in consultation with the community partners listed in subdivision 2, shall develop the criteria and procedures used to allocate grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit for grant recipients. At the time a grant is awarded, the commissioner must provide a grant recipient with information on the outcomes established according to subdivision 3.

(b) A grant recipient must coordinate its activities to reduce health disparities with other entities receiving funds under this section that are in the grant recipient's service area.

Subd. 7.Community grant program; immunization rates, prenatal care access and utilization, and infant mortality rates. (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or more of the following priority areas:

(1) decreasing racial and ethnic disparities in infant mortality rates.

(2) decreasing racial and ethnic disparities in access to and utilization of high-quality prenatal care; or

(3) increasing adult and child immunization rates in nonwhite racial and ethnic populations.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

(1) is supported by the community the applicant will serve;

(2) is research-based or based on promising strategies;

(3) is designed to complement other related community activities;

(4) utilizes strategies that positively impact two or more priority areas;

(5) reflects racially and ethnically appropriate approaches; and

(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 7a. Minority-run healthcare professional associations. The commissioner shall award grants to minority-run healthcare professional associations to achieve the following:

(1) provide collaborative mental health services to minority residents;

(2) provide collaborative, holistic, and culturally competent health care services in communities with high concentrations of minority residents; and

(3) collaborate on recruitment, training, and placement of minorities with healthcare providers.

Subd. 8. Community grant program; other health disparities. (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or more of the following priority areas:

(1) decreasing racial and ethnic disparities in morbidity and mortality rates from breast and cervical cancer;

(2) decreasing racial and ethnic disparities in morbidity and mortality rates from HIV/AIDS and sexually transmitted infections;

(3) decreasing racial and ethnic disparities in morbidity and mortality rates from cardiovascular disease;

(4) decreasing racial and ethnic disparities in morbidity and mortality rates from diabetes; or

(5) decreasing racial and ethnic disparities in morbidity and mortality rates from accidental injuries or violence.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, determining community priority areas, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, and community clinics. Applicants shall submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

(1) is supported by the community the applicant will serve;

(2) is research-based or based on promising strategies;

(3) is designed to complement other related community activities;

(4) utilizes strategies that positively impact more than one priority area;

(5) reflects racially and ethnically appropriate approaches; and

(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 9. Health of foreign-born persons. (a) The commissioner shall distribute funds to community health boards for health screening and follow-up services for tuberculosis for foreign-born persons. Funds shall be distributed based on the following formula:

(1) $1,500 per foreign-born person with pulmonary tuberculosis in the community health board's service area;

(2) $500 per foreign-born person with extrapulmonary tuberculosis in the community health board's service area;

(3) $500 per month of directly observed therapy provided by the community health board for each uninsured foreign-born person with pulmonary or extrapulmonary tuberculosis; and

(4) $50 per foreign-born person in the community health board's service area.

(b) Payments must be made at the end of each state fiscal year. The amount paid per tuberculosis case, per month of directly observed therapy, and per foreign-born person must be proportionately increased or decreased to fit the actual amount appropriated for that fiscal year.

Subd. 10. Tribal governments. The commissioner shall award grants to American Indian tribal governments for implementation of community interventions to reduce health disparities for the priority areas listed in

subdivisions 7 and 8. A community intervention must be targeted to achieve the outcomes established according to subdivision 3. Tribal governments must submit proposals to the commissioner and must demonstrate partnerships with local public health entities. The distribution formula shall be determined by the commissioner, in consultation with the tribal governments.

Subd. 11. Coordination. The commissioner shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts.

Subd. 12. Evaluation. Using the outcomes established according to subdivision 3, the commissioner shall conduct a biennial evaluation of the community grant programs, community health board activities, and tribal government activities funded under this section. Grant recipients, tribal governments, and community health boards shall cooperate with the commissioner in the evaluation and shall provide the commissioner with the information needed to conduct the evaluation.

Subd. 13. Reports. (a) The commissioner shall submit a biennial report to the legislature on the local community projects, tribal government, and community health board prevention activities funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. These reports are due by January 15 of every other year, beginning in the year 2003.

(b) The commissioner shall release an annual report to the public and submit the annual report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over public health on grants made under subdivision 7 to decrease racial and ethnic disparities in infant mortality rates. The report must provide specific information on the amount of each grant awarded to each agency or organization, an itemized list submitted to the commissioner by each agency or organization awarded a grant specifying all uses of grant funds and the amount expended for each use, the population served by each agency or organization, outcomes of the programs funded by each grant, and the amount of the appropriation retained by the commissioner for administrative and associated expenses. The commissioner shall issue a report each January 15 for the fiscal year beginning January 15, 2016.

Subd. 14. Supplantation of existing funds. Funds received under this section must be used to develop new programs or expand current programs that reduce health disparities. Funds must not be used to supplant current county or tribal expenditures.

Subd. 15. Promising strategies. For all grants awarded under this section, the commissioner shall consider applicants that present evidence of a promising strategy to accomplish the applicant's objective. A promising strategy shall be given the same weight as a research or evidence-based strategy based on potential value and measurable outcomes.

APPENDIX B: EHDI Infant Mortality Grantees Program Description, Population and Geography Served, Fiscal Year 2022

Grantee Organization (Program Name)	Description	Population(s) Served	Geography Served
American Indian Family Center (Wakanyeja Kin Wakan Pi or Our Children Are Sacred)	A specific, comprehensive, wrap-around model for women who are pregnant and/or parenting that includes, educational and support classes to increase parenting knowledge, increase participation in screening and assessment, and develop family wellness care plan.	American Indian	East Metro area including Ramsey, Washington, and Dakota counties
Minnesota Indian Women's Resource Center (Life Skills Parenting)	Direct service programs to support Native families at risk for or involved with Child Protection in developing positive parenting skills, accessing needed home stabilization resources, and connecting with health and educational interventions that will assist both parents and children in need of such. Additionally, support non-Native providers and government entities in understanding the impact of historical trauma on our families, and promoting policy changes that will help reduce the disproportional involvement of Native families in Child Protection.	American Indian	Hennepin County