



Eliminating Health Disparities Initiative: Infant Mortality Grants Fiscal Year 2018

**Report to the Minnesota Legislature
March 2019**

Eliminating Health Disparities Initiative Infant Mortality Grants

Report to the Minnesota Legislature 2019

Minnesota Department of Health
Center for Health Equity
P.O. Box 64975, St. Paul, MN 55164-0975
(651) 201-5813
<http://www.health.state.mn.us/divs/che/>

As requested by Minnesota Statute 3.197: This report cost approximately \$4,128 to prepare, including staff time, printing and mailing expenses.

Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper/

Table of Contents

Executive Summary	1
Infant Mortality Overview	3
Introduction	3
Infant Mortality	3
Infant Mortality Reduction Plan for Minnesota	4
EHDI Infant Mortality Grantees in Fiscal Year 2018	5
Funded Programs	5
Funding Levels	5
Appropriation Retained for Administrative Purposes.....	5
Objectives, Strategies and Activities	6
Reach	7
Evaluation	8
Shared Measurement System	8
Potential Cost Savings	9
Conclusions	11
Appendix A: Minnesota Statute 145.928	13
Appendix B: EHDI Infant Mortality Grantees Program Description, Population and Geography Served, Fiscal Year 2018	18
Appendix C: EHDI Infant Mortality 2018 Grantees Evaluation.....	19
Appendix D: Stories	22
References	23

Executive Summary

The Eliminating Health Disparities Initiative (EHDI) is a grant program within the Minnesota Department of Health (MDH) Center for Health Equity (CHE). Established in 2001 by the Minnesota Legislature (Minnesota Statute 145.928), the initiative was a response to mounting evidence that disparities in health outcomes between Minnesota's white residents and those from populations of color and American Indian communities were distressingly wide and on a clear trajectory to grow even wider. Even though Minnesota ranks high in terms of general health status compared to other states, it has some of the worst racial and ethnic health disparities.

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

Based on 2010-2014 data, the five leading causes of infant deaths in Minnesota are congenital anomalies or birth defects (26.4% of all infant deaths), prematurity (18.5%), obstetric conditions or pregnancy complications (12.4%), Sudden Unexpected Infant Deaths or SUIDS (10.8%), and injury (1.8%). These causes vary by population. Sleep-related causes are a primary source of infant deaths in the American Indian community, while it is birth defects for other populations.

Infant mortality rates for the country as a whole have exhibited a declining trend. Rates in Minnesota are lower than U.S. rates, but they mask significant disparities in certain populations. Data from 2011-2015 show that the infant mortality rate for American Indians (10.4) and for African Americans (9.6) was more than double the rate for whites (4.2).

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

This report covers EHDI infant mortality data for fiscal year 2018 (July 1, 2017 to June 30, 2018 grant period) which is the second year of a three year grant.

Fiscal Year 2018

In fiscal year 2018 (FY18) three organizations were awarded EHDl grants to implement infant mortality programs: American Indian Family Center, Leech Lake Band of Ojibwe, and NorthPoint Health and Wellness Center.

The infant mortality grantees received a total of \$395,986 in FY18. 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 employed include:

- 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 2,553 individuals in FY18 through both direct and indirect contacts. Additionally, some of the accomplishments reported by grantees based on their evaluations are:

- Increased ability to secure participants affordable housing or shelter
- Decreased (0%) infant mortality deaths in the 2nd year grant period
- 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.



Figure 1: Families Having Fun at the Community Baby Shower at American Indian Family Center

Grantees reported on specific outcomes including the percentage of mothers who report safe sleep practices (78% of African American and 90% of American Indian mothers).

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 2015. The sad news is that more than 23,000 infants died in the same year. The infant mortality rate in the United States in 2015 was 5.9; for Minnesota this number was 5.2.¹ 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 2000-2014. Minnesota rates were lower than those for the U.S. throughout this period. Most recently it was at its lowest in 2009 at 4.6, 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, the rates of infant mortality among American Indians (10.4) and African Americans (9.6) are more than double the rate of whites (4.2)². Disparities are observed when variables such as mother's nativity, age, smoking status, and education are factored in. Please refer to page 70 of the [2019 EHD Request For Proposals](#) for more information on infant mortality disparities.

Infant Mortality Reduction Plan for Minnesota

MDH released the [Infant Mortality Reduction Plan for Minnesota: Part 1](#) in March of 2015. The document serves as a "call-to-action" to address the persistent racial and ethnic disparities in infant mortality and poor birth outcomes in the state. The plan was developed with input from a diverse group of 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. EHD is one of several statewide efforts to reduce infant mortality rates. EHD 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, EHD grantee efforts can make important contributions to the elimination of disparities in infant mortality in Minnesota.

EHDI Infant Mortality Grantees in Fiscal Year 2018

Information in this section was obtained from annual reports submitted by grantees on EHDI activities during the reporting period July 1, 2017 through June 30, 2018 (FY18).

Funded Programs

In FY18, 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 Africans/African Americansⁱ in North Minneapolis and American Indians in three East Metro counties and the Leech Lake Reservation (see Appendix B). In fiscal year 2019, all three organizations will receive continued funding for another year.

Funding Levels

For FY18, the three infant mortality grantees received a total of \$430,687, with the total amount spent of \$395,987.

Table 1: All Uses of Grant and Total Funds Awarded to Infant Mortality Grantees, Fiscal Years 2018.

	Salaries and Fringe	Travel	Supplies	Indirect	Other	Total Spent	Total Awarded
American Indian Family Center	92,471	2,472	17,033	11,203	1,600	124,779	123,232
Leech Lake Band of Ojibwe	72,263	22,789	4,320	10,311	0	109,684	138,161
North Point Health and Wellness Center	147,384	3,304	10,611	0	224	161,524	169,294
TOTAL	312,118	28,565	31,964	21,514	1,824	395,987	430,687

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.

ⁱNorthPoint Health and Wellness Center targeted population was African/African American. However, they also served American Indians, Hispanic/Latino, Whites, and Asian/Pacific Islanders participate in their programs.

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 focused on the RFP objectives, and utilized selected strategies, and practices in their work as described in the chart below.

Table 1: Infant Mortality EHDl Grantee Project Objectives, Strategies and Activities | FY 2018

Infant Mortality EHDl Grantee Project Objectives, Strategies and Activities (FY 2018=3)	
Objectives	
<ul style="list-style-type: none"> • 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 	
Strategies	# FY 2018 Grantees
<ul style="list-style-type: none"> • Increase access to health and preventive care before, during and between pregnancies • Provide culturally responsive outreach and care coordination during pregnancy and birth • Change behaviors that lead to acute and chronic conditions • Provide education and support for pregnant and parenting teens • Ensure that all infants receive high-quality care at birth and infancy • Reduce infant deaths from SIDS and sleep-related unintentional injuries • Improve infant nutrition and health, physical growth and development • Reduce infant deaths from unintentional injury and violence 	<p>3</p> <p>3</p> <p>2</p> <p>1</p> <p>2</p> <p>2</p> <p>2</p> <p>2</p>
Types of Activities	
<u>Example of Evidence-Based Strategies</u>	
<ul style="list-style-type: none"> • 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 	
<u>Example of Culturally Responsive Strategies</u>	
<ul style="list-style-type: none"> • Use of Back to Sleep message, Cribs for Kids Program to prevent sleep-related injuries • Host Community Baby Showers to celebrate and welcome new babies and parents 	

Reach

EHDI grantees have reached a large number of individuals and families over the years. Table 2 shows the number of individuals reached by infant mortality grantees through direct and indirect contacts. In total, EHDI infant mortality grantees reached 2,553 individuals in FY18. 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 and community baby showers in three counties, 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 758 individuals in FY18.

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 1,795 individuals in FY18 through indirect contacts. AIFC had a higher indirect contacts compared to the other two grantees because they counted the number of fliers given out and social media views of targeted content (facebook, YouTube, Twitter). 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.

Table 2. Number of Individuals Reached by EHDI Infant Mortality Grantees by Type of Contact, Fiscal Year 2018

Grantee Name	Direct Contacts	Indirect Contacts	Total
American Indian Family Center	285	1200	1485
Leech Lake Band of Ojibwe	381	381	762
NorthPoint Health & Wellness Center	92	214	306
Total	758	1,795	2,553

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) hosting a community baby shower ceremony where 17 new mothers attended (LLBO); 2) hosting 32 classes in prenatal/parenting education classes (AIFC); 3) 68 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 3 shows data for the infant mortality shared measurement health indicators. 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.

Three grantees worked to reduce infant mortality, with a primary focus on the two most impacted populations. 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 75 African American women (along with 17 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 below for all participants, because of variability on longevity with the program and access to health care records.

Table 3. Infant Mortality Health Indicator Reporting

Infant Mortality	African/African American	American Indian	Asian/Pacific Islander	Hispanic/Latino
% of infants under 12 months completed most recent well-child visit	52% (39 of 75)	64% (44 of 69)	67% (2 of 3)	56% (5 of 9)
% of 1-year-olds who had 5 or more well-child visits	36% (14 of 39)	66% (40 of 61)	n/a	n/a
% of mothers reporting safe sleep practices	78% (14 of 18)	90% (47 of 52)	n/a	n/a
% of mothers who initiated pre-natal care in first trimester	n/a	62% (24 of 39)	n/a	n/a

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 EHD infant mortality grantees can lead to potential cost savings on health care costs and the Minnesota state. For example, in 2017 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 study in 2005 found that the average first-year medical costs for a preterm baby was \$32,325 compared to \$3,325 for term births⁵. Adjusted for inflation of 25.4% from 2005 to 2017, the cost for a preterm baby in 2017 would be \$40,543.63. In fiscal year 2017, the program had eight babies born full term. Had they been all born preterm they would have cost \$324,349.04 (\$40,543 per

preterm birth). Additional cost savings would also come from early intervention services, special education costs, and lost household and labor market productivity.

For Leech Lake, potential cost saving came from the prevention of babies born with Neonatal Abstinence Syndrome (NAS) and infant deaths. 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 came 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 2018 indicate that EHDI is making significant contributions towards the goal of reducing infant mortality disparities. Grantees reached a total of 2,553 individuals in FY18 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 2,553 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.⁶⁷ 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 change³. 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 2018

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 2018 Grantees Evaluation

Grantee/EHDI Program	Description	Target Groups	Evaluation Findings
American Indian Family Center/ Wakanyeja Kin Wakan Pi (Our Children are Sacred)	<p>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.</p>	<p>American Indian community in the East Metro area including Ramsey, Washington and Dakota counties</p>	<p>Outputs and outcomes</p> <ul style="list-style-type: none"> ▪ Held 32 classes in prenatal/parenting education classes, 9 mother’s circle support group, first annual community baby shower ▪ 44 (100%) participants were screened and assessed ▪ 75% of 45 pregnant women participated in the prenatal education classes ▪ 75% of participants improved their parenting knowledge <p>Shared Measurement outcomes</p> <ul style="list-style-type: none"> ▪ 18 out of 45 of women, with a child up to 12 months of age, had their child complete their most recent well-child visit ▪ 13 out of 27 of women, who had a child reach 1 year of age, had their child have 5 or more well-child visits during their first 12 months of life ▪ 13 out of 18 of 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 ▪ All women (N=17) who had pregnancy initiated pre-natal care in the first trimester ▪ 100% of participating women developed family wellness care plan, 70% achieved 1 goals per quarter.

Grantee/EHDI Program	Description	Target Groups	Evaluation Findings
Leech Lake Band of Ojibwe/Family Spirit	<p>FSP provides assistance and education to pregnant women from 28 weeks gestation until the 3rd year of the child’s life. Participants receive information 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.</p>	<p>Leech Lake Band of Ojibwe members at the Leech Lake Reservation encompassing Beltrami, Cass, Hubbard, and Itasca counties</p>	<p>Output and outcomes</p> <ul style="list-style-type: none"> ▪ Conducted 188 educational home visits ▪ 17 new mother attended the first annual “Welcome Babies – Thank Moms” ceremony as a community baby shower ▪ 24 out of 34 women received training modules on prenatal care and child development ▪ 31 out of 34 women were referred/connected to various LLBO clinics and provided transportation for healthcare appointments <p>Shared Measurement outcomes</p> <ul style="list-style-type: none"> ▪ All women (N=26), who had a child up to 12 months of age, has their child completed their most recent month well-child visit ▪ 27 out of 34 of women 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 ▪ 10 out of 34 of women who had an infant under the age of 6 months, reported their infant always slept on the infant’s back, and all of the women (n=34) reported that their infant always slept on their own firm surface with no loose bedding or soft objects. ▪ 7 out of 22 women who had pregnant initiated prenatal care in the first trimester.

Grantee/EHDI Program	Description	Target Groups	Evaluation Findings
NorthPoint Health and Wellness Center/Healthy Families	<p>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 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.</p>	<p>Pregnant women and their families, mainly African American but also serve American Indian and Hispanic/Latino, in the Near Northside of Minneapolis</p>	<p>Output and Outcomes</p> <ul style="list-style-type: none"> ▪ 68 out of 92 women participated in intensive care coordination which included 1-1 visits, counseling, home visits, and parenting, safety, and breastfeeding classes ▪ All participants received referral for internal and external care/services such as food shelves, housing, and parenting support groups ▪ Offered a new culturally specific class (Karibu Mama) on parenting and education ▪ 26 out of 68 women's infants are up to date with immunization, a slight increase from last year ▪ 49 out of 68 of the women received intensive care coordination, and all participated in at least one parenting/education support class <p>Shared Measurement</p> <ul style="list-style-type: none"> ▪ 39 out of 75 women with a child up to 12 months of age had their child complete the most recent well-child visit ▪ 14 out of 39 women who have 1 year old child had their child complete 5 or more well-child visits during their first 12 months of life

Appendix D: Stories

American Indian Family Center

Traditional hand drums represent the heartbeat of the mother and healing strength for future generations. The AIFC hosted a 2-day event in May called Hand Drum Making during which 41 attendees created 14 drums. Moms learned the dangers of alcohol use while pregnant and/or planning a pregnancy while creating a traditional hand drum which represents the heartbeat of the mother and healing strength for future generations. Many details went into the making of this event which was a team effort by all partners involved and the success was seeing all the hand drums when they were finished and the smiles and proud looks of the families who were involved in the event. This is a concrete example of utilizing cultural practices as a vehicle to prevent infant mortality.

NorthPoint Health & Wellness Center

A lot of times health is achieved through successful navigation of the systems at play, those that greatly influence your day-to-day and long term circumstances. This year, NorthPoint helped one mother and her family get in to stable housing and improve her employment outcomes. She was couch surfing with her four kids, considering relocating to another city as a last hope. The CHW was able to refer the mother to rapid housing through Hennepin County, and support her along the way. After connecting the family to the County, they were placed in a home within 30 days. Additionally, the CHW connected this family to a partner organization, Project for Pride in Living (PPL), to help the mother get a better paying job. She'd been complaining about her current work and was insecure about being capable to get anything better, especially with a felony on her record and other issues in her background. This mother was able to join PPL's Re-entry to work program and now continues to work and is doing a lot better to take care of her family.

References

- ¹ Centers for Disease Control. At a Glance 2016: Infant Mortality: Protecting Our Next Generation. Retrieved from: <http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2016/aag-infant-health.pdf>.
- ² Minnesota Department of Health (2014). Center for Health Statistics: Retrieved from: <http://www.health.state.mn.us/divs/chs/>
- ³Prevalence of Selected Maternal and Child Health Indicators* for Minnesota, Pregnancy Risk Assessment Monitoring System (PRAMS), 2012-2015, <https://www.cdc.gov/prams/pramstat/pdfs/mch-indicators/Minnesota-508.pdf>
- ⁴ Minnesota Department of Health (2014). Advancing Health Equity in Minnesota: Report to the Legislature. Retrieved from: http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf
- ⁵Institute of Medicine. 2007. Preterm Birth: Causes, Consequences, and Prevention. Washington, DC: The National Academies Press. <https://doi.org/10.17226/11622>.
- ⁶ Rogowski, J. (1998). Cost-effectiveness of care for very low birth weight infants. *Pediatrics*. 102, 35-42.
- ⁷ Devaney, B. (1992). *Very Low Birthweight Among Medicaid Newborns in Five States: The Effects of Prenatal WIC Participation* (Contract No. 53-3198-0-033). Alexandria, VA: USDA.
-