Eliminating Health Disparities Initiative: Infant Mortality Grants Fiscal Year 2023

October 18, 2024

Eliminating Health Disparities Initiative Infant Mortality Grants Report

Minnesota Department of Health
Health Equity Strategy and Innovation Division
P.O. Box 64975, St. Paul, MN 55164-0975
(651) 201-5813
https://www.health.state.mn.us/communities/equity/ehdi/index.html

Table of Contents

Executive Summary

The Eliminating Health Disparities Initiative (EHDI) is a grant program within the Minnesota Department of Health (MDH) Health Equity Bureau, in the Division of Health Equity Strategy and Innovation. 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, cardiovascular disease, diabetes, HIV/AIDS and sexually transmitted infections, immunizations for adults and children, infant mortality and access to and utilization of high-quality prenatal care, teen pregnancy prevention, and unintentional injuries and violence.

This report covers EHDI activities for the state fiscal year 2023 (FY 2023) from July 1, 2022, to June 30, 2023, the fourth and last year of the EHDI 2019-2023 grant cycle. There were 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 focused 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 after COVID-19 was declared a pandemic, the grantees had to adapt their programming in response to this public health emergency. Many in-person activities that moved to virtual settings during the height of COVID-19 resumed in FY 2023, while still taking precautions to ensure the safety of participants, staff, and partners. Despite all the challenges that COVID presented, the combined efforts of AIFC and MIWRC produced 938 interactions with people to increase awareness around infant mortality, 165 people reached in efforts to increase access to healthcare, 227 participants in targeted prevention activities such as parent education, and 14 people involved in tailored intervention services, such as substance use 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 used their grant funds and the amount expended for each use. In FY 2023, the two grantees spent 78% of funding on salaries and fringe, 4% on contractual services, 6% on supplies, 8% on other expenses, 0.7% on travel, and 3% on indirect (overhead) expenses.

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.

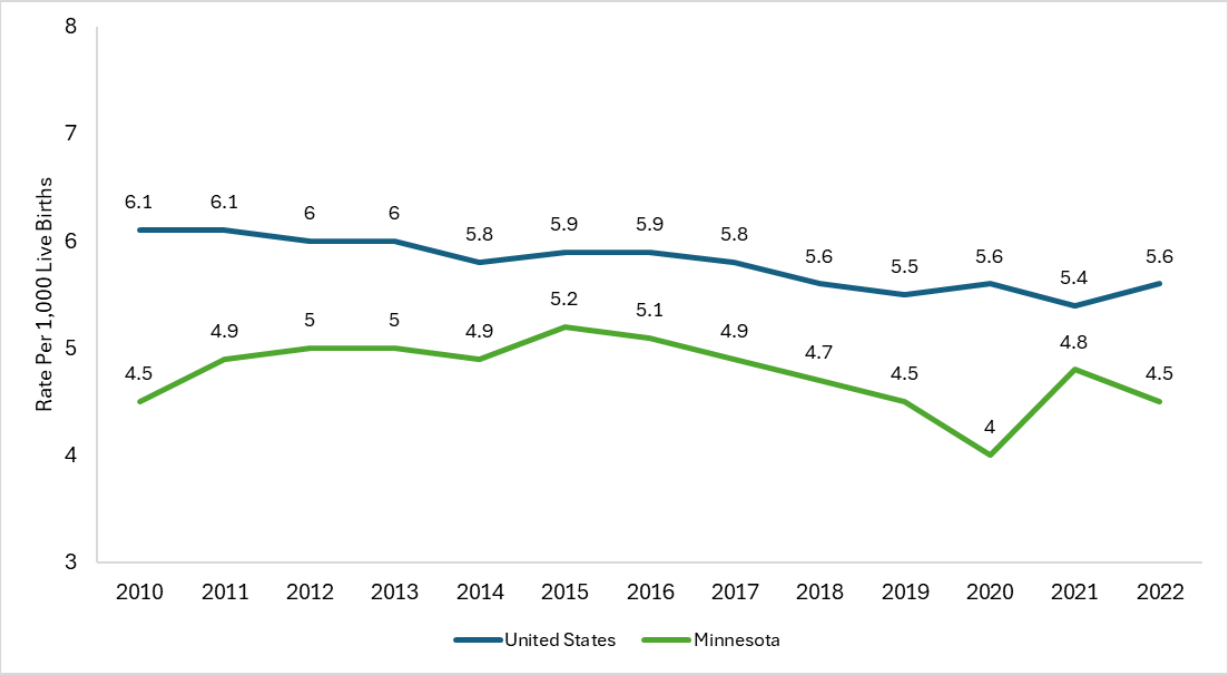
I. Infant Mortality in Minnesota

Infant Mortality Rates and Disparities

Infant mortality is defined as the death of an infant before their 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. Based on data from the U.S. Centers for Disease Control and Prevention (CDC), Minnesota's infant mortality rate in 2022 declined six percent from the previous year, from 4.8 infant deaths per 1,000 live births in 2021 to 4.5 infant deaths per 1,000 live births in 2022.[1] This means that for every 1,000 infants that were born alive in Minnesota in 2022, four died before their first birthday.

The infant mortality rate in the U.S. exhibited a declining trend from 2010 to 2021, then inched back up in 2022 (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 5.2.

Figure 1: Infant Mortality Rates, United States and Minnesota, 2010-2022



Source: CDC – National Center for Health Statistics - Homepage (https://www.cdc.gov/nchs/). August 5, 2024.

[1] Ely, D. M., & Driscoll, A. K. (2024). Infant Mortality in the United States, 2022: 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, 73(5), 1-19.

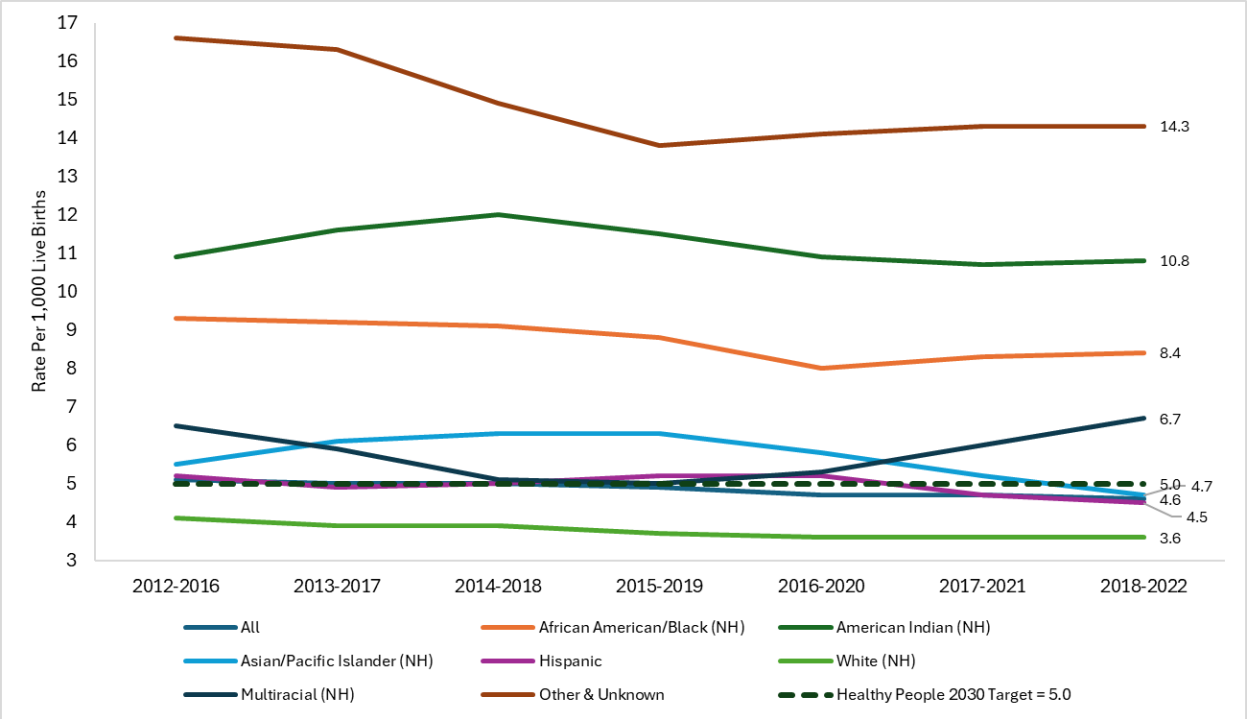
However, the declining infant mortality rates mask significant disparities. Table 1 and Figure 2 show that in Minnesota for the periods 2012-2016 to 2018-2022, the rates of infant mortality among American Indians (10.8), African American/Black (8.4), Asian/Pacific Islander (4.7) and Hispanics (4.5) are higher than the rate for non-Hispanic White (3.6). This means that compared to babies who are White, American Indian and African American/Black babies are more than twice as likely to die before reaching their first birthday. Moreover, while the infant mortality rate for all of Minnesota declined from the previous period from 4.7 to 4.6 and stayed the same for Whites, rate increased for African American/Black (8.3 to 8.4), American Indian (10.7 to 10.8), and Multiracial (6.0 to 6.7).

Table 1: Infant Mortality Rates (five-year rolling averages) by Maternal Race/Ethnicity, Minnesota, 2012-2016 to 2018-2022

	2012-2016	2013-2017	2014-2018	2015-2019	2016-2020	2017-2021	2018-2022
All	5.1	5	5	4.9	4.7	4.7	4.6
African American/Black, Non-Hispanic	9.3	9.2	9.1	8.8	8	8.3	8.4
American Indian, Non-Hispanic	10.9	11.6	12	11.5	10.9	10.7	10.8
Asian/Pacific Islander, Non-Hispanic	5.5	6.1	6.3	6.3	5.8	5.2	4.7
Hispanic	5.2	4.9	5	5.2	5.2	4.7	4.5
White, Non-Hispanic	4.1	3.9	3.9	3.7	3.6	3.6	3.6
Multiracial, Non-Hispanic	6.5	5.9	5.1	5	5.3	6	6.7
Other & Unknown	16.6	16.3	14.9	13.8	14.1	14.3	14.3

Source: 2022 Minnesota Final Linked Birth-Infant Period Cohort Death File. Minnesota Department of Health.

Figure 2: Infant Mortality Rates (five-year rolling averages) by Maternal Race/Ethnicity, Minnesota, 2012-2016 to 2018-2022



Source: 2022 Minnesota Final Linked Birth-Infant Period Cohort Death File. Minnesota Department of Health.

The cause of these infant deaths vary by race. Based on 2018-2022 data, the leading causes of infant mortality in Minnesota are prematurity (31.8% of all infant deaths), followed by congenital anomaly or birth defect (25.1%), other perinatal conditions (15.8%), and sudden infant death syndrome or sudden unexpected infant death (SIDS/SUID) (11.7%)[2]. For the same period, prematurity was the leading cause of infant deaths for babies born to Black/African American, Asian/Pacific Islander, and Hispanic mothers, while SIDS/SUID was the leading cause 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 (also known as social determinants of health or 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, Medicaid status, and education are factored in (charts can be found in Appendix A).

- 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.

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

- Infant mortality rates are higher among women who smoke, but compared to smokers who are White, they are more than double for smokers in communities of color and American Indian communities.
- Those who experience poverty and thus have less access to adequate health care have higher rates of infant mortality (for example, those on Medicaid).
- 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/Black and American Indian women even if they have received more years of education than women who are White.

Statewide Infant Mortality Reduction Plan

MDH released the Infant Mortality Reduction Plan for Minnesota: Part 1 (https://www.health.state.mn.us/docs/people/womeninfants/infantmort/infantmortality.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 listed 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 sudden infant death syndrome (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.

MDH's Infant Mortality Reduction Plan has expired, but the work continues under the broader recommendations outlined in the plan and under the Title V Maternal and Child Health Block Grant Program. The Infant Mortality Reduction Initiative (https://www.health.state.mn.us/people/womeninfants/infantmort/index.html) continues to raise awareness and offer resources about reducing infant mortality, Sudden Unexpected Infant Deaths (SUIDs), preterm births, and abusive head trauma (which also includes Shaken Baby Syndrome or SBS). Infant Mortality Awareness Week is observed each September in Minnesota. The event is an opportunity for individuals, organizations, government entities, health care systems, community partners, and coalitions to promote awareness and education about infant mortality.

In 2023, the Healthy Beginnings, Healthy Families Act: Infant Health (https://www.health.state.mn.us/people/womeninfants/infantmort/hbhfinfant.html) was established which created additional opportunities for the state to address infant mortality. Work under this act builds equitable,

inclusive, and culturally and linguistically responsive systems that ensure the health and well-being of young children and their families by establishing the Minnesota Partnership to Prevent Infant Mortality, and funding statewide grants to improve infant health outcomes. The grants are administered by the Maternal and Child Health Section in MDH's Child and Family Health Division.

II. The Health Equity Bureau 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, created in 2013 to provide leadership for MDH's efforts to advance health equity across the state, has grown dramatically in recent years. Recognizing this growth and the center's role in providing health equity support and technical assistance across MDH, the center was elevated to a division. Currently, the Division of Health Equity Strategy and Innovation operates under the Health Equity Bureau.

The Eliminating Health Disparities Initiative (EHDI) is a grant program administered by the Health Equity Strategy and Innovation Division. 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 residents who are White 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 Minnesota's populations of color and American Indians in Minnesota compared to White in eight priority health areas Breast and cervical cancer, Cardiovascular disease, Diabetes, HIV/AIDS and sexually transmitted infections, Immunizations for adults and children, Infant mortality and access to and utilization of high-quality prenatal care, Teen pregnancy prevention, and Unintentional injuries and violence. The legislature added prenatal care as a ninth priority health area during the 2019 legislative session with no specific appropriation, and thus it was blended into the Infant mortality 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, 2022 to June 30, 2023 (FY 2023).

Fiscal Year 2023 Overview

In FY 2023, two organizations received EHDI funding to implement infant mortality programs: American Indian Family Center and Minnesota Indian Women's Resource Center (Appendix B). They served primarily American Indians in Ramsey, Dakota, and Washington counties. These organizations are funded for the current grantee

cycle of FY 2020-2023 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 FY2023. Information on how grantees expended these funds is provided in the next section. 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 pages 11-12.

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 are provided in the Program Reach section, Table 3.

EHDI grantees, like the rest of the world, had to adapt 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.

In FY 2023, two organizations received EHDI funding to implement infant mortality programs: American Indian Family Center (AIFC) and Minnesota Indian Women's Resource Center (MIWRC). They focus primarily on American Indians in Ramsey, Dakota, and Washington counties through their EHDI programs Wakanyeja Kin Wakan Pi or Our Children Are Sacred (AIFC) and Life Skills Parenting (MIWRC).

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 2 shows how the two infant mortality grantees used their EHDI funding in FY 2023.

Table 2: All Uses of Grant and Total Funds Awarded to Infant Mortality Grantees, Fiscal Year 2023

	Salaries & Fringe	Contractual Services	Travel	Supplies	Other	Indirect	Total Spent	Total Awarded
AIFC	$167,735	$900	$1,726	$10,993	$18,138	$51	$199,543	$199,543[a]
MIWRC	$101,472	$13,905	$841	$8,505	$11,082	$10,906	$146,711	$169,012
Total	$269,207	$14,805	$2,567	$19,498	$29,220	$10,957	$346,254	$368,555
% of Total Spent	77.7%	4.3%	0.7%	5.6%	8.4%	3.2%		

[a] AIFC's Total Awarded amount of $199,543 includes $178,171 annual funding and $21,372 rolled over from the previous year. EHDI funds are awarded in the first fiscal year of the biennium. Any unused funding from the first fiscal year can be moved to the second fiscal year of the biennium. July 2022 to June 2023, which this report covers, was the second fiscal year of the biennium.

Salaries and fringe was the largest expense at 78% of the total for both grantees. They also spent 6% on supplies, 4% on contractual services, less than 1% on travel, 8% on other expenses, and 3% on indirect expenses.

Supplies included those used for group activities such as journals, yoga mats, paint, and canvas. Travel expenses included mileage reimbursement to and from program events, home visits, and program promotion, as well as airfare, lodging, and per diem for staff training. Other expenses included incentives to participants for taking part in evaluation activities. Finally, indirect expenses covered overhead costs such as utilities and rent.

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

Since 2001, EHDI has funded and supported strategies that communities of color and American Indian communities deem effective in their communities and that build on community strengths and assets. A key recommendation that emerged from a 2015 EHDI community input process was to encourage grantees to broaden program activities to address the social and economic conditions for health, also known as the social determinants of health. This meant allowing 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.

In their FY 2023 work plans, 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 mothers and fathers using a culturally specific parenting curriculum
    - Host Community Baby Showers 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 Syndrome (FAS) screenings
    - Provide therapeutic Life Coaching
    - Conduct culturally sensitive home visits
- Objective 2A: Build the capacity of service providers to provide culturally specific services to American Indian women (Level 2)
    - Build the capacity of service providers to help clients navigate the health and human services systems
    - Conduct culturally competent outreach to health care providers to improve their enrollment strategies and increase community access to primary care
- 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 using a culturally specific curriculum
    - Develop partnerships with health and community organizations to work collaboratively to review and discuss culturally specific curriculums and service delivery models
    - Participate in coalitions and councils at the local, county, and state levels to inform stakeholders of culturally specific curriculums, service delivery models, and best practices around working with the American Indian community

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 to families
    - Provide direct client assistance
    - Host Traditional Foods education event
    - Host Indigenous Cradleboards education event
- 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, advocate for policies 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 FY 2018, marking a critical first step in better understanding the collective impact of the EHDI program. Since then, EHDI has sought ways to better understand and assess outcomes achieved within and across EHDI populations. However, the COVID-19 pandemic has significantly impacted the implementation of the SMS. It was paused in FY 2021 and FY 2022 to allow grantees to focus their energies in addressing urgent COVID-19 related needs in their communities. The SMS was slowly brought back in FY 2023 by asking grantees to report on program reach. Data obtained during this reporting period still needs to catch up on the many meaningful ways grantees are tracking changes in the health of their participants as described in their annual reports. It is also narrower in scope than past years' SMS outputs and outcomes (see for example 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 FY 2020, 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. EHDI 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 Interventions** 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 FY 2023, EHDI infant mortality grantees reached 1,340 American Indian community members in all four ways described above (counts may be duplicated since some members were reached in more than one way). They had approximately 938 interactions with people in support and discussion groups to grow awareness; they provided access to 165 people through services, referrals, and training; 223 people participated in targeted prevention activities such as mentoring and cooking classes; and 14 people received recovery medicine and diabetes assistance (Table 3).

Table 3. Number of People reached by EHDI Infant Mortality Grantees by strategy, FY 2023

Reach Strategy	# American Indians Reached
Growing Awareness	938
Ensuring Access	165
Targeted Prevention	223
Tailored Intervention	14
All	1,340

Specific examples of activities within each reach strategy area are:

- Growing awareness: lactation support circle on Facebook, roundtable discussion on supporting Black and Brown mothers
- Ensuring access: weekly parenting sessions, weekly support groups, community baby shower, drum circle sessions, sweat lodge ceremonies, wrap-around services (such as Rule 25, advocacy, housing), historical trauma training, in-house referrals to outpatient substance abuse treatment
- Targeted prevention: one-on-one parent mentoring, parenting groups, healthy cooking class
- Tailored intervention: recovery medicine teaching, diabetes teaching

Evaluation

EHDI grantees are 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 were waived in FY 2020 and FY 2021. They were brought back slowly in FY 2023, which limited the available evaluation data.

Infant mortality grantees reported outputs that resulted from their activities. AIFC held 35 weekly parenting sessions in the women's program and 42 sessions in the men's program, 40 weekly father and men's support groups, one-on-one mentoring to 19 parents, 32 Drum Circle sessions, 16 Sweat Lodge ceremonies, and one community baby shower. MIWRC reported holding regular Indigenous perinatal lactation support circles on Facebook, holding parenting groups for client relatives, collaborating with DHS to host a roundtable on Black/Brown mothers, providing wrap-around services (Rule 25, advocacy, housing, education, and resources) to an estimated 25 moms and 10 children, historical trauma training to 20 adults and three children, in-house referrals for substance abuse services to four adults and five children, and a virtual class about healthy foods.

Both grantees reported program outcomes but were not specific about the levels achieved. For example, according to AIFC, the increase in participation levels they saw in their women's program shows that the safe space and the positive support they provide are helping the women become better parents; moms received lactation support and education about breastfeeding and risks of post-partum depression, infant infections, and other illnesses; the activities in their men's program (support groups, drum circles, and sweat lodge ceremonies) helped 8-12 men make significant life changes to better themselves; one father found employment at AIFC after participation in the men's program.

MIWRC participants received education on child development, healthy bonds, and self-improvement; families received assistance with basic household supplies, transportation, clothing and gear; community engagement activities (such as ribbon skirt making, sage picking, education on cultural food and Native seeds, and historical trauma training) and trainings received by MIWRC staff helped them understand their families better and customize their offerings based on the families' interests.

Stories of Success in FY 2023

In their FY 2023 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)

Our key accomplishment in year 4 was getting back to in-person and starting a consistent and steady weekly group. Having in-person groups is extremely important; participation levels went up and we witnessed how a safe space and positive support can go a long way in helping our women and moms make positive changes in their lives and be the best parents they can be. The same in men's programming. The men look forward to having a cultural venue where they could build trust and support each other. One participant is now employed within our organization and provides inspiration to other men/fathers in our community to better themselves. The support groups, drum and sweat lodge helped at least 8-12 men make significant life changes to better themselves and be better men, fathers and community members. In the Parent Mentor Program, we were able to conduct groups for families both virtually and in person. During in person sessions, gift bags were distributed consisting of self-care items, traditional medicines, cultural items, crafting supplies, books to build a home library, food items, garden supplies to start home gardens, and traditional plant medicines. Families received tools for stress relief, learned body movements to help with trauma, and made hand drums and ribbon skirts to learn traditional songs and attend ceremonies.

Minnesota Indian Women's Resource Center (MIWRC)

Some of the key accomplishments in year four are trainings staff attended which helped us to better serve the community we work with. Every event and group we offered to families is a highlight because we were able to get knowledge out to our families. With community engagement activities, we were able to understand our families better and offer them knowledge and training on their interests. During this year, Life Skills Parenting offered families individual and group parenting education through our cultural curriculum. Client assistance provided families with basic hygiene help, basic household supplies, transportation assistance, school clothes, and gear. This grant made it possible to offer cultural groups and events to engage the community, such as ribbon skirt making, sage picking, cultural food knowledge, seed knowledge, and training on historical trauma.

IV. Conclusions

The Minnesota Legislature established EHDI in 2001 to close the gap in the health status of populations of color and American Indians 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.

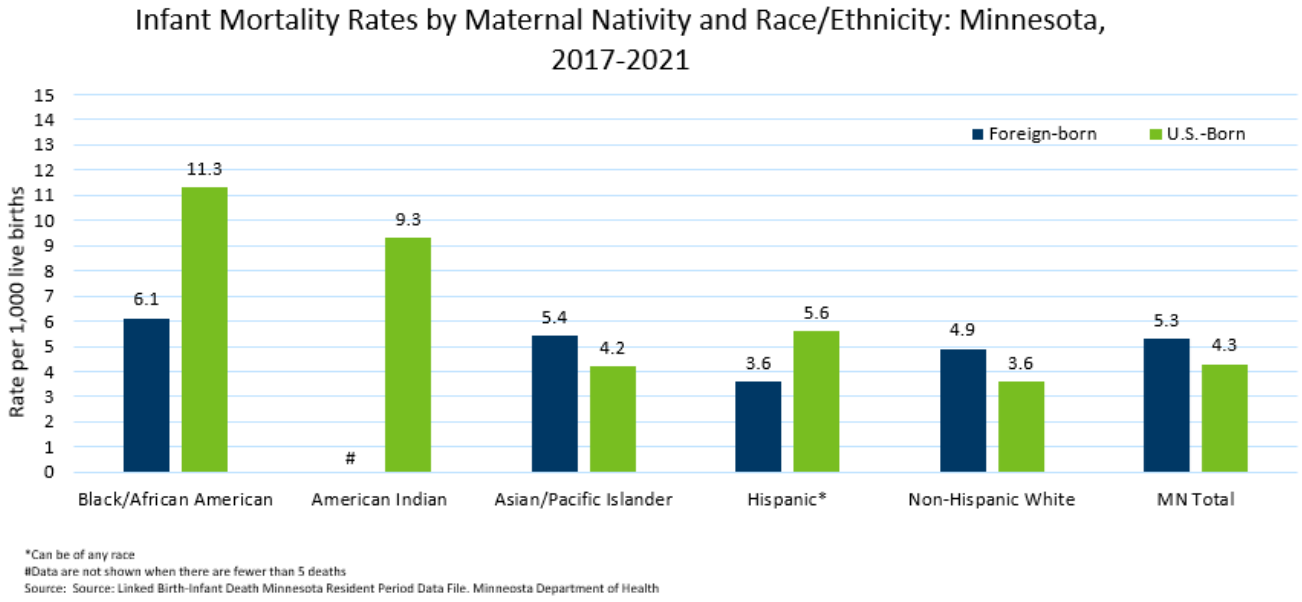
U.S. infant mortality rates have been gradually declining in the last few decades, reaching their lowest between 2015 and 2020. In Minnesota, infant mortality rates have exhibited a similar downward trend. Additionally, Minnesota's infant mortality rates are generally lower than the national rate and most states. Despite this seemingly rosy picture for the state, the health gaps between White and populations of color and American Indians remain. If Minnesota is to advance health equity, the state must pay attention to inequities 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 2023 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. In FY 2023 they reached a total of 1,340 American Indian community members. They had approximately 938 interactions with people in support and discussion groups to grow awareness of infant mortality; they provided access to 165 people through services, referrals, and training; 223 people participated in targeted prevention activities such as mentoring and cooking classes; and 14 people received recovery medicine and diabetes assistance. Grantees reported these accomplishments despite the continued challenges posed by COVID-19.

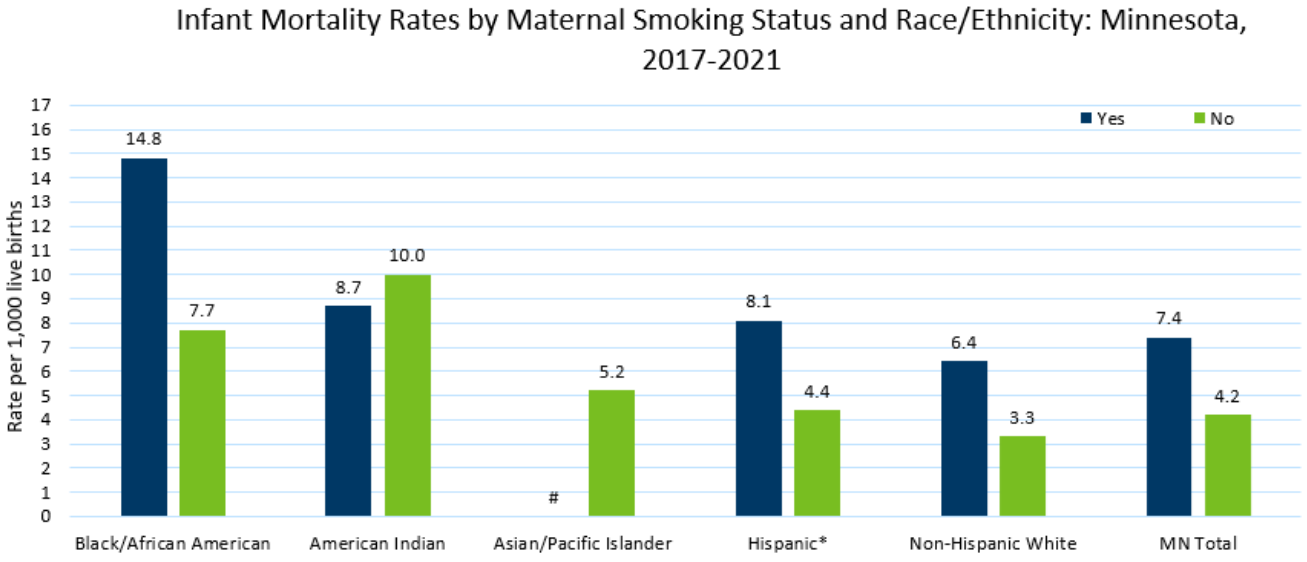
Strategies employed included increasing health care access, providing culturally specific outreach and care coordination, trainings, workshops, and community events to honor and support their participants and to increase awareness of infant mortality; providing health and social services and referrals to improve the health of mothers, babies, and children; and increasing 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. Infant Mortality Rates and Selected Social Determinants of Health, Minnesota

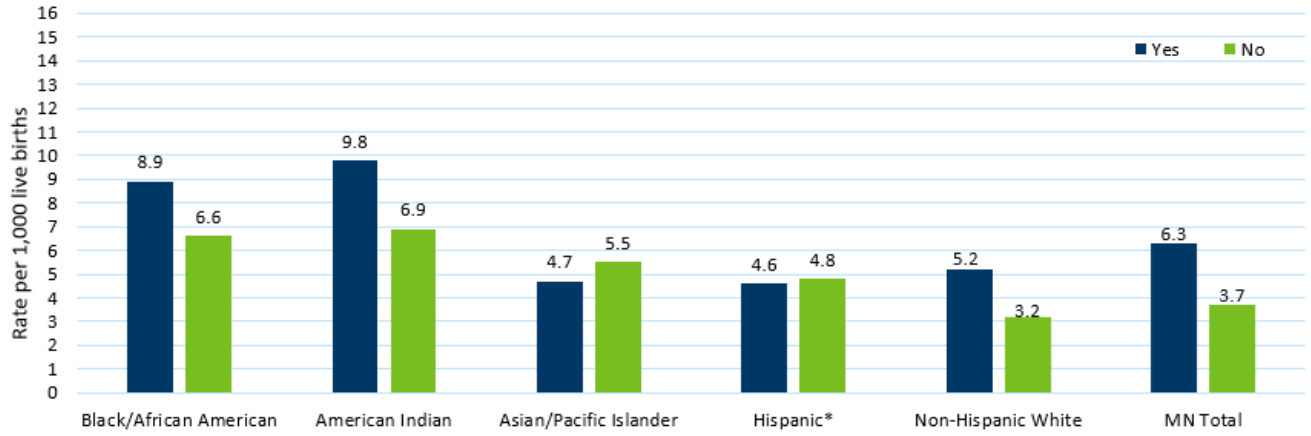


*Can be of any race
#Data are not shown when there are fewer than 5 deaths
Source: Source: Linked Birth-Infant Death Minnesota Resident Period Data File. Minnesota Department of Health



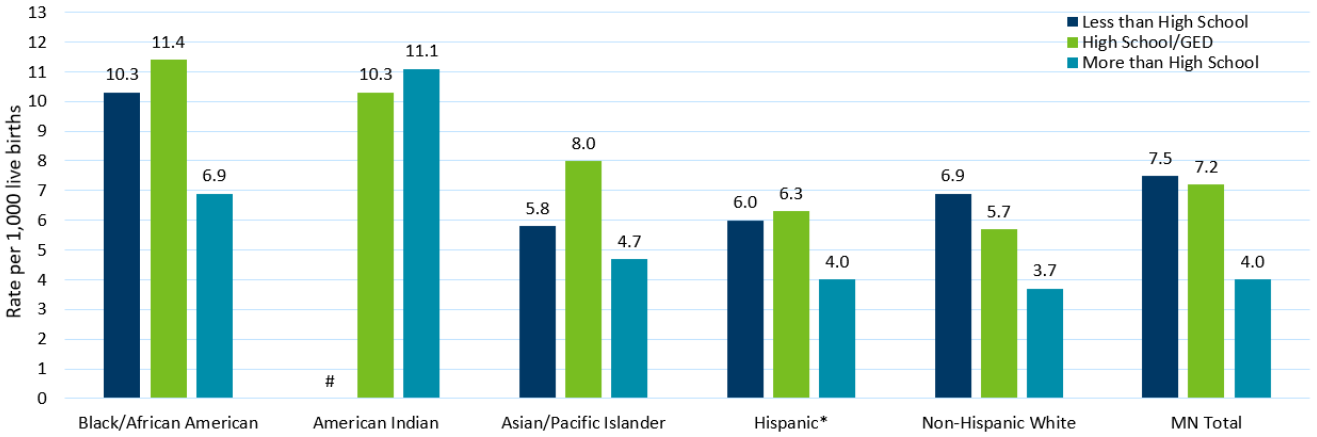
*Hispanic can be of any race
#Data are not shown when there are fewer than 10 deaths
Source: Source: Source: Linked Birth-Infant Death Minnesota Resident Period Data File. Minnesota Department of Health

Infant Mortality Rates by Maternal Medicaid Status and Race/Ethnicity: Minnesota 2017-2021



*Hispanic can be of any race
Source: Source: Linked Birth-Infant Death Minnesota Resident Period Data File. Minneosta Department of Health

Infant Mortality Rates by Maternal Education and Race/Ethnicity: Minnesota, 2012-2016



*Hispanic can be of any race
#Indicates an unstable rate; fewer than 20 cases
Source: Minnesota Department of Health. Linked Birth/Infant Death File

APPENDIX B. EHDI Legislation

2023 MINNESOTA STATUTES
ELIMINATING HEALTH DISPARITIES 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 White. 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 Latino 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 non-White 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 health care professional associations.

The commissioner shall award grants to minority-run health care 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 health care 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 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 previous 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 C: EHDI Infant Mortality Grantees Program Description, Population and Geography Served, FY 2023

Grantee Organization (Program Name)	Program Description	Population Served	Geography Served
American Indian Family Center (Wakanyeja Kin Wakan Pi or Our Children Are Sacred)	The Wakanyeja Kin Wakan Pi (WKWP), Our Children are Sacred project provides direct services to mother's and father's which target the priority health area of infant mortality. The WKWP project provides culturally specific and family centered parent education and community resources to families with infants and/or children who reside in Ramsey, Dakota, and Washington counties. The project also provides culturally specific and individualized case management and support to families with infants and/or children, develops marketing materials, develops a guide for navigating health and human services in Ramsey County for providers to give to clients, and conducts intergenerational community gatherings and/or workshops to address infant mortality in the American Indian community.	American Indian	East Metro area including Ramsey, Washington, and Dakota counties
Minnesota Indian Women's Resource Center (Life Skills Parenting)	The Life Skills Parenting Program is an innovative partnership with Hennepin County that aims to improve outcomes for Native families by providing family counseling, parenting support, life skills training, appropriate referrals, and education in child development and cultural values. Direct service programs 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. It supports non-Native providers and government entities in understanding the impact of historical trauma on families, and promote policy changes that will help reduce the disproportional involvement of Native families in Child Protection.	American Indian	Hennepin County