Eliminating Health Disparities Initiative: Infant Mortality Grants Fiscal Year 2024

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Eliminating Health Disparities Initiative Infant Mortality Grants Report

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

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Executive Summary

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

EHDI provides funds to close the gap in the health status of Africans, African Americans, American Indians, Asian/Pacific Islanders, and Hispanics/Latine in Minnesota compared to whites in eight priority health areas: Breast and cervical cancer, Cardiovascular disease, Diabetes, HIV/AIDS and sexually transmitted infections, Immunizations for adults and children, Infant mortality and access to and utilization of high-quality prenatal care, Teen pregnancy prevention, and Unintentional injuries and violence.

This report covers EHDI infant mortality activities for the state fiscal year 2024 (FY 2024) from July 1, 2023 to June 30, 2024, the first year of the EHDI 2024-2028 grant cycle. The infant mortality grantees are Leech Lake Band of Ojibwe, Portico Healthnet, and Wilder Foundation (African American Babies Coalition). Together, they directly reached 1,244 individuals in the 12-county Twin Cities metro area and Leech Lake Reservation, primarily serving African Americans, American Indians, and Latinas/Latinos/Hispanics. Aside from targeting individual-level changes (such as increasing or improving awareness, knowledge, or behaviors), their programs focused on changes at the organizational or community level and addressing broader social determinants of health as the root causes of inequities.

Notable highlights from FY 2024 include 26 new mothers receiving home visiting services around prenatal care, post-partum care, and infant care; 17 newborns receiving immunizations and well-child checks; 147 fathers participating in cultural family camps; 255 pregnant people and 152 newborns enrolled in health insurance; hosted the Black and Brown Birthing Summit with 220 attendees, and Experiences of Mothers and Birthing While Incarcerated workshop with 38 attendees, and Birthing Fruition Training with 6 participants; established the Safer Birth Consortium advisory group, launched a resource exchange for providers to share birth equity resources; and developing a Maternal Mental Health and Child Development curriculum.

EHDI legislation requires that MDH report how the infant mortality grantees used their grant funds and the amount expended for each use. In FY 2024, the three grantees spent 60.3% on salaries and fringe, 15.9% on contractual services, 1.8% on travel, 1.5% on supplies, and 3.5% on other expenses. Their indirect cost was 17.1% of total expenses.

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

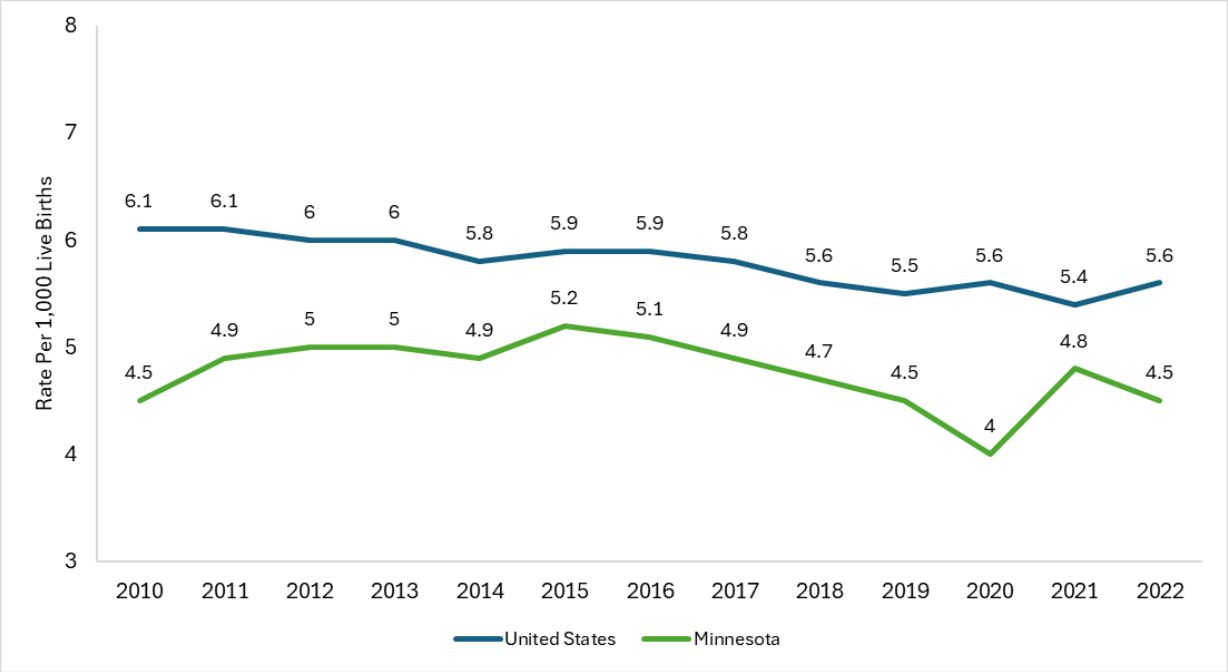
I. Infant Mortality in Minnesota

Infant Mortality Rates and Disparities

Infant mortality is defined as the death of an infant before their first birthday. The infant mortality rate is measured in terms of the number of infant deaths per 1,000 live births. It is considered a key indicator of maternal and child health, as well as overall societal health. Based on data from the U.S. Centers for Disease Control and Prevention (CDC), Minnesota's infant mortality rate in 2022 declined 6% from the previous year, from 4.8 infant deaths per 1,000 live births in 2021 to 4.5 infant deaths per 1,000 live births in 2022.[1] This means that for every 1,000 infants that were born alive in Minnesota in 2022, four died before their first birthday.

The infant mortality rate in the U.S. exhibited a declining trend from 2010 to 2021, then inched back up in 2022 (Figure 1). Minnesota rates were lower than those for the U.S. during these years, and in 2020 reached its lowest rate at 4.13 after peaking in 2015 at 5.2.

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



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

[1] Ely, D. M., & Driscoll, A. K. (2024). Infant Mortality in the United States, 2022: Data From the Period Linked Birth/Infant Death File. National Vital Statistics Reports: From the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, 73(5), 1-19.

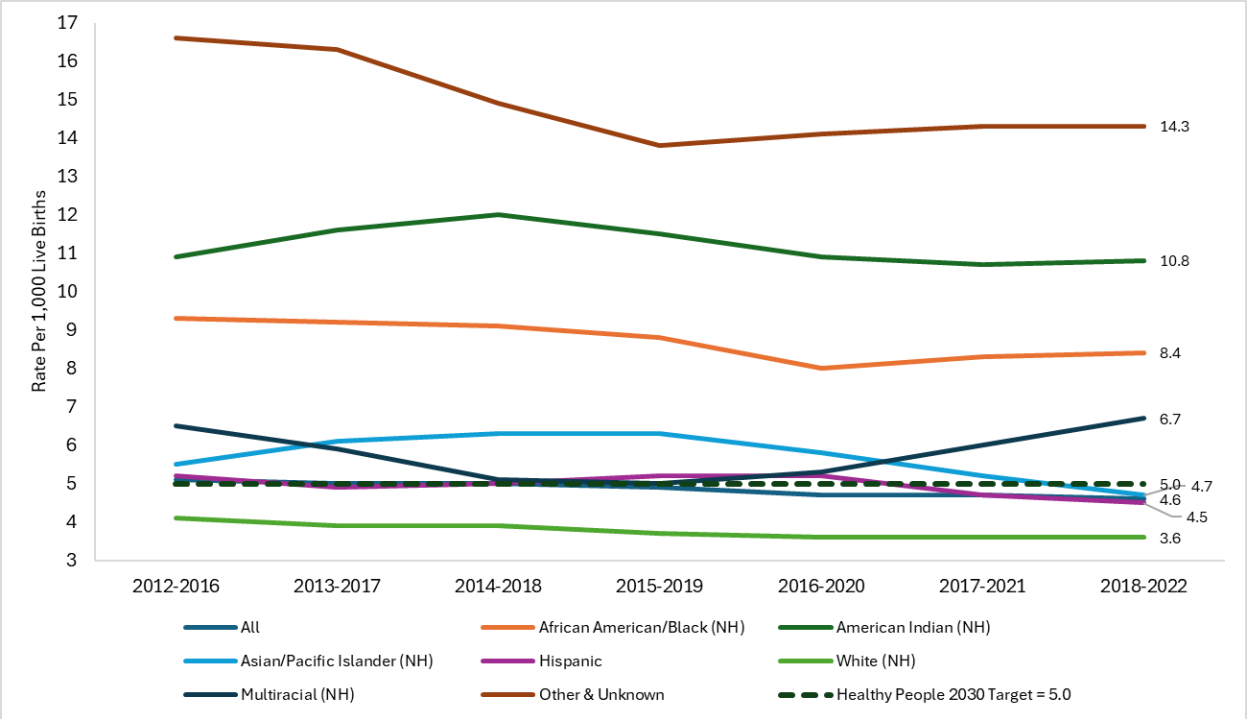
However, the declining infant mortality rates mask significant disparities. Table 1 and Figure 2 show that in Minnesota for the periods 2012-2016 to 2018-2022, the rates of infant mortality among American Indians (10.8), African American/Black (8.4), Asian/Pacific Islander (4.7) and Hispanics (4.5) are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

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

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

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

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



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

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

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

For example, disparities are observed when variables such as mother's nativity, age, smoking status, Medicaid status, and education are factored in (charts can be found in Appendix A).

- Infant mortality rates are higher for U.S.-born compared to foreign-born African American, Asian/Pacific Islander, and Hispanic women compared to whites, due to the immigrant effect; that is, they retain the advantages of healthier lifestyles and food they were used to in their home countries when they move to the U.S.

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

- Infant mortality rates are higher among women who smoke, but compared to smokers who are white, they are more than double for smokers in communities of color and American Indian communities.
- Those who experience poverty and thus have less access to adequate health care have higher rates of infant mortality (for example, those on Medicaid).
- Infant mortality rates are generally higher among women with fewer years of education. By race/ethnicity, however, it is striking that rates are still higher among African American/Black and American Indian women even if they have received more years of education than women who are white.

Statewide Infant Mortality Reduction Plan

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

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

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

In 2023, the Healthy Beginnings, Healthy Families Act: Infant Health was established which created additional opportunities for the state to address infant mortality. Work under this act builds equitable, inclusive, and culturally and linguistically responsive systems that ensure the health and well-being of young children and their families by establishing the Minnesota Partnership to Prevent Infant Mortality, and funding statewide grants to improve infant health outcomes. The grants are administered by the Maternal and Child Health Section in MDH's Child and Family Health Division.

II. The Health Equity Bureau and EHDI

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

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

The Eliminating Health Disparities Initiative (EHDI) is a grant program administered by the Health Equity Strategy and Innovation Division. It was established by the Minnesota Legislature in 2001 (Minnesota Statute 145.928 in Appendix A) in response to mounting evidence that disparities in health outcomes between Minnesota's residents who are white and residents from populations of color and American Indian communities were distressingly wide and on a clear trajectory to grow even wider. EHDI provides funds to close the gap in the health status of Minnesota's populations of color and American Indians in Minnesota compared to white in eight priority health areas Breast and cervical cancer, Cardiovascular disease, Diabetes, HIV/AIDS and sexually transmitted infections, Immunizations for adults and children, Infant mortality and access to and utilization of high-quality prenatal care, Teen pregnancy prevention, and Unintentional injuries and violence. The legislature added prenatal care as a ninth priority health area during the 2019 legislative session with no specific appropriation, and thus it was blended into the Infant mortality priority health area.

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

III. EHDI Infant Mortality Grants

Information in this section was obtained from annual reports submitted by grantees covering the reporting period July 1, 2023 to June 30, 2024 (FY 2024).

Infant Mortality Grantees Overview

In FY 2024, three organizations received EHDI funding to implement infant mortality programs: Leech Lake Band of Ojibwe (Family Spirit program), Portico Healthnet (Increase Protective factors for Pregnant Persons & Newborns), and Amherst H. Wilder Foundation (African American Babies Coalition) (Appendix B). Their EHDI programs served African Americans, American Indians, and Hispanics/Latinos in Minnesota in the 12-county Twin Cities metro area as well as the Leech Lake Reservation.

The infant mortality grantees were awarded a total of $537,000 in FY2024. Information on how grantees expended these funds is provided in the next section. Grantees worked to address health disparities beyond providing programs that target individual-level changes (such as awareness, knowledge, behavior, or skill). They also focused on broader social determinants of health, such as changing policies, systems, or environments to address the root causes of inequities.

- Leech Lake Band of Ojibwe is implementing an evidence-based and culturally tailored home visiting intervention called the Family Spirit program that supports Native American women who are pregnant or women pregnant with Native American babies, fathers, or any family raising Native American babies and children.
- Portico HealthNet helps under-resourced pregnant persons and newborns residing in Ramsey County enroll in health insurance programs, and uses a customizable service model designed to increase protective factors for pregnant persons and infants in order to reduce infant mortality.
- Wilder Foundation's African American Babies Coalition develops training curricula focused on maternal and infant health and convenes health leaders, researchers, and practitioners to address incarceration as a social determinant of health (SDOH) that impacts healthy birthing.

Program description, populations served, and geographic areas served can be found in Appendix C. Specific grantee objectives, strategies, and activities at each level of change are shown in Appendix D.

Use of Grant Funds

EHDI legislation requires that MDH's infant mortality report include information on specific uses of grant funds and the amount expended for each use. Table 2 shows how the two infant mortality grantees used their EHDI funding in FY 2024.

Table 2: All Uses of Grant and Total Funds Awarded to Infant Mortality Grantees, Fiscal Year 2024

	Salaries & Fringe	Contractual Services	Travel	Supplies	Other	Indirect[a]	Total Spent	Total Awarded
Leech Lake	$63,247	$0	$7,084	$4,967	$4,940	$17,999	$98,237	$180,000
Portico	$99,459	$42,500	$0	$653	$0	$14,261	$156,874	$177,000
Wilder	$89,377	$23,763	$334	$464	$9,687	$39,096	$162,721	$180,000
Total	$252,083	$66,263	$7,418	$6,085	$14,627	$71,357	$417,832	$537,000
% of Total Spent	60.3%	15.9%	1.8%	1.5%	3.5%	17.1%		

[a]Indirect rates are as follows: Leech Lake=24% (federally approved rate), Portico Healthnet=10%, and Wilder=32% (federally approved rate).

Salaries and fringe was the largest expense at 60.3% of the total amount spent by the three grantees. They also spent 15.9% on contractual services, 1.8% on travel, 1.5% on supplies, and 3.5% on other expenses. Their indirect cost was 17.1% of total expenses.

Contractual expenses included payments to evaluation consultants, graphic design consultants, trainers (health education and birthing), and curriculum developers. Travel expenses included staff travel to and from meetings, and mileage reimbursement and lodging for invited guests of an annual gathering hosted by a grantee. Supplies expenses were incurred during group events and activities such as refreshments, printing of training materials, and office supplies. Other expenses included stipends for trainers and event participants, cash and non-cash incentives and childcare for participants in evaluation activities (for example, focus groups), training registration fees, freight and shipping fees, marketing and communications, space occupancy, and cost

of hosting development committee sessions. Finally, indirect expenses covered overhead costs such as utilities and rent.

Appropriation Retained for Administrative Purposes

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

Levels of Change, Objectives, Strategies, and Activities

Since 2001, EHDI has funded and supported strategies that communities of color and American Indian communities deem effective in their communities and that build on community strengths and assets. A key recommendation that emerged from a 2015 EHDI community input process was to encourage grantees to broaden program activities to address the social and economic conditions for health, also known as the social determinants of health. This meant allowing grantees to expand programming to go beyond targeting individual-level changes (such as awareness, knowledge, behavior or skill) to focus on broader social determinants of health, such as changing policies, systems or environments that address the root causes of inequities. Beginning in the FY20-FY23 grant cycle, EHDI allowed applicants to choose to work within one or more levels of change to address one or more of the PHAs. The three levels of change are:

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

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

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

Leech Lake Band of Ojibwe's EHDI program is focused on Level 1 change, Portico Healthnet is focused on Level 1 and Level 2 changes, and Wilder is focused on Level 2 and Level 3 changes.

Level 1 objectives of Leech Lake Band of Ojibwe and Portico Healthnet are about improving infant health outcomes, expanding services to increase protective factors against infant mortality, helping fathers develop a healthy lifestyle so they can support family wellbeing, improving recruitment, and improving community relationships.

Level 2 objectives of Portico Healthnet and Wilder include developing a customizable service model to increase protective factors against infant mortality, improving access to prenatal care, and increasing capacity to provide culturally sensitive prenatal care services.

Wilder's Level 3 objective is about creating a more culturally responsive and integrated system of care for black and brown birthing people.

Strategies employed include increasing health care access; addressing protective and risk factors contributing to infant mortality; developing resources on healthy birth outcomes; empowering the community by forming a community advisory committee for their grant program; utilizing community assets and strengths by incorporating cultural practices, beliefs, and values into programming; informing, educating, and training providers and community members on infant mortality issues and culturally responsive care; and participating in, hosting, or leading collaboratives, networks, meetings, and events to share best practices and resources.

Program activities include hiring staff, planning project expansion, recruiting program participants, developing resources such as curricula or modules, conducting home visiting, conducting trainings and other learning activities, providing support services such as transportation and appointment scheduling, building and strengthening relationships, holding large public events, and conducting evaluation.

Grantee-specific objectives, strategies, and activities are shown in Appendix D.

Evaluation

EHDI grantees are required to evaluate their programs, including developing a logic model and an evaluation plan, participating in a shared measurement system (SMS), and submitting an annual report. EHDI tracks number of individuals reached by grant activities, outputs produced from activities, shared measurement system (SMS) results, and grantee-specific outcomes.

Program Reach

EHDI grantees document the number of individuals directly reached through the activities in their workplan. This number excludes indirect or passive outreach activities such as number of views on social media or attendees in health fairs. Their total reach may include duplicate numbers, for example, if the same individual participated in more than one program activity then they are counted twice.

In FY 2024, EHDI infant mortality grantees directly reached a total of 1,244 individuals (Table 3). Based on the populations their programs served in FY 2024, 50% of the individuals reached were Native/Indigenous/American Indian, followed by Hispanic/Latino/Latine at 42%. Smaller numbers were African American (3%), Asian/Pacific Islander (2%), white (2%), and Multiracial (less than 1%).

Table 3. Number of Individuals Directly Reached by EHDI Infant Mortality Grantees by Priority Population, FY 2024

Population / Grantee	Leech Lake	Portico HealthNet	Wilder	All Grantees (% of Total)
African American	n/a	17	26	43 (3%)
Native/Indigenous/ American Indian	628	n/a	n/a	628 (50%)
Hispanic/Latino/Latine	n/a	525	3	528 (42%)
Asian/Pacific Islander	n/a	23	n/a	23 (2%)
white	n/a	6	13	19 (2%)
Multiracial	0	0	3	3 (<1%)
All Populations	628	571	45	1,244

n/a means the population was not directly served in FY 2024.

Outputs and Outcomes

Grantees were not required to report on evaluation results in the first year to give them enough time to build out their programs. Evaluation reporting will begin in the second year, FY 2025. However, the three infant mortality grantees included some outputs and outcomes when they provided updates on workplan activities in the Year 1 annual report.

Leech Lake Band of Ojibwe: Outputs

- 26 new mothers and 147 fathers began the modules on prenatal/infant/toddler care, My Growing Child, My Family and Me, and Health Living (it takes up to 1.5 years to complete the modules)
- 26 participants received home visiting on prenatal care, post-partum care, and infant care
- 26 participants were provided transportation to their appointments
- All 17 babies born during this reporting period received immunizations and attended well-child checks
- 213 caregivers/parents learned about available family resources
- 213 caregivers/parents learned how to make appointments for themselves and access the medical facilities of their choice
- 398 individuals attended presentations on prenatal care, opiate/alcohol/and other substance use during pregnancy, and the Ojibwe Cultural Teachings about pregnancy and substance use
- 26 participants plus 185 people received in-home lessons or group lessons on SIDS/SUIDS
- 26 lessons on Sudden Infant Death Syndrome (SIDS)/Sudden Unexpected Infant Death Syndrome (SUIDS) were given to Tribal entities
- 26 participating families plus another 33 families created baby moccasins and learned the Ojibwe cultural teachings about baby moccasins
- 331 group sessions were held with fathers in outpatient treatment programs, the Recovery Center, and jails
- 147 fathers participated in cultural and Ojibwe Language family camps
- Staff attended 42 community events

Portico Healthnet: Outputs and Outcomes

- Increased MNsure Navigator capacity by adding 0.5 FTE through the Minnesota Community Care (MCC) partnership
- The additional 0.5 FTE resulted in 319 applications submitted for pregnant people, 264 have outcome determination as of 7/15/24, and 255 were approved and successfully enrolled in health insurance (that is, 97% of pregnant person applications resulted in health insurance enrollment).
- Received 306 pregnant person referrals from MCC, and out of this, 232 (76%) were successfully contacted and educated about their health insurance benefits
- Received 427 newborn referrals from MCC, and out of this, 314 (74%) were successfully contacted and educated on their newborn's health insurance benefits.
- The additional 0.5 FTE resulted in 192 applications submitted for newborns, 155 have outcomes determined as of 7/15/24, and 152 were approved and successfully enrolled in health insurance (that is, 98% of newborn applications submitted resulted in health insurance enrollment)
- Identified three communities for project expansion: Black women who are more likely to be late to prenatal care or be inadequate users of prenatal care and are at higher risk for maternal mortality associated with low prenatal care utilization, pregnant people in rural communities who face greater

health system access challenges including steadily increasing distances to travel to obtain obstetric care, and American Indian women who face some of the highest health disparities in the nation.

- Portico Healthnet held three retrospective focus groups and sent out 54 supplemental (online) surveys to pregnant people and parents of newborns who received assistance.
    - *Process outcomes:* participant satisfaction
        - 98% strongly agreed or agreed that Portico staff were sensitive to their cultural background
        - 100% felt respected throughout the process
        - 95% felt that the navigator they worked with explained the insurance enrollment process to them in a way they could understand
        - 98% were satisfied with the services they received
        - 22% said they were connected to other services
    - *Summative outcome:* 78% of respondents felt very confident in their ability to use their insurance coverage moving forward.

Wilder Foundation: Outputs and Outcome

- Hosted Black and Brown Birthing Summit in Fall 2023 with 210 attendees
- Hosted “Experiences of Mothers and Birthing While Incarcerated” workshop in June 2024 with 38 attendees
- Hosted Birthing Fruition training in May 2024 with 6 participants
- Established the Safer Birth Consortium, a 12-member advisory group focused on addressing maternal health disparities, promoting doula access, and addressing issues related to incarceration and its effect on birth equity. The consortium met twice, in December 2023 and June 2024.
- Launched the resource exchange which includes a directory of partner organizations, upcoming trainings and events, and birth equity resources
- Developed the "Prioritizing the Wellbeing of Black and Brown Women: A Guide for Connecting Maternal Mental Health to Child Development" curriculum
- Engaged with 13 different partners: UCare Clinic, LEAP Clinic, St. Paul Promise Neighborhood, Interfaith, Wilder Foundation Public Policy, Minnesota Department of Health, Cultural Wellness Center, Ramsey County Birth Equity Community Council (BECC), Healthy Black Pregnancies Board (HBP), Collective Action Lab, Northpoint Health and Wellness, Diva Moms, The Minnesota Prison Doula Project, and Erase The Stigma
- *Summative outcome:* Increase in understanding on the impact of incarceration on birth outcomes. AABC collected 25 surveys at the “Experiences of Mothers and Birthing While Incarcerated” workshop in June 2024 with 38 attendees (66% response rate).
    - Using the scale Very much so, Somewhat, A little, and Not at all: To what extent did participating in today's training improve your understanding of the following topics?
        - The unique challenges faced by incarcerated mothers: 96% Very much so, 4% A little
        - The stigma experienced by mothers while incarcerated: 88% Very much so, 12% Somewhat
        - Impacts incarceration has on the family: 96% Very much so, 4% Somewhat

Shared Measurement System

A shared measurement system (SMS) is a system of tracking, measuring, and reporting on the collective or shared reach and outcomes that are common across grantees within a priority health area. EHDI first

implemented an SMS in FY 2018, marking a critical first step in better understanding the collective impact of the EHDI program. Since then, EHDI has sought ways to better understand and assess outcomes achieved within and across EHDI populations. Due to the COVID-19 pandemic, the SMS was paused in FY 2021 and FY 2022 to allow grantees to focus their energies in addressing urgent COVID-19 related needs in their communities. The SMS was slowly brought back in the current grant cycle. It was introduced to grantees in late fall 2024, and SMS reporting will start with the FY 2025 annual report.

Level of Change Narratives

Grantees were asked to share a specific example or story from the past year that illustrated the approaches or strategies they used to improve well-being by addressing root causes or social conditions for health, and the difference they have made. They were encouraged to include specifics about barriers they experienced and how they addressed those barriers in their EHDI grant program. These narratives help MDH more fully understand how EHDI grantees promote change.

Leech Lake Band of Ojibwe (LLBO)

Level 1 Narrative: *The way that we make change is through teaching cultural and ceremonial life skills. We are strengthening Tribal leadership by bringing back the Ojibwe culture, language, and life skills. One example is the Welcome Baby Celebration. The LLBO leadership is learning how to welcome new babies to our Tribe, and how to thank the women for being the pathway for bringing these spirits to our Tribe. They are also learning the sacredness of women, and how men fit within the community, families, and the world. Learning happens through the stories, actions, and events surrounding the lessons and language. This is inspiring the whole tribe to engage in ceremonies and events, and in learning or practicing the language. Our Tribal leadership is learning the language at the request of tribal elders, so that they can better understand their leadership roles. They're doing well with it. We teach language in all our lessons, and share what the words mean. The actual meaning of our language and the events and ceremonies go hand in hand. Because we are based in culture and are ceremonial, we don't do anything without ceremony. It has helped our Tribe to strive to incorporate culture into other programs too, such as gardening. There is less fighting, and people are working together and breaking down silos within the Tribe. Programs are coming together and working together, and it is due to us reaching out and bringing all these different programs into what Family Spirit does. The way that Governor Walz and [Lieutenant Governor] Peggy Flanagan explained to us is, that we are healing Minnesota. Family Spirit is helping to heal Minnesota because we also reach out beyond our borders. Our tribal leaders say we are assisting the Band to heal ourselves.*

Portico Healthnet

Level 1 Narrative: *In May of 2024, our Maternal and Child Health Navigator, Mayeli, met with the following client and shared her story.*

"I had a client who recently arrived from Mexico. After being in Minnesota for two weeks she found out she was pregnant. My client doesn't have family or friends in the States. She moved here to start a new life away from violence as she describes. The first time Portico reached out to the client, an appointment was scheduled, but on the day of the appointment, she declined services because she was afraid and didn't have information about health coverage. I conducted the screening on the day of the appointment and provided my phone number for future questions or concerns. After a few months, the client reached out to me and asked for assistance. She was diagnosed with aggressive anemia and needed iron infusions as soon as possible. I assisted her with the

application for MNSure insurance [MNSure is Minnesota's health insurance marketplace]. I added a note explaining that this was an urgent medical situation and that the client could potentially go back to the emergency room. She was approved for Medical Assistance (MA) under eligibility as a pregnant woman. On June 14, 2024, I received a phone call from the client asking for assistance to add the newborn to the case. I assisted with reporting the newborn, and the child now has an active MA. Unfortunately, the county listed the newborn with two last names and no first name. I placed a phone call to the county and the child's information was updated in 24 hours."

Despite the client initially declining assistance due to fear, Mayeli was able to establish a level of trust with the client and provided her the means to reach her if she needed assistance in the future. The client did reach out to Mayeli when she had a health event. Mayeli helped her complete a health insurance application and communicated to the county the urgency of expediting her application. After giving birth, the client already knew she could count on Mayeli to assist with adding the newborn to her coverage and to correct the error in county processing. Mayeli's extensive training and experience working with newly immigrated pregnant people is a major factor in the success of targeted enrollment services for populations facing particularly high barriers to accessing coverage and care.

Level 2 Narrative: *A barrier to utilizing insurance coverage is misinformation regarding what is covered and for how long. A common misunderstanding about Medical Assistance (MA) coverage for pregnant people is that coverage will continue for a year after the pregnancy ends, regardless of whether they plan to parent or the pregnancy ends in a miscarriage or abortion. In the third quarter of 2023, Portico updated our referral process with Minnesota Community Care [medical clinic in Minnesota] to include indicators of special circumstances such as patients with a threat of miscarriage and patients not planning to parent, whether that is due to plans to end their pregnancy or plans to pursue adoption. The inclusion of these indicators better prepared our Navigators to approach each client's experience with sensitivity and ensure that coverage information is shared in a way that is relevant to the individual. Instead of explaining duration of coverage with phrases such as "time after the baby is born", the Navigator will instead use phrases like "time after the pregnancy ends". The Navigator can also add additional clarifying language such as "regardless of how pregnancy ends, your coverage will remain for a year to support your health." This organizational change ensures that all pregnant patients are educated about the details of their coverage in a way that is both sensitive and relevant to their circumstances, improving the likelihood that clients will utilize their insurance coverage effectively.*

Wilder Foundation (African American Babies Coalition)

Level 2 Narrative: *AABC recruited and trained Community Host Trainers who represent BIPOC communities and have direct contact with formerly incarcerated women to use their advocacy skills to improve birth outcomes for Black and Indigenous mothers facing incarceration. They attended the "Experiences of Mothers and Birthing While Incarcerated" training workshop in June 2024 which was attended by a total of 38 individuals. The training is designed to shed light on the unique challenges that incarcerated mothers face during childbirth, and bring attention to individuals' experiences and issues with the judicial system during their time of giving birth. The training focused on needed systemic changes to better support birthing individuals and provide them the resources they need.*

Level 3 Narrative: *Wilder's AABC project hosted the 2023 Black and Brown Birthing Summit. The summit's theme centered on "Women, Babies, and Families in the Present Crisis." The objective was to examine the contemporary challenges encountered by Black and Brown parents within the community. Keynote speakers from Atlanta presented data illustrating the health system's inadequate service to Black women during and*

post-pregnancy. The 2023 Black and Brown Blood Stream aimed to highlight the multitude of issues impacting Black and Brown communities. Future initiatives involve overhauling the healthcare system to support all birthing women more effectively.

IV. Conclusions

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

U.S. infant mortality rates have been gradually declining in the last few decades, reaching their lowest between 2015 and 2020. In Minnesota, infant mortality rates have exhibited a similar downward trend. Additionally, Minnesota's infant mortality rates are generally lower than the national rate and most states. Despite this seemingly rosy picture for the state, the health gaps between 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 are what need to change. The EHDI infant mortality grantees are doing just that.

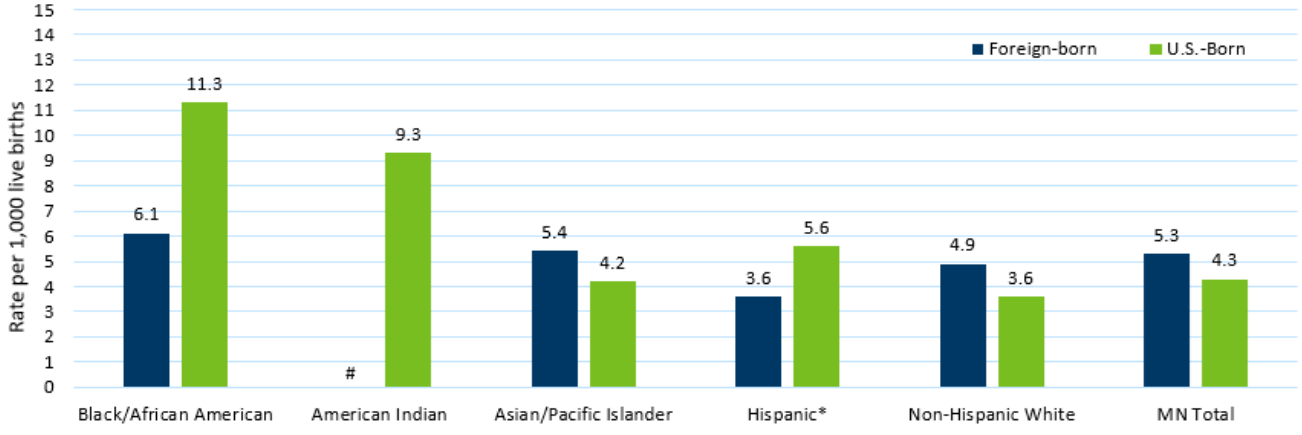
Information gathered from infant mortality grantees in FY 2024 indicate that EHDI is making significant contributions towards the goal of reducing infant mortality disparities. The infant mortality grantees are serving populations most impacted by infant mortality disparities, African Americans, American Indians, and Latinas/Latinos/Hispanics. In FY 2024 they directly reached a total of 1,244 individuals through their activities. This number will increase by thousands more if indirect interactions, for example through social media and tabling at community events, are counted. Examples of accomplishments in the first year include providing home visiting services to 26 new mothers; helping 17 newborns receive immunizations and well-child checks; hosting cultural family camps for 147 fathers to strengthen their role in family wellbeing; assisting 255 pregnant people and 152 newborns with health insurance enrollment; hosting trainings, workshops, and summits for service providers and community members; empowering community by establishing a Safer Birth Consortium advisory group; launching a resource exchange to share birth equity resources; and developing curricula. Their plans for expansion point to serving larger numbers in more settings in the coming years.

Strategies they successfully employed include increase health care access; addressing protective and risk factors contributing to infant mortality; developing resources on healthy birth outcomes; empowering the community by forming a community advisory committee for their grant program; utilizing community assets and strengths by incorporating cultural practices, beliefs, and values into programming; informing, educating, and training providers and community members on infant mortality issues and culturally responsive care; and participating in, hosting, or leading collaboratives, networks, meetings, and events to share best practices and resources.

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

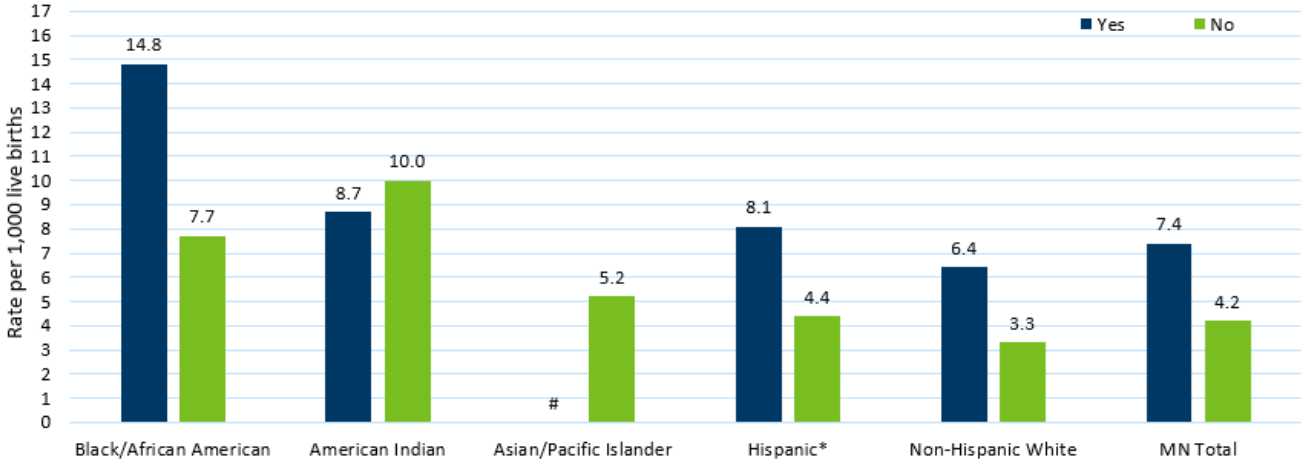
APPENDIX A. Infant Mortality Rates and Selected Social Determinants of Health, Minnesota

Infant Mortality Rates by Maternal Nativity and Race/Ethnicity: Minnesota, 2017-2021



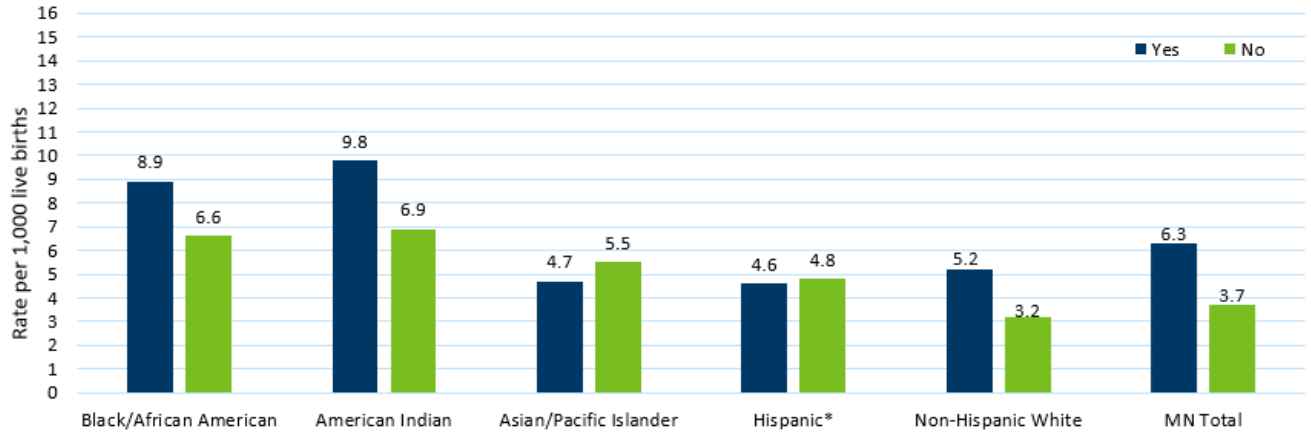
*Can be of any race
#Data are not shown when there are fewer than 5 deaths
Source: Source: Linked Birth-Infant Death Minnesota Resident Period Data File. Minneosta Department of Health

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



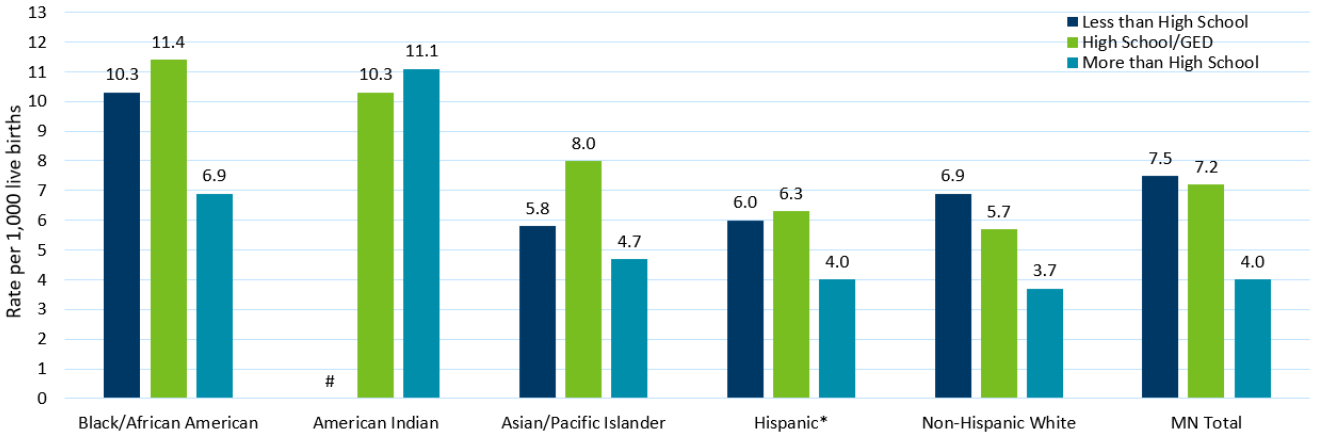
*Hispanic can be of any race
#Data are not shown when there are fewer than 10 deaths
Source: Source: Source: Linked Birth-Infant Death Minnesota Resident Period Data File. Minneosta Department of Health

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



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

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



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

APPENDIX B. EHDI Legislation

2023 MINNESOTA STATUTES

ELIMINATING HEALTH DISPARITIES 145.928

Subdivision 1.Goal; establishment.

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

Subd. 2.State-community partnerships; plan.

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

Subd. 3.Measurable outcomes.

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

Subd. 4.Statewide assessment.

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

Subd. 5.Technical assistance.

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

Subd. 6.Process.

(a) The commissioner, in consultation with the community partners listed in subdivision 2, shall develop the criteria and procedures used to allocate grants under this section. In developing the criteria, the commissioner

shall establish an administrative cost limit for grant recipients. At the time a grant is awarded, the commissioner must provide a grant recipient with information on the outcomes established according to subdivision 3.

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

Subd. 7.Community grant program; immunization rates, prenatal care access and utilization, and infant mortality rates.

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

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

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

(3) increasing adult and child immunization rates in non-white racial and ethnic populations.

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

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

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

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

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

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

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

(5) reflects racially and ethnically appropriate approaches; and

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

Subd. 7a.Minority-run health care professional associations.

The commissioner shall award grants to minority-run health care professional associations to achieve the following:

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

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

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

Subd. 8.Community grant program; other health disparities.

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) reflects racially and ethnically appropriate approaches; and

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

Subd. 9.Health of foreign-born persons.

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

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

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

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

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

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

Subd. 10.Tribal governments.

The commissioner shall award grants to American Indian tribal governments for implementation of community interventions to reduce health disparities for the priority areas listed in subdivisions 7 and 8. A community intervention must be targeted to achieve the outcomes established according to subdivision 3. Tribal governments must submit proposals to the commissioner and must demonstrate partnerships with local public health entities. The distribution formula shall be determined by the commissioner, in consultation with the tribal governments.

Subd. 11.Coordination.

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

Subd. 12.Evaluation.

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

Subd. 13.Reports.

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

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

Subd. 14.Supplantation of existing funds.

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

Subd. 15.Promising strategies.

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

APPENDIX C: EHDI Infant Mortality Grantees Program Description, Population and Geography Served, FY 2024

Grantee Organization (Program Name)	Program Description	Primary Population Served	Geography Served
Leech Lake Bank of Ojibwe (Family Spirit)	The Family Spirit and Empowerment Program is an evidence based and culturally specific "Home Visiting" Program for Native Americans. LLBO's Family Spirit program is designed to be delivered by Tribal Paraprofessionals with a core strategy to support and educate Native American families in daily life skills in an Ojibwe specific manner. The program supports Native American women who are pregnant or women pregnant with Native American babies, fathers, or any family raising Native American babies and children.	American Indian	Leech Lake Band of Ojibwe territory (reservation) and 25 miles off territory (adjacent communities)
Portico Healthnet (Increase protective factors for pregnant persons & newborns)	Portico Healthnet helps racially and culturally diverse Minnesotans enroll in health insurance, understand how to use the health care system, and access community and county resources that support their wellbeing. In partnership with Minnesota Community Care and Region's Hospital, Portico helps under-resourced pregnant persons residing in Ramsey County and their newborns to enroll in health insurance. Since 2021, Portico Healthnet has assisted over 1,000 pregnant persons and 679 newborns to enroll in health insurance. Portico's EHDI program will develop a customizable service model designed to increase protective factors for pregnant persons and infants facing health disparities in targeted communities, create a leadership development network to continually refine and hone the model, and implement the model in partnership with identified communities.	Hispanic/Latino	Statewide; majority of clients served reside in the 12-county Twin Cities metro area
Amherst H. Wilder Foundation (African American Babies Coalition)	The African American Babies Coalition and Projects (AABC), a program of the Amherst H. Wilder Foundation, seeks to expand its programming to further develop training curricula focused on maternal and infant health and address the issue of incarceration as a social determinant of health (SDOH) that impacts healthy birthing. AABC's approach	African American	Hennepin and Ramsey counties

Grantee Organization (Program Name)	Program Description	Primary Population Served	Geography Served
	includes 1). training, outreach, and engagement with both the African American community as well as healthcare workers and service providers and 2). systems change strategies that convene key healthcare leaders, agency staff, and researchers to inform and advance work that addresses racial disparities in prenatal care and birth outcomes.		

APPENDIX D: EHDI Infant Mortality Grantees Levels of Change, Objectives, Strategies, and Activities, FY 2024

Leech Lake Band of Ojibwe (Family Spirit)

Level 1: Health Promotion/Direct Service

- Objective 1A: Improve pregnancy outcomes
    - Conduct family home visiting using the Family Spirit Model
    - Provide transportation to prenatal and well child visits
    - Assist participants with appointment scheduling for prenatal appointments, post-partum appointments, infant, toddler, child immunizations, well-child checks, and Medication-Assisted Treatments (MAT)
    - Conduct presentations on prenatal care, opiate/alcohol/and other substance use during pregnancy, Ojibwe Cultural Teachings about pregnancy and substance use, safe sleep; baby hammock making activity
    - Conduct trainings on Cultural Birthing & Breastfeeding
- Objective 1B: Fathers develop a healthy lifestyle to support family wellbeing
    - Hold Baby Moccasin Making and cultural teachings activities
    - Conduct family home visiting using the Family Spirit Model and Fatherhood Teachings
    - Facilitate Men Supporting Men groups through Ojibwe Cultural teachings and beliefs.
- Objective 1C: Family Spirit Program and the LLBO community members improve recruitment, retain new resources, and improve relationships with all communities in and surrounding the LLBO territories.
    - Participate in All Babies Born Healthy Indigenous Group, LLBO events and meetings, Tribal Nurse Collaborative, Reflective Practice meetings
    - Create referrals between all entities.

Portico Healthnet (Increase protective factors for pregnant persons & newborns)

Level 1: Health Promotion/Direct Service

- Objective 1A: Increase protective factors against infant mortality.
    - Implement expanded Regions Hospital newborn health insurance enrollment footprint with existing Regions Hospital partnership.
- Objective 1B: Expand service model to address at least one additional protective factor for preventing infant mortality.
    - Conduct focus groups with initial service participants (Minnesota Community Care families) about experience with program; identify positive and negative factors to prenatal care and WIC services access; identify needs, opportunities and/or missing services.

Level 2: Organizational/Institutional Change

- Objective 2A: Develop a customizable service model designed to increase protective factors for pregnant persons and infants facing health disparities in targeted communities.
    - Hire and/or appoint project team
    - Review literature on health outcomes and protective factors
    - Conduct one-on-one interviews with current project collaborators
    - Using local data on uninsured rates and leadership network input, identify communities that could benefit from pregnant person/newborn enrollment services

Wilder Foundation (African American Babies Coalition)

Level 2: Organizational/Institutional Change

- Objective 2A: Participating black and indigenous community members increase their knowledge of healthy birthing, including how to advocate for and access high quality perinatal care for black birthing mothers who are incarcerated.
    - Recruit and train Community Host Trainers who represent BIPOC communities and have direct contact with formerly incarcerated women.
    - AABC staff, community partners, and clinics promote, refer, and register potential BIPOC Host Trainers working with incarcerated families.
    - Implement cohort of Community Host Training led by African American and Indigenous elders in accessible and inclusive spaces; introduce Birthing Fruition curriculum.
    - Evaluate Community Host training participant changes in knowledge, skills, and attitudes with respect to improving birth outcomes for Black and Indigenous mothers facing incarceration.
- Objective 2B: Increase number Black and Brown Perinatal Navigators (Doulas) who are trained and equipped to provide navigation and support to black and brown birthing people who have experienced incarceration.
    - 2B.1.1 Recruit African American and indigenous community members to participate in doula community advisory committee
- Objective 2C: Participating institutional partners will increase their capacity provide culturally sensitive perinatal services to African American and indigenous birthing people and their families.
    - Build communication networks addressing availability of and access to resources, training, upcoming events, and information regarding policies with the BIPOC community
    - Design the resource exchange platform and distribution method
    - Engage in outreach to health care professionals, clinical staff, childcare providers, and agency partner staff to facilitate use of the knowledge and resource exchange. i.e., training cohorts, curriculums, partners resources, trainer registry of BIPOC and Native expertise, websites, upcoming events.
    - Develop mental health modules for the Birthing Fruition curriculum focused on incarcerated mothers, birthing mothers experiencing post-partum depression, and isolation
    - Provide Birthing Fruition training to healthcare workers at partner clinics and agencies

- Evaluate changes in knowledge and practices among training participants

Level 3: Root Causes/Conditions for Health

- Objective 3A: System of care for black and brown birthing people is more culturally responsive and integrated.
    - Co-create the Black and Brown Birthing (BBB) summit agenda focused on equity and justice with community partners and stakeholders
    - Host annual Black and Brown Birthing Summit (BBB) in October.
    - Evaluate the impact of the BBB Summit