Eliminating Health Disparities Initiative: Infant Mortality Grants Fiscal Year 2021

Report to the Minnesota Legislature 2021
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Eliminating Health Disparities Initiative Infant Mortality Grants

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Table of Contents

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/Latinx 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 2021 (July 1, 2020, to June 30, 2021), the second 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 second year in a row, the grantees have had to adapt to the COVID-19 pandemic. Many activities were put on hold so they could take care of community members' most urgent needs such as food, housing, and COVID-19 testing and vaccination. In-person activities were modified to become virtual engagements, and new strategies to engage community members remotely had to be developed. All these while ensuring the safety of participants, staff, and partners. Despite all the challenges that COVID-19 presented, in FY2021 AIFC and MIWRC reached a combined 95,882 interactions through efforts to increase awareness around infant mortality, 2,924 interactions focused on efforts to increase people's access to healthcare, 430 interactions in targeted prevention activities, and 199 interactions focused on tailored intervention services (these are duplicated numbers, as some people were reached in more than one way).

EHDI grantees participate in a shared measurement system (SMS) as part of their evaluation. SMS is a way to track, measure, and report on shared or collective outcome measures that grantees selected within each priority health area. In addition to the SMS outcomes, grantees also report on their own evaluation measures. Due to the unique challenges posed by COVID-19 in FY2021, grantees were not required to report on organization-specific or shared measurement system outcomes. Infant mortality grantees did report outputs that resulted from their activities, such as the number of participants or recipients of services as described above, events held, or products created.

Specific activities they implemented in FY2021 were:

- Provided government workers with high quality, Native-developed training on the root causes of disproportional rates of infant mortality, experiences of injury and violence associated with

involvement in the child protection system, impact of historical trauma and removal of Native children from their families.

- Provided training and capacity building to other state, local, and non-profit organizations to improve culture competency and quality of curriculums and parent education programs.
- Hosted Community Baby Showers to celebrate and welcome new babies and parents.
- Engaged in social media campaigns and other community outreach.
- Worked directly with new moms to create contextualized and tailored safe sleep and breastfeeding plans.
- Provided tailored intervention such mental health services.

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.

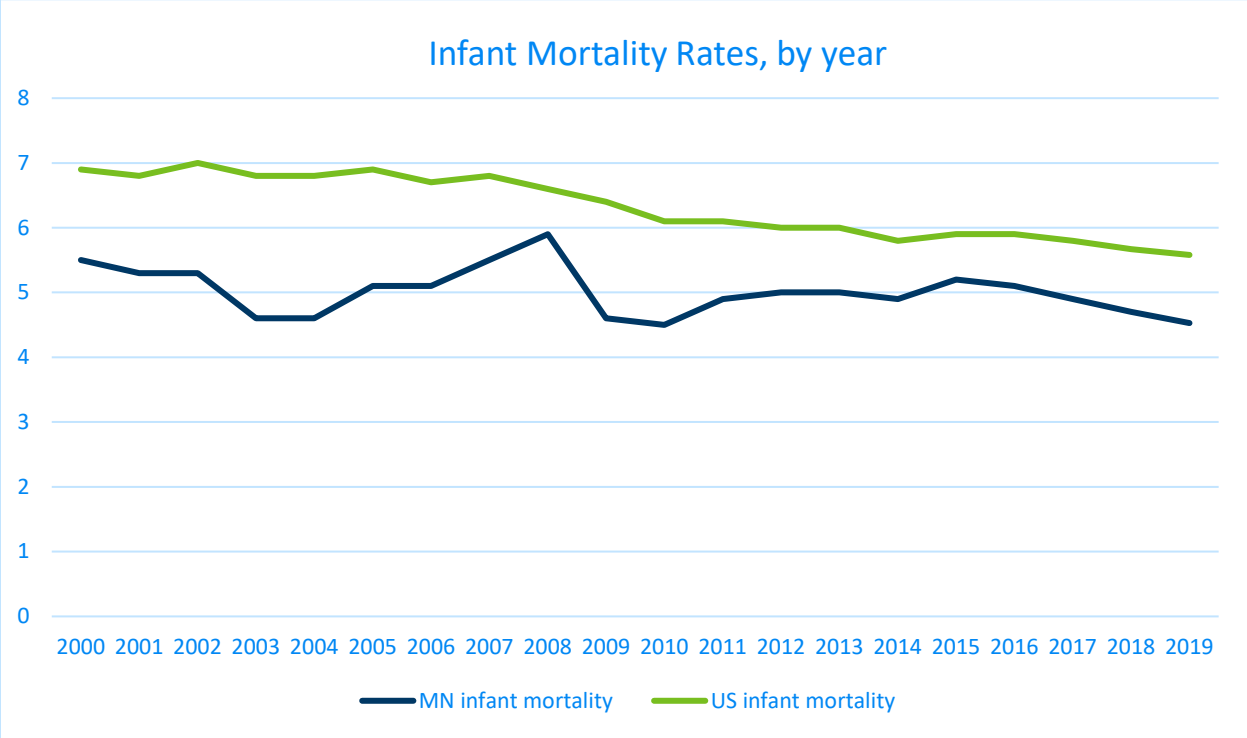
Infant Mortality in Minnesota

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), there were 3.75 million live births in the U.S. in 2019. But there were also 20,927 infant deaths in the same year, giving rise to an infant mortality rate of 5.58, or 6 infant deaths per 1,000 live births. For Minnesota this number was 4.5 in 2019.[1] This means that for every 1,000 infants that were born alive in Minnesota, five died before their first birthday.

The infant mortality rate in the U.S. exhibited a declining trend from 2000-2019 (Figure 1). Minnesota rates were lower than those for the U.S. during these years and was at its lowest in 2010 at 4.55 but since then has been inching closer to the national rates.

Fig. 1. Infant Mortality Rates



Source: Minnesota Center for Health Statistics.

[1] Centers for Disease Control and Prevention. (2021). Minnesota. https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-14.pdf

However, the declining infant mortality rates mask significant disparities in certain groups. In Minnesota from 2014-2018, the rates of infant mortality among American Indians (10.5), African American/Black (9.0), Asian/Pacific Islander (6.3) and Hispanics (5.2) are higher than the rate for whites (3.9).[2] This means that compared to white babies, American Indian and African American babies are more than twice as likely to die before reaching their first birthday.

Based on 2014-2018 data, the five leading causes of infant deaths in Minnesota are congenital anomalies or birth defects (26.3% of all infant deaths), prematurity (25.4%), obstetric conditions or pregnancy complications (11.8%), Sudden Unexpected Infant Deaths or SUIDS (11.1%), and Injury (1.6%).[3] 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 congenital anomalies and obstetric condition equally are the leading causes of infant deaths for babies born to American Indian mothers.

Infant mortality rates may be explained by variations in 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.

- Infant mortality rates are higher for U.S.-born compared to foreign-born African American, Asian/Pacific Islander, and Hispanic women compared to whites, possibly 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 our 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. What is striking however, is that rates are still higher among African American and American Indian women even if they have received more education than white women.

[2] Minnesota Department of Health. (2021). Infant Mortality. Source: Minnesota Center for Health Statistics. https://data.web.health.state.mn.us/infant_mortality

[3] Minnesota Department of Health, Linked Birth/Infant Death File 2014-2018.

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.

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. EHDI is a grant program within CHE. EHDI 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. The initiative was designed to strengthen local control and decision-making in communities across the state toward the elimination of these disparities.

EHDI provides funds to close the gap in the health status of Africans/African Americans, American Indians, Asian/Pacific Islanders, and Hispanics/Latinx 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. 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).

EHDI Infant Mortality Grants

Information in this section was obtained from annual reports submitted by grantees covering the reporting period July 1, 2020 to June 30, 2021 (FY2021).

Fiscal Year 2021 Overview

Two organizations received EHDI funding in fiscal year 2021 (FY2021): 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 as well as improve health care systems across the state to address infant mortality. AIFC was an EHDI grant recipient previously funded to address infant mortality in the prior grant cycle; MIWRC is a new grantee in this current funding cycle.

The infant mortality grantees were awarded a total of $397,997.49 for FY2021. Information on how grantees expended these funds is provided on page 6. 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 8.

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 8-9.

EHDI grantees, like the rest of the world, were forced to adapt to the reality thrust upon them by the COVID-19 pandemic. In-person activities were modified to become virtual engagements, and new strategies to engage community members remotely had to be developed. Agencies also created safety protocols to ensure the well-being of staff and community members interacting in person. Meanwhile these frontline organizations also pivoted to provide basic needs and ensure 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.

Funded Programs

In FY2021, 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 2020-2023. Both AIFC and MIWRC were an EHDI grant recipient previously funded to address infant mortality in the prior grant cycle

Funding Levels

For FY2021, the two infant mortality grantees were awarded a total of $377,183 with the total amount spent of $397,993; the difference of $20,810 represents the amount carried over from FY2020.

Table 1: All Uses of Grant and Total Funds Awarded to Infant Mortality Grantees, Fiscal Years 2021.

	Salaries and Fringe	Travel	Supplies	Indirect	Other	Total Spent	Total Awarded
AIFC	$132,213	$813	$36,925	$17,294	$1,850	**$189,095**	**$178,171**
MIWRC	$130,972	$1982	$24,366	$16,187	$35,391	**$208,898**	**$199,012**
TOTAL	$263,185	$2,795	$61,291	$33,481	$37,241	**$397,993**	**$377,183**
Percentage of use	66%	<1%	15%	8%	9%		

Note: Percentage does not add to 100 because of decimals and rounding.

The grantees spent 66 percent of funding on salaries and fringe, 15 percent on supplies, nine percent on other expenses, eight percent on indirect expenses, and less than one percent of funding 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.

Level of Change Strategies, Objectives, and Activities

This section describes the strategies, objectives, and activities implemented by the two infant mortality grantees.

In response to community and stakeholder feedback and based on the community driven EHDI philosophy, funding is meant to be flexible and responsive to community needs. 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. Also, in response to community feedback, in FY20 MDH changed its approach from the previous grant cycle and recommended that grantees align their projects with three levels of change. This was intended to allow grantees to expand beyond providing programs that target 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. This is consistent with the MDH philosophy to focus on multiple levels of change – including addressing the social determinants of health – in order to ultimately achieve health equity. Grantees could choose the level of change that aligns best with their project and identified corresponding objectives. The three levels of change are:

1. **Level 1- Providing direct service to people to:**
    - Overcome societal, structural barriers to access
    - Change perspectives, gain knowledge and new skills
    - Build trust, community and relationships

2. **Level 2- Working to dismantle organizational barriers to care:**
    - Building and maintaining existing partnerships, connecting to better serve communities
    - Adapting policies and practices to better serve communities in pandemic (intra-organizational work)
    - Providing educational and technical resources to partners

3. **Level 3- Addressing root causes of disparities:**
    - Incorporating the impact of historical trauma and societal barriers into strategies
    - Ensuring strong connection to culture in advocacy and health initiatives
    - Working collaboratively with partners/neighboring organizations to collectively eliminate barriers/disparities

The two grantees funded to address infant mortality identified intended objectives and corresponding strategies at all three levels of change (Table 2).

Table 2: EHDI Infant Mortality Grantee Levels of Change, Fiscal Year 2021

Change Levels	# FY 2021 Grantees
Level of change 1: Health Promotion/Direct Service	2
Level of change 2: Organizational/Institutional Change	2

Change Levels	# FY 2021 Grantees
Level of change 3: Root Causes/Condition for Health	1

Level 1 change:

- AIFC offered a weekly men's group.
- Provided information about safe sleep, breastfeeding, historical trauma and social media posts.

Level 2 change:

- MIWRC adapted their programming to a virtual platform and provided tablets and smartphones to families who needed access to the technology.

Level 3 change:

- AIFC started the "A Mask for Everyone Initiative," where the team provided masks for individuals, families, and communities.
- COVID-19 Town Halls, where the community had conversations about vaccine, had conversations with a medical director, and county services.

Objectives

- Reduce risk factors that can lead to infant mortality and increase protective factors.
- Reduce Native maternal-child morbidity/mortality (including Infant Mortality).
- Avoid or reduce the unintentional violence and injury associated with Child Protection involvement.
- Build the capacity of service providers to provide culturally specific health services to American Indian women.
- Increase the amount of effective, culturally appropriate parenting program knowledge available to entities seeking to reduce Native maternal-child morbidity/mortality.
- Build the capacity of local social service organizations to provide culturally specific health services to American Indian women
- Increase the capacity of MIWRC to advocate on behalf of urban Native American families for policies that support breastfeeding.
- 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.

Activities

- Provide government workers with high quality, Native-developed training on the root causes of disproportional rates of infant mortality, experiences of injury and violence associated with involvement in the child protection system, impact of historical trauma and removal of Native children from their families
- Provide training and capacity building to other state, local, and non-profit organizations to improve cultural competency and quality of curriculum and parent education program delivery.
- Host Community Baby Showers to celebrate and welcome new babies and parents.

Reach

Prior iterations of EHDI funding cycles have reported on direct and indirect reach. While this neatly summarized the types of contact grantees made, it did not reflect the nuances around the manner and purpose of engagement. In an effort to improve upon this reporting practice for FY2021, MDH first conducted a qualitative analysis of the shared work grantees engaged in, prior to and during the COVID-19 crisis.

Grantees' own proposed outputs as indicated in their evaluation plans were summarized into four categories- growing awareness, ensuring access, targeted prevention, and tailored intervention. *Growing awareness* and *ensuring access* roughly 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 FY2021, EHDI infant mortality grantees reached community members in all four ways described above. They reached 95,882 interactions with social media campaigns and other outreach strategies (growing awareness); they provided 2,924 interactions focused on wrap around services and trained on providing culturally relevant healthcare (ensuring access); 430 interactions focused on targeted prevention activities such as working directly with new moms to create contextualized and tailored safe sleep and breastfeeding plans, and 199 interactions focused on tailored intervention services (Table 3).

Table 3. Number of People reached by EHDI Infant Mortality Grantees by strategy, Fiscal Year 2021

Reach Strategy	American Indian
Growing Awareness	95,882
Ensuring Access	2,924
Targeted Prevention	430
Tailored Intervention	199

Evaluation

Grantees are required to conduct an evaluation of their programs, including the development of a logic model and an evaluation work plan. In FY18, for the first time in EHDI history, grantees were encouraged to participate in a shared measurement system as part of their evaluation. The shared measurement system is a system of tracking, measuring, and reporting on the collective or shared reach and outcomes common across grantees within each of the eight priority health areas. In addition to reporting on the shared measures, grantees still report on their own evaluation measures. In this second year of the current grant cycle, as in the first year, grantees were not required to report on organization-specific or shared measurement system outcomes due to the unique challenges posed by COVID-19..

Infant mortality grantees did report specific and measurable 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 10 parent education sessions, and MIWRC provided mental health and educational intervention screening services to 31 adults and 53 children

Stories of Success in a Challenging Year

Grantees shared stories of program successes amidst the challenging work of adapting to COVID-19 and the corresponding emergent community needs.

Level one: Individual Change

American Indian Family Center (AIFC)

"Over the last several years, the AIFC has not had much of a Father & Men's group. It mainly consisted of the Family & Youth Services Director maintaining contact with a community member who led the Men's athletic leagues and their participation. This year, staff were able to successfully offer not only the Men's athletic leagues but staff were also able to offer a consistent, weekly men's group. In addition to the group, staff were also to begin discussions and preparations to include Traditional Lacrosse, known as the Creators Game, to our athletics components.

Unlike the other recreational sports AIFC's Men participate in, the Creators Game allows the program to take a multigenerational approach, offering traditional teachings, culture, and skill building for fathers

and men participating in the program. The community does not always have immediate access to the Creators Game, and not all of the community has learned how to play the game. By being able to provide participants with a location, teachings, and the equipment, the program have removed that barrier to accessing participants' culture. The Creators Game is about teaching its participants to work out aggression without violence. With this teaching, staff are able to provide all intergenerational participants with skills to peacefully resolve disputes and the ability to heal.

The Men's group has been a success, with participants from not only the Twin Cities Metro area, but through out the state and the surrounding states. Men had stated that if it weren't for the virtual nature of group, they wouldn't be able to attend as many groups as they had due to their work schedule, transportation, and childcare. For those living outside of the Twin Cities area, it has shown to be beneficial to have this support through the pandemic."

Minnesota Indian Women's Resource Center

"In the past year, the goal of this program has been to help families remain educated about the importance of health and wellness check-ups as well as to remain safe and have access to resources in the community due to the Covid-19 Pandemic. Staff encourage them to have yearly wellness check-ups for themselves and their children. Due to the Covid-19 outbreak, a community that was once a walk-in or face to face office visit has now became all virtual. One of the barriers staff saw with appointments being virtual was that many families had either no access or limited access to a computer or electronic device. Staff were able to offer Tablets and Smart phones to families in programming for this new adaptation."

COVID-19 Impact

Because of COVID-19, staff at both agencies have transitioned to working remotely. All in-person programming has been put on hold. Staff, including those working with EHDI, are working to come up with ideas to support community members in trying to offer remote program services, 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. It was difficult for families to access food because the bus systems were down and stores in some of the targeted communities were closed due to the civil unrest caused by George Floyd's murder. 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 engaged by the grantees, 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.

In their own words, grantees provided examples of how COVID-19 impacted their communities and their work.

American Indian Family Center

"AIFC was able to start the 'A Mask for Everyone Initiative' and COVID-19 Town Halls. Masks could be requested at an individual, family, and community wide basis. More than 135,000 makes have been

distributed through this initiative, with almost 16,00 going to individuals, families, and households, 60,000 going to community organizations, and 60,000 going to local businesses. Conversations at the COVID-19 Town Halls included vaccine community conversations, Community Conversations with Medical Director Dr. Lynne Ogawa, and county services.

Additionally, staff started to offer programming on a virtual platform. When programs were working on projects, staff took the time to either deliver the supplies or have them shipped to them. Staff found that, through this process, there were more people attending programming than there would have if it were in person. Virtual programming removed many barriers, but it is still a learning process as they move forward."

Minnesota Indian Women's Resource Center

"Due to Covid-19, MIWRC had to adapt to multiple safety guidelines and adapt to a now virtual world. This consisted of no in-person or face-to-face visits mandated by the state. All home visiting or office visits became virtual visits over the computer, smart phone, or tablet. There became a six feet apart rule from one another in person and a mask mandate. MIWRC provided families with masks and hand sanitizer if needed. MIWRC followed any State regulation that was required for our agency."

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 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. For example, in FY 2021 American Indian Family Center's potential cost saving came from healthcare costs avoided related to preterm birth or low birth weight through early parent education on topics including safe sleep practices and breastfeeding. 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.[1] 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.[2]

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/Latinx 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.

Available data from 2000-2014 show that U.S. infant mortality rates have been gradually declining. In Minnesota, infant mortality rates have fluctuated; rates are lower than the national rate and most states. However, the 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 in social and economic factors which are the key contributors to health disparities and ultimately are what need to change[3]. The EHDI infant mortality grantees are doing just that.

Information gathered from infant mortality grantees in FY 2021 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 had 95,882 interactions; 2,924 interactions referred to services or training aimed at ensuring access to culturally relevant healthcare; 430 interactions focused on targeted prevention activities, and 199 interactions focused on intervention services. They provide services to American Indians residing in Ramsey, Dakota, and Washington counties.

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.

Though it is still too early to determine the impact of program interventions, grantees have reported several accomplishments despite the extreme challenges posed by COVID-19.

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 Latinx 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 2021

Grantee Organization/ EHDI Program	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	American Indian	Hennepin County

Grantee Organization/ EHDI Program	Description	Population(s) Served	Geography Served
	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.		

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