Eliminating Health Disparities Initiative: Infant Mortality Grants Fiscal Year 2020

Report to the Minnesota Legislature 2020
1/15/2021

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

As requested by Minnesota Statute 3.197: This report cost approximately $4,594 to prepare, including staff time, printing and mailing expenses.

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Executive Summary

The Eliminating Health Disparities Initiative (EHDI) is a grant program within the Minnesota Department of Health (MDH) Center for Health Equity (CHE). Established in 2001 by the Minnesota Legislature (Minnesota Statute 145.928), the initiative was a response to mounting evidence that disparities in health outcomes between Minnesota's white residents and those from populations of color and American Indian communities were distressingly wide and on a clear trajectory to grow even wider. Even though Minnesota ranks high in terms of general health status compared to other states, it has some of the worst racial and ethnic 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. The initiative was designed to strengthen local control and decision-making in communities across the state towards elimination of these disparities in the four priority populations. Funding sources include state General Funds and Federal Temporary Assistance to Needy Families or TANF (only Teen Pregnancy Prevention grantees receive TANF funds).

Based on 2012-2016 data, the five leading causes of infant deaths in Minnesota are congenital anomalies or birth defects (26.0% of all infant deaths), prematurity (24.7%), obstetric conditions or pregnancy complications (12.6%), and Sudden Unexpected Infant Deaths or SUIDS (12.5%). These causes vary by population. Congenital anomalies or birth defects are the primary leading cause of infant deaths for babies born to Asian, Hispanic, and White mothers. On the other hand, prematurity is the leading cause of infant deaths for babies born to Black and African American mothers and sudden unexpected infant deaths (SUID) is the leading cause of infant deaths for babies born to American Indian mothers.

Infant mortality rates for the country as a whole have exhibited a declining trend. Rates in Minnesota are lower than U.S. rates, but they mask significant disparities in certain populations. Data from 2014-2018 show that the infant mortality rate for American Indians (10.5) and for African Americans (9.0) was more than double the rate for whites (3.9) 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.

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.

This report covers EHDI infant mortality data for fiscal year 2020 (July 1, 2019 to June 30, 2020 grant period) which is the first year of a four year grant.

Fiscal Year 2020

In fiscal year 2020 (FY20) two organizations were awarded EHDI grants: 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 $ $377,183 in FY20, which is a decrease from $395,986 in FY19. 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 that address the root causes of inequities. This is described through the following levels of intended change:

1. Level 1 Change- Providing **direct service to people**
2. Level 2 Change- Working to **dismantle organizational barriers to care**
3. Level 3 Change- **Addressing root causes of disparities**

To begin measuring the collective reach of strategies intended to bring about these changes, grantees reported on the number of people who were provided with targeted prevention and tailored intervention services (level 1), as well as the number of people who were engaged through efforts to ensure culturally relevent health care access (level 2). Reach measures are also employed to capture extensive efforts aimed at building community awareness. While such efforts are often not sufficient in and of themselves to bring about change, they are necessary to increase awareness of the health issue and assistance available through grantee organizations. In FY2020, AIFC and MIWRC reached:

- 51,440 people through strategies of *growing awareness*.
- 29 people received training aimed at *ensuring access* to culturally relevant healthcare.
- 265 people participated in *targeted prevention* activities and 78 people with diagnosed or identified health conditions received *tailored intervention* services.

This work took many forms and including:

- Providing information about safe sleep, prevention of Infant Mortality, breastfeeding education and car seat safety education;
- Collaborating with other organizations to hold cultural events on the importance of being alcohol free during pregnancies and when planning for a pregnancy;
- Hosting Community Baby Showers to celebrate expecting moms;
- Conducting parenting education classes on healthy relationships; and,
- Providing government workers with high quality, Native-developed training on the root causes of disproportional rates of Infant Mortality as well as culturally competent curriculum and parent education program delivery.

In these and other ways, grantees are serving one of the populations most impacted by infant mortality disparities. EHDI grantees, like the rest of the world, were forced to adapt to the reality thurst upon them by the COVID-19 pandemic. In-person activities were modified to 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 front-line organizations also pivoted to provide basic needs and ensure community members were equipped with ongoing COVID-19 related information. These achievements were accomplished despite the emergencies created by COVID-19, and the added additional pressures facing American Indian communities.

Infant Mortality Overview

Introduction

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 provides leadership for MDH's efforts to advance health equity. The Eliminating Health Disparities Initiative (EHDI) is a grant program within CHE. It was established by the Minnesota Legislature in 2001 (Minnesota Statute 145.928 in Appendix A) in response to mounting evidence that disparities in health outcomes between Minnesota's white residents and residents from populations of color and American Indian communities were distressingly wide and on a clear trajectory to grow even wider. 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.

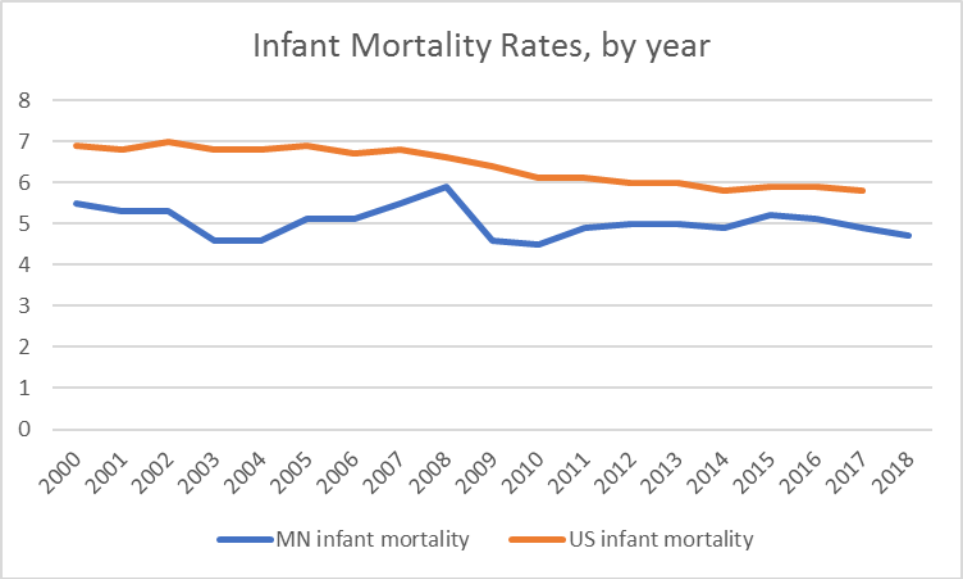
EHDI provides funds to close the gap in the health status of Africans/African Americans, American Indians, Asian/Pacific Islanders, and Hispanics/Latinx in Minnesota compared to whites in eight priority health areas: Breast and Cervical Cancer Screening, Diabetes, Heart Disease and Stroke, HIV/AIDS and Sexually Transmitted Infections, Immunizations for Adults and Children, Teen Pregnancy Prevention, Unintentional Injury and Violence, and Infant Mortality. Prenatal care was added by the legislature as a ninth priority health area during the 2019 legislative session. No additional funds were allocated along with this additional priority health area.This report is focused on infant mortality.

Infant Mortality

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 close to 4 million live births in the U.S. in 2019. The sad news is that more than 20,000 infants died in the same year resulting in a 2019 infant mortality rate in the United States of 5.7. For Minnesota this number was 4.9[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, Minnesota rates were lower than those for the U.S. throughout this period. Most recently it 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. National data is not yet available for 2018.

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 more than double the rate of white infants (3.9).[2] Disparities are observed when variables such as mother's nativity, age, smoking status, and education are factored in.[1]

Infant Mortality Reduction Plan for Minnesota

MDH released the Infant Mortality Reduction Plan for Minnesota: Part 1 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 in order 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.

[1] Please refer to page 70 of the 2019 EHDI Request For Proposals for more information on infant mortality disparities.

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 proud to submit this report to the legislature as one of several statewide efforts to reduce infant mortality rates. This report demonstrates how EHDI infant mortality grantees contribute to the implementation of Recommendations 1, 2, 4, 5, and 6 of the Infant Mortality Reduction Plan. With continued support from the state, EHDI grantee efforts can make important contributions to the elimination of disparities in infant mortality in Minnesota.

EHDI Infant Mortality Grantees in Fiscal Year 2020

Information in this section was obtained from annual reports submitted by grantees on EHDI activities during the reporting period July 1, 2019 through June 30, 2020 (FY20). It is important to note that this is the first year of the four year grant period (2020-2023). FY20 has been challenging for the grantees due to the COVID-19 pandemic. Grantees have adapted to the uncertainty in the best possible way, however certain services, particularly those planned to be provided in-person and through groups, have been impacted.

Funded Programs

In FY20, two organizations were awarded EHDI grants 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 2020-2023. 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.

Funding Levels

For FY20, the two infant mortality grantees were awarded a total of $377,183 with the total amount spent of $265,938; the remaining $111,245 will be carried over into the following fiscal year. The amount allocated is a decrease from $395,986 in FY19.

Table 1: All Uses of Grant and Total Funds Awarded to Infant Mortality Grantees, Fiscal Years 2020.

	Salaries and Fringe	Travel	Supplies	Indirect	Other	Total Spent	Total Awarded
AIFC	$134,088	$2,707	$10,218	$14,824	$1,805	**$163,641**	**$178,171**
MIWRC	$81,716	$2,159	$5,017	$8,065	$5,340	**$102,296**	**$199,012**
TOTAL	$215,803	$4,865	$15,235	$22,889	$7,145	**$265,938**	**$377,183**

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 Strategies and Activities

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

Grantees funded for their efforts to address infant mortality identified intended objectives and corresponding strategies at all three levels of change.

Proposed 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.

Types of 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, and removal of Native children from their families
- Provide training and capacity building to other state, local, and non-profit organizations to improve the quality and cultural competence of curriculum and parent education program delivery.
- Host Community Baby Showers to celebrate and welcome new babies and parents.

Table 3. EHDI Infant Mortality Grantee Levels of Change, Fiscal Year 2020

Change Levels	# FY 2020 Grantees
Level of change 1: Health Promotion/Direct Service	2
Level of change 2: Organizational/Institutional Change	2
Level of change 3: Root Causes/Condition for Health	1

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 FY20, MDH first conducted a qualitative analysis[2] of the shared work grantees engaged in, prior to and during the COVID-19 crisis.

Grantees' own proposeed output categories from 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 these strategies grantees use 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 FY20, EHDI infant mortality grantees reached 51,440 people with media campaigns and other outreach strategies (growing awareness); 29 people received training on providing culturally relevant healthcare (ensuring access); 265 people participated in targeted prevention activities and 78 people with diagnosed mental health or educational intervention needs received tailored intervention services.[3]

The two grantees both work holistically with families to provide wrap around services while also training health care providers on culturally relevant services to ensure access to quality care. The grantees also work directly with new moms to create contextualized and tailored safe sleep and breastfeeding plans.

Table 3. Number of People reached by EHDI Infant Mortality Grantees by different strategies, Fiscal Year 2020

Strategy	American Indian
Growing Awareness	51,440
Ensuring Access	29
Targeted Prevention	265
Tailored Intervention	78

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 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. Due to this being the first year in a new funding cycle in which grantees normally spend significant time building up program infrastructure (ie. hiring and onboarding staff, updating curriculum, gathering of community feedback to inform programming) and the unique challenges posed by COVID-19, grantees were not required to report on organization-specific or shared measurement system outcomes for this year.

Infant mortality grantees did report specific and measurable outputs, reach data as described above, and submitted an evaluation plan to measure outcomes as the grant cycle progresses. Outputs are counts of people, events, or products. Some of the specific outputs reported by grantees for this first year include: 1) hosting 25 classes in prenatal/parenting education classes (AIFC); 2) providing 38 families including a total of 88 children a needs assessment, safety planning and goals planning program (MIWRC).

Stories of success amidst a challenging year

Grantees provided stories to highlight the impact of their program amidst the challenging work of adapting to COVID-19 and the corresponding emergent community needs in their own words.

Level one: Individual Change

American Indian Family Center

> An elder in the community, who has participated in the Bimaadiziwin Mikana Parent Education sessions previously, finally made a breakthrough in being a mentor for our young parents. This program participant initially did not believe she would be a good mentor due to the barriers she was facing in trying to raise grandchildren, such as affording rent on a fixed income, and lacking transportation to support herself and her grandchildren's involvement in mental health services, and initially not believing she could offer anything of importance to

other program participants. In the cultural sense, she is an Aunt, Grandma, and Sister to many members in the community. Instead of participating in the Parent Education sessions as another parent/grandparent, this year she requested that she act as a mentor for the other program participants.

She took on the mentor role, and the other parents in the group liked having her as a mentor and as an elder because they were able to make a connection with her on two different levels. This program participant recently lost her daughter to addiction and took over the legal role as her grandchildren's guardian. She had to learn how to cope with her grief as a mom and support her grandchildren and their grief. Other program participants looked to her for support as they have gone through similar loss due to addiction, and also looked to her for her wisdom in raising her children and grandchildren. This participant made significant personal growth and this has encouraged her to work with the community as she addresses her trauma in a meaningful way.

Minnesota Indian Women's Resource Center

The goal of this program is to help improve the well-being of clients by simply having personal conversations as well as a discuss specific topics related to parenting, highlighting the importance of primary health check-ups. Staff encourage families to have yearly wellness checks for themselves and their children and provide resources for medical, dental, and therapy services as well as tools and resources for healthier eating. Additionally staff provide referrals for children who require therapists, case managers or skills worker. This was done from the beginning of the grant until March.

Staff continue to provide these services amidst additional barriers when everything transitioned to Zoom and staff cannot be in person to do these visits. This also makes it harder for clients to connect with other professionals who use language that participants don't understand. Clinical words are used and often the professionals will not speak to the participants in layman's terms. For some of our families this discourages them to make follow up appointments. Staff support clients in navigating these systems by instructing clients to write down what the doctor has said or request a written synopsis of the appointment, so staff could explain what the participant did not understand. Staff also encourage participants to advocate for what they need by requesting that doctors explain things in terms that are universal instead of clinical. Some participants have become comfortable in doing this.

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. Likewise many of 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 community disparity and destruction. Many in the community do not have access to vehicles and this makes shopping and access to essential needs additionally difficult. Likewise regardless of the geographic location, many of the people engaged by the grantees 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 was impacting their communities and their work.

American Indian Family Center

> In March 2020, the AIFC began working remotely due to COVID19. Staff quickly began reaching out to program participants to ensure our families had essential household goods such as food and cleaning supplies, and even coming up with plans to prevent our community from experiencing high rates of infection. Staff have been connecting with families to ensure they have access to basic needs as the majority of them are no longer working, and their children are distance learning. The AIFC has utilized community partnerships to assist with food support but are unable to provide long-term supports due to funding restrictions.
>
> The Bimaadiziwin Makana Parent Education program has started offering programming remotely, but parents who do not have access to specific devices can not join during the group time. Instead, the Family Empowerment Coach provides participants with directions and offers support over the phone. This can be isolating during these unprecedented times, but our families are doing their best to stay involved. As we continue to overcome these barriers, we acknowledge the fact that program numbers are notgoing to be the same as they were while meeting face-to-face with program participants. Our costs have also shifted to adjust for remote services.

Minnesota Indian Womens' Resource Center

> MIWRC prioritized staff and community health by closing the agency to in-person services in late March, ahead of the Governor's stay-at-home mandate. They created and administered a series of staff questionnaires to get a sense of how to proceed with an eventual reopening; when it became apparent that over 70% of staff either live with a health condition or share living space with someone who lives with a health condition that leaves them particularly vulnerable to severe COVID illness, they planned for a very conservative reopening vision that can be adapted as necessary throughout the remainder of the pandemic.
>
> Like other agencies, we consider our acclimation to the unexpected emergence of COVID-19 to be our most notable Year 1 accomplishment. Staff were able to transition in-service support to phone/video conferencing and supplies drop-off rather than taking clients shopping. Despite the crisis and service provision transitions, we were able to serve 38 families - 8 more than our Year 1 goal of 30.

Potential Cost Savings

The work of EHDI infant mortality grantees can lead to potential cost savings on health care costs and the Minnesota state. For example, in FY 2020 American Indian Family Center's potential cost saving came from healthy term births as opposed to preterm birth or low birth weight and healthy infants through early parent education on topics including safe sleep practices and breastfeeding. Likewise, both grantees implemented parenting education programs which have generally demonstrated cost savings, societal benefit, and economic benefit. This includes tax savings from a reduced need for remedial social and education programs, reduced child maltreatment, child developmental delays, school failure, and criminal activity as well as increased productivity from a better prepared workforce. One study found that the United States would save $13 billion per year and prevent an excess of 911 deaths if 90% of families breastfeed exclusively for 6 months.[iii] Utilizing data regarding the avoidance of infant sleep-related deaths and incapacitating injuries to infants as a result of motor vehicle accidents due to parent education activities, one study calculated a return on investment of $31 for every $1 spent by the program.[iv] While given the data available from grantees this year we are unable to extrapolate and make exact cost savings estimates for these two grantees, other studies have demonstrated the cost effectiveness or economic benefits to society of their efforts.

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.

Information gathered from infant mortality grantees in FY 2020 indicate that EHDI is making significant contributions towards the goal of reducing infant mortality disparities.

The grantees are serving one of the populations most impacted by infant mortality disparities. Through strategies of growing awareness grantees reached 51,440 people; 29 people received services or training aimed at ensuring access to culturally relevant healthcare; 265 people participated in targeted prevention activities and 78 people with diagnosed or indentified health conditions received tailored intervention services. They provided 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 a number of accomplishments despite the extreme challenges posed by COVID-19 experienced by grantees and the communities they serve.

Available data from 2000-2014 show that U.S. infant mortality rates have been declining. In Minnesota, rates have gone up and down but are still lower than 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[v]. The EHDI infant mortality grantees are doing just that.

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 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 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 2020

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 understanding the impact of historical trauma on our families, and promoting policy changes that will help reduce the disproportional involvement of Native families in Child Protection.	American Indian	Hennepin County

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