# Eliminating Health Disparities Initiative: Infant Mortality Grants Fiscal Year 2019

**Report to the Minnesota Legislature 2019**
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# Eliminating Health Disparities Initiative Infant Mortality Grants

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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. Minnesota ranks high in terms of general health status compared to other states, but 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/Latinos 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).

This report covers EHDI infant mortality data for fiscal year 2019 (July 1, 2018 to June 30, 2019 grant period) which is the third year of a three year grant.

In fiscal year 2019 (FY19), three organizations were awarded EHDI grants to implement infant mortality programs: American Indian Family Center, Leech Lake Band of Ojibwe, and NorthPoint Health and Wellness Center. They received a combined $395,986 in grants in FY19. Their programs focused on two objectives:

- Improve the health status of women before, during and between pregnancies,
- Provide parent education, outreach and resources to parents who are planning a pregnancy, currently pregnant or have an infant under one year old, and improve the health status and safety of infants from birth to one year.

Examples of strategies they have continuously employed over the past three fiscal years are:

- Increasing access to preventative care before, during, and after pregnancies
- Providing culturally-specific outreach and care coordination during pregnancy and birth
- Providing education and support to high-risk pregnant women
- Addressing maternal psychosocial skills

Grantees reached 2,530 individuals in FY19 through both direct and indirect contacts.

Examples of accomplishments reported by grantees based on their evaluations are:

- Increased ability to secure participants affordable housing or shelter
- Provided information about safe sleep, dangers of shaken baby, second and third hand smoke, and promoting car seat safety
- Enhanced care coordination to standardize the care delivery of participants
- Assisted with immunization, physicals, transportation, and education on nutrition
- Continues to conduct home visits to families and provided education on birth outcomes, Fetal alcohol spectrum disorders (FASD), drug and other substances, smoking during pregnancy, and Sexually Transmitted Diseases (STDs)
- Collaborated with other organization to hold a cultural event on the importance of being alcohol free during pregnancies/planning pregnancy
- Conducted a Community Baby Shower to celebrate expecting moms, and conducted parenting education class on healthy relationships.

The work of EHDI infant mortality grantees can lead to potential cost savings for the State. For example, in FY 2019 American Indian Family Center's potential cost savings came from healthy term births as opposed to preterm birth or low birth weight and developmental consequences. For Leech Lake, cost savings come from the prevention of babies born with Neonatal Abstinence Syndrome (NAS) and infant deaths. Examples of potential cost savings for NorthPoint come from management of co-existing mental health or chronic disease within the ambulatory care setting thus keeping patients out of the hospital, using NorthPoint Gap services for uninsured adults to avoid serious health consequences due to lack of preventive care or delayed care, and preventing child out-of-home placement and associated county court and legal fees for mothers at risk of Child Protection Services involvement.

# 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 department-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/Latinos 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. 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 (CDC), there were close to 4 million live births in the U.S. in 2018. The sad news is that more than 23,000 infants died in the same year. The infant mortality rate in the United States in 2017 was 5.8; for Minnesota this number was 4.8[1]. This means that for every 1,000 infants that were born alive in Minnesota, five died before their first birthday. Nonetheless, these rates still fall below the Healthy People 2020 goal of reducing infant mortality in the U.S. to 6.0 deaths per 1,000 live births by the year 2020.

The infant mortality rate in the U.S. exhibited a declining trend from 2000-2017 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. However, the declining infant mortality rates mask significant disparities in certain groups. For example, nationally the infant mortality rate is over two times as high for black infants than for white infants (11.3 versus 4.9 in 2015), and is still significantly higher among babies born to teenage mothers than older mothers across races and ethnicities. In Minnesota from 2012-2016, the rates of infant mortality among American Indians (10.3), American and African Americans (9.3), Asians and Pacific Islanders (5.5), Hispanics (5.5) are more than double the rate of whites (4.1)[2]. Disparities are observed when variables such as mother's nativity, age, smoking status, and education are factored in. Please refer to page 80 of the 2022 EHDI Request For Proposals (PDF) for more information on infant mortality disparities.

## Infant Mortality Reduction Plan for Minnesota

MDH released the Infant Mortality Reduction Plan for Minnesota: Part 1 (PDF) in March of 2015. The document serves as a "call-to-action" to address the persistent racial and ethnic disparities in infant mortality and poor birth outcomes in the state. The plan was developed with input from a diverse group of stakeholders from diverse groups of communities and professionals 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.
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.

Recognizing the importance of eliminating racial and ethnic disparities in infant mortality, Minnesota has implemented various programs and policies designed to improve birth outcomes. EHDI is one of several statewide efforts to reduce infant mortality rates. EHDI is in a good position to take action to implement 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 2019

Information in this section was obtained from annual reports submitted by grantees on EHDI activities during the reporting period July 1, 2018 through June 30, 2019 (FY19).

## Funded Programs

In FY19, three organizations were awarded EHDI grants to implement infant mortality programs: American Indian Family Center, Leech Lake Band of Ojibwe, and NorthPoint Health and Wellness Center. They served primarily Africans/African Americans in North Minneapolis and American Indians in three East Metro counties and the Leech Lake Reservation (see Appendix B). In the next grantee cycle of 2019-2022 American Indian Family Center was funded to continue its work around infant mortality prevention.

## Funding Levels

For FY19, the three infant mortality grantees received a total of $430, 687, with the total amount spent of $448,898, due to additional funded carried over from the previous fiscal year.

**Table 1: All Uses of Grant and Total Funds Awarded to Infant Mortality Grantees, FY 2019**

| | Salaries & Fringe | Travel | Supplies | Indirect | Other | Total Spent | Total Awarded* |
|---|---|---|---|---|---|---|---|
| **American Indian Family Center** | 90,738 | 3,288 | 16,507 | 11,194 | 450 | **122,177** | **123,232** |
| **Leech Lake Band of Ojibwe** | 97,993 | 18,738 | 14,648 | 13,971 | 4,335 | **149,685** | **138,161** |
| **North Point Health & Wellness Center** | 140,839 | 6,998 | 9,845 | 15,236 | 4,118 | **177,036** | **169,294** |
| **TOTAL** | 329,570 | 29,024 | 41,000 | 40,401 | 8,903 | **448,898** | **430,687** |

**Grantees were able to carry over unspent funds from FY 2018, allowing total spent in FY 2019 to exceed total awarded.*

## 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, Strategies and Activities

As part of the Request for Proposal (RFP) process, MDH recommended that grantees align their projects with MDH-recommended key objectives, strategies, and associated evidence-based or promising practices.

Grantees were also encouraged to implement evidenced-based, promising, or culturally responsive practices that:

- Meet the needs of communities of color and American Indians already affected by teen pregnancy or affected by the underlying contributing risk factors for teen pregnancy
- Provide individual or group-based services; or change policies, systems, or the environment
- Are culturally responsive and linguistically appropriate
- Give community residents a voice in program planning, implementation, and evaluation
- Strengthen working relationships and partnerships in the community

Grantees objectives included:

- Improve system, community and family/individual factors that contribute to infant deaths
- Improve the health status of women before, during, and between pregnancies
- Improve the health status and safety of infants from birth to one year

Grantee strategies and the number of grantees implementing each are described in Table 2.

**Table 2: Infant Mortality EHDI Grantee Project Strategies, FY 2019**

| Strategy | # FY 2019 Grantees |
|---|---|
| Increase access to health and preventive care before, during and between pregnancies | 3 |
| Provide culturally responsive outreach and care coordination during pregnancy and birth | 3 |
| Change behaviors that lead to acute and chronic conditions | 2 |
| Provide education and support for pregnant and parenting teens | 1 |
| Ensure that all infants receive high-quality care at birth and infancy | 2 |
| Reduce infant deaths from SIDS and sleep-related unintentional injuries | 2 |
| Improve infant nutrition and health, physical growth and development | 2 |
| Reduce infant deaths from unintentional injury and violence | 2 |

Grantee activities included:

- Use of American Indian-specific curricula such as the Manidoo-Ningadoodem (Family Spirit) Program which is a core strategy to support young, Native parents from pregnancy to 3 years post-partum (based on an evidence-based strategy)
- Use of Back to Sleep message, Cribs for Kids Program to prevent sleep-related injuries (based on a culturally responsive strategy)
- Host Community Baby Showers to celebrate and welcome new babies and parents (based on a culturally responsive strategy)

## Reach

EHDI grantees have reached a large number of individuals and families over the years. Table 3 shows the number of individuals reached by infant mortality grantees through direct and indirect contacts in FY 2019.

**Table 3. Number of Individuals Reached by EHDI Infant Mortality Grantees by Type of Contact, FY 2019**

| Grantee Name | Direct Contacts | Indirect Contacts | Total |
|---|---|---|---|
| **American Indian Family Center** | 58 | 300 | **358** |
| **Leech Lake Band of Ojibwe** | 681 | 1240 | **1,921** |
| **NorthPoint Health & Wellness Center** | 80 | 171 | **251** |
| **Total** | **819** | **1,711** | **2,530** |

In total, EHDI infant mortality grantees reached 2,530 individuals in FY19. The variation in numbers reached reflects differences in programs and the settings where grantees implement activities. For example, AIFC conducts several group activities such as parent and early childhood classes community baby showers in three counties, and Mother's Circle groups. Whereas NorthPoint's activities take place mainly in a clinical setting and only in Minneapolis.

Direct contacts include one-to-one/individual contact (e.g. counseling, clinical services, screenings, education in private settings) as well as group contacts (e.g. classes, workshops, and group education sessions). There may be duplicate numbers in the total number of direct contacts if a person participated in both individual-type and group-type contacts (e.g., received individual counseling but was also part of a class). EHDI infant mortality grantees directly reached 819 individuals in FY19.

Indirect contacts are usually minimal or fleeting, such as when an organization conducts outreach at a large event by handing out flyers, publishes an article in a newspaper, or appears on an education segment on radio, television, or online, in which case circulation or audience size or website visits is used to estimate indirect numbers. EHDI infant mortality grantees reached 1,711 individuals in FY19 through indirect contacts. Leech Lake Band of Ojibwe  had a higher indirect contacts compared to the other two grantees based on attendance sheet data that was collected). North Point had fewer direct contact numbers because of the intense care coordination program set up that included one-on-one visits, counseling, home visits, parenting education and more.

## 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 required 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 outcomes common across grantees working in each of the eight priority health areas.

Infant mortality grantees reported specific and measurable outputs and outcomes as part of their evaluation (Appendix C). Outputs are counts of people, events, or products at a single point in time (i.e., not comparing across time). Some of the outputs reported by grantees include: 1) 80% of the moms attempted breastfeeding after receiving information and education on the benefits of breastfeeding (LLBO); 2) hosting 32 classes in prenatal/parenting education classes (AIFC); 3) 49 women participating in intensive care coordination that included 1-1 visits, counseling and referrals for services (NP).

Grantees also reported on outcome measures. Outcome measures are changes observed in or reported by participants as a result of program interventions. Examples of outcome measures include improved knowledge and awareness on prenatal care and parenting (LLBO, AIFC), and increased knowledge on community resources and services available to help keep mothers and their families healthy and safe (NP). See Appendix C for more information on outputs and outcomes.

Appendix D includes stories grantees provided to highlight the impact of their program at the individual level.

## Shared Measurement System

The shared measurement system is a system of tracking, measuring, and reporting on collective or shared outcomes common across grantees working in each of the eight priority health areas. Fiscal year 2018 was the first year EHDI grantees tracked the same outcomes/indicators across projects. Table 4 shows data for the infant mortality shared measurement health indicators for FY 2019. These indicators were focused on completion of recent well-child visits for infants

under 12 months, five or more well-child visits for 1-year-old infants, mothers' utilization of safe sleep practices, and pre-natal care initiation in the first term by pregnant women.

**Table 4. Infant Mortality Health Indicator Reporting (Percent of Participants)**

| Indicator | African/African American | American Indian | Asian/Pacific Islander | Hispanic/ Latino |
|---|---|---|---|---|
| **% of infants under 12 months completed most recent well-child visit** | n/a | 68% (90/131) | n/a | 56% (5/9) |
| **% of 1-year-olds who had 5 of more well-child visits** | 52% (11/21) | 52% (45/87) | n/a | 100% (4/4) |
| **% of mothers reporting safe sleep practices** | 100% (1/1) | 100% (49/49) | n/a | n/a |
| **% of mothers who initiated pre-natal care in first trimester** | 71% (35/49) | 95% (35/33) | 50% (1/2) | n/a |

The three infant mortality grantees served multiple populations but focused primarily on the two most impacted populations, African/African American and American Indian.

- Given social determinates of health that impact the health of African American women, studies show that neonatal infant mortality rates (those within the first 28 days of life) are highest in the African American community. Therefore, one grantee is working to reduce those numbers by preventing prematurity and promoting women's and infant health. That grantee worked with 70 African American women (along with 7 additional women from other racial and ethnic backgrounds) to promote holistic healthcare needs during and after pregnancy.
- Grantees working with the American Indian community focused more on the prevention of sleep-related unintentional injuries among infants under six months, as that is a leading risk factor in infant mortality. However, grantees were not able to assess the specific measures for all participants, because of variability on longevity with the program and access to health care records.

Each of the programs provide wraparound services to pregnant and post-partum mothers and their children to assess needs, address issues and create holistic education, care and resource referral plans for families.

## 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 2019 American Indian Family Center's potential cost saving came from healthy term births as opposed to preterm birth or low birth weight and developmental consequences. A study conducted by the Institute of Medicine in 2005 found that the average first-year medical costs for a preterm baby was $32,325 compared to $3,325 for term births, a cost difference of $29,000[3]. Adjusted for inflation from 2005 to

2019, the additional cost for a preterm baby in 2019 would be $54,194 In fiscal year 2019, the program worked with 27 pregnant participants, all of whom initiated prenatal care in the first trimester. Assuming initiation of early prenatal care supports all 26 pregnancies resulting in full term birth as opposed to preterm birth, the cost savings is approximately $1,409,044. Additional cost savings would also come from early intervention services, special education costs, and lost household and labor market productivity.

For Leech Lake cost savings would come from the prevention of babies born with Neonatal Abstinence Syndrome (NAS) and infant deaths. Reports estimate that the average cost per infant with NAS in hospital charges is $53,400[4]. Leech Lake gave prenatal care to 9 participants in their funded work, these efforts potentially saved $480,600. The LLBO ranks second in Minnesota in terms of highest drug use and loss of babies before or shortly after birth. Estimates are four out of seven pregnant women will have babies born with NAS, one will have an infant death before or shortly after birth, and two will have healthy live births.

Potential cost savings for NorthPoint come from: (1) Management of co-existing mental health or chronic disease within the ambulatory care setting, thus keeping patients out of the hospital; (2) Policy opportunities to support the transformation of all primary care sites serving vulnerable patients to medical homes and to create financial incentives to promote and sustain them; (3) Providing an array of basic health services to patients, thus reducing cost and duplication of services; (4) utilization of NorthPoint Gap services for uninsured adults, thus avoiding serious health consequences due to lack of preventive care or delayed care; and (5) preventing child out-of-home placement and associated county court and legal fees for mothers at risk of Child Protection Services involvement.

# 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/Latinos 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 2019 indicate that EHDI is making significant contributions towards the goal of reducing infant mortality disparities. Grantees reached a total of 2,530 individuals in FY19 through both direct and indirect contacts. In addition, the following conclusions can be derived based on information gathered from their annual reports:

1. The grantees are serving the populations most impacted by infant mortality disparities. Through both direct and indirect means, they reached 1,712 individuals in the American Indian and African/African American communities, the populations experiencing the biggest infant mortality disparities in the state. They provided services in the metro area and Leech Lake Reservation.
2. Though it is still too early to determine the impact of program interventions on infant mortality disparities, grantees have reported a number of accomplishments that show they are making good progress towards their goals. For example, they have: enrolled participants in classes, trainings, workshops and support groups; held community events to honor and support their participants and to increase awareness of infant mortality; provided health and social services and referrals to improve the health of mothers and babies; increased organizational capacity to serve their priority populations; and, strengthened or improved their collaborations or partnerships. Participants also have reported increased interest to learn more about their own culture and values and increased social connections and support.
3. They are implementing evidence-based and promising practices shown to be effective in reducing infant mortality, choosing to focus on the objectives of improving the health status of women before, during and between pregnancies, and improving the health status and safety of infants. Strategies they employ include increasing health care access, providing culturally specific outreach and care coordination, changing behaviors, improving infant growth and development, and reducing infant deaths.
4. They are utilizing community assets and strengths by implementing culturally responsive practices, for example, incorporating cultural elements into their programming.
5. There are strong arguments to be made in favor of supporting the EHDI grant program which tackles infant mortality as one of its priority areas. From an economic point of view, significant savings in medical costs can accrue, for example, from preventing low birth

weight. One study estimates that an increase of 250 grams (about half a pound) in birth weight saves an average of $12,000 to $16,000 in first year medical expenses, or prenatal interventions that result in a normal birth (over 2500 grams or 5.5 pounds) saves $59,700 in medical expenses in the infant's first year [5]. Another study estimated that Medicaid costs in Minnesota are reduced by $10,231 per low birth weight birth prevented and by $35,106 per very low birth weight birth prevented [6]. The EHDI grantees sustainability and cost saving efforts are sound investments in the health of their communities that can pay off in the long run.

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[7]. The EHDI infant mortality grantees are doing just that. NorthPoint Health and Wellness Center, through collaboration with Project for Pride and Living and EMERGE, is providing high at risk pregnant women and new mothers the opportunity to further their education by receiving their GED and/or obtaining other necessary life skills. Leech Lake Band of Ojibwe provide participants with activities to further their skills and education such as sewing classes, soap making classes, moccasin making classes and other culturally related skill-based activities.

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: Minnesota Statute 145.928

Subdivision 1. Goal; establishment. It is the goal of the state, by 2010, to decrease by 50 percent 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, 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 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 both of the following priority areas:

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

(2) 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 both 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 both 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. Report. (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 submit an 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, 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 B: EHDI Infant Mortality Grantees Program Description, Population and Geography Served, Fiscal Year 2019

| 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 |
| **Leech Lake Band of Ojibwe (Family Spirit)** | Assists pregnant women during pregnancy and into the third year of the child's life by educating mothers, families and community about prenatal care, well-child visits, and parenting knowledge on optimal child growth. | Leech Lake Band of Ojibwe members | Leech Lake Reservation encompassing four counties: Beltrami, Cass, Hubbard and Itasca |
| **NorthPoint Health & Wellness Center (Maternal Child Health Phase 2 Program)** | Provides intensive care coordination, and ongoing behavioral health support and/or referrals to previously identified high-risk pregnant women through the post-partum period, up until the baby's first year of life | African/African American, American Indian, Hispanic/Latino, Whites, Asian/Pacific Islander | Northside, Minneapolis |

# Appendix C: EHDI Infant Mortality FY 2019 Grantees Evaluation

| Grantee/EHDI Program | Description | Target Groups | Evaluation Findings |
|---|---|---|---|
| **American Indian Family Center/**<br><br>**Wakanyeja Kin Wakan Pi (Our Children are Sacred)** | WKWP is a culturally specific, comprehensive, wrap-around model for American Indian women who are pregnant and/or parenting. It provides intensive case management support and parenting education groups to participants. The current program is an expansion of a previously EHDI-funded program; it now aligns with another component of WKWP focused on preventing Fetal Alcohol Spectrum Disorder (FASD) thereby streamlining intake, screening, and communication, and improves outreach to, recruitment of, and participation by pregnant and parenting American Indian women and families as well as those struggling with chemical health issues. | American Indian community in the East Metro area including Ramsey, Washington and Dakota counties | Outputs and outcomes<br>▪ Held 32 classes in prenatal/parenting education classes, 9 mother's circle support group, first annual community baby shower, 45 American Indian women were screened and assessed through a holistic intake process, and 2 14-week ECFE Parent Education sessions were offered<br>▪ 75% of 45 pregnant women participated in the prenatal education classes<br>▪ 75% of participants improved their parenting knowledge<br><br>Shared Measurement outcomes<br>▪ 27 out of 27 women, who had an infant under the age of 6 months, reported their infant always slept on the infant's back, and that their infant always slept on their own firm surface with no loose bedding or soft objects<br>▪ 27 out of 27 women, who had pregnancy initiated pre-natal care in the first trimester |
| **Leech Lake Band of Ojibwe/Family Spirit** | FSP provides assistance and education to pregnant women from 28 weeks gestation until the 3rd year of the child's life. Participants receive information | Leech Lake Band of Ojibwe members at the Leech Lake Reservation encompassing Beltrami, | Output and outcomes<br>▪ Conducted 188 educational home visits<br>▪ 17 new mother attended the first annual "Welcome Babies – Thank Moms" ceremony as a community baby shower |

| Grantee/EHDI Program | Description | Target Groups | Evaluation Findings |
|---|---|---|---|
| | about pregnancy, fetal development, lifestyle issues and related concerns, as well as parental support. It collaborates with tribal, local, state and national organizations interested in advancing and promoting a healthy pregnancy outcome, a healthy child, and a healthy family. Health Educators receive high quality professional education opportunities so they can support and prepare pregnant women for childbirth and creating a healthy family. | Cass, Hubbard, and Itasca counties | ▪ 24 out of 34 women received training modules on prenatal care and child development<br>▪ 31 out of 34 women were referred/connected to various LLBO clinics and provided transportation for healthcare appointments<br><br>Shared Measurement outcomes<br>▪ All women (N=76), who had a child up to 12 months of age, has their child completed their most recent month well-child visit<br>▪ All women (N=31),who had a child reach one year of age, had their child complete 5 or more well-child visit during their first 12 months of life<br>▪ All women (N=23)women who had an infant under the age of 6 months, reported their infant always slept on the infant's back<br>▪ 7 out of 9 women who had pregnant initiated prenatal care in the first trimester. |
| **NorthPoint Health and Wellness Center/Healthy Families** | NorthPoint works with previously identified high risk pregnant women through the post-partum period up until the baby's first year of life. NorthPoint estimates that over 60 percent of pregnant women that present for care at | Pregnant women and their families, mainly African American but also serve American Indian and Hispanic/Latino, in the | Output and Outcomes<br>▪ 68 out of 92 women participated in intensive care coordination which included 1-1 visits, counseling, home visits, and parenting, safety, and breastfeeding classes<br>▪ All participants received referral for internal and external care/services such as food shelves, housing, and parenting support groups |

| Grantee/EHDI Program | Description | Target Groups | Evaluation Findings |
|---|---|---|---|
| | their clinic score high in two to three risk areas during prenatal assessment. A reassessment at post-partum, a period when they are at increased risk for psychosocial risk factors, determines whether the risk factors have been resolved during pregnancy, and if there are old unresolved and new risk factors that require intervention. Women participating in the program receive intensive care coordination, psychiatric diagnostic assessments, parenting/safety education, ongoing therapy support, and connection to local resources in collaboration with community partners up until the baby's first year. | Near Northside of Minneapolis | ▪ Offered a new culturally specific class (Karibu Mama) on parenting and education<br>▪ 26 out of 68 women's infants are up to date with immunization, a slight increase from last year<br>▪ 49 out of 68 of the women received intensive care coordination, and all participated in at least one parenting/education support class<br>▪ 38% of infants are up to date with immunizations<br>▪ 65% of women who participated in parenting/education offerings received intensive care coordination<br>▪ 97% of participants strongly agreed or agreed that they are more aware of community resources and services that can help keep them and their families healthy and safe<br>▪ 95% of participants strongly agreed or agreed that the community resources and services shared were helpful<br>▪ 97% of participants reported improvements in knowledge and understanding of infant safety practices<br><br>Shared Measurement<br>▪ 16 out of 28 women who have 1 year old child had their child complete 5 or more well-child visits during their first 12 months of life<br>▪ 35 out of 49 participants who had a pregnancy initiated pre-natal care in the first trimester |

# Appendix D: Stories

**American Indian Family Center**

This year has been a productive and wonderful year for the Wakanyeja Kin Wakan Pi (Our Children are Sacred) project. We have done many great things with the WKWP parents. The most memorable events were the making of the traditional buffalo hide rattles and the faceless spirit dolls. These were two-day events with over 20 clients per event who learned how to make these special items. We held these events to increase cultural identity, historical trauma, and self-care. These special items are considered sacred because they represent a part of our culture; when we take care of them, we learn responsibility and respect for ourselves. The theme of the rattle event was “shake this and not a baby.” The spirit dolls were made to promote “self-care and wellness.” Our clients come from many different tribes, but we share similar teachings which we learn from each other. These events are a part of bringing culture to our people and learning the teachings of why we make things the way we do. Many of our clients had never made a traditional rattle or a spirit doll so the joy on their faces when they completed their project made these events worthwhile. Learning the many skills and techniques to our traditional crafts and bringing it to our community is what makes the WKWP project so special and why the families enjoy coming here.

**NorthPoint Health & Wellness Center**

Amber was enrolled in the EHDI funded program when she was two months pregnant with her second pregnancy. The assessment she completed indicated that she was at high-risk for psychosocial needs, PTSD, depression, and chronic homelessness. The first step was to refer Amber to our behavioral health department to start helping stabilize her mental health status. Our community health worker helped Amber get admitted to a shelter home where she and her, now 3 year-old daughter would have a safe place to stay. Through grant funds, we were able to provide her and her kids with transportation to and from clinic appointments and other day-to-day errands. Through the grant our obstetric critical care (OBCC) care team focused on Amber’s pregnancies and her health. Staff encouraged Amber to cut or quit smoking completely which at first was hard, but after a few visits and education she started to understand the dangers of substance use on her growing fetus. Amber started coming to some of the classes that were being offered through the EHDI grant. These classes helped her acquire skills about trauma-informed care and other skills such as parenting skills. Our community health worker, with coordination conjunction with the social workers, worked together to secure Amber an apartment. They also assisted her in finding employment and daycare for her children. Amber had a successful birth and breastfed her child through the first year. All these were made possible through the support she received from our staff with the help of the EHDI grant.

**Leech Lake Band of Ojibwe**

Long ago the chiefs in the Leech Lake Nation visited families who gave birth to a new member, the baby. The chief would bring a gift to the baby and welcome the baby to the Nation. The chief would also gift the mom for being the pathway through which the new little human spirit came. This celebration of new life was the Nation's way of letting the families know how important new life is and how sacred the women were in their ability to bring life. It has been a lost celebration for many years. The LLBO Family Spirit staff learned of the celebration through the supervisor who is old enough to remember the celebration, and the staff decided to bring the celebration back to the leaders and Tribal members. They celebrated their first Welcome Baby in June 2018, and the Chairman of the Tribe who welcomed the new babies stated that he saw a beautiful receiving of the Ceremony and requested it happen yearly. The ceremony was again held in June 2019 and the numbers of participants grew. The celebration is now part of a NEW celebration that lasts a week long. The leaders show appreciation of the Tribal members with a huge reservation-wide event of picnics and games, followed by an appreciation of staff, and then a Powwow for all nations across the USA, Mexico, and Canada. The celebration of Welcome to Babies is now changing the women in many ways and assisting them to find their drug-free place in their own lives and communities. The celebration is also bringing the men back to their drug-free selves and they are relearning how to be men in their families and communities. All of this is also assisting the leaders to know more about their own customs, celebrations, language, and culture to have the ability to be better leaders who are culturally able to make better decisions on behalf of their people.

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