Eliminating Health Disparities Initiative: Infant Mortality Grants Fiscal Year 2025

January 15, 2026

Eliminating Health Disparities Initiative Infant Mortality Grants Report

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Eliminating Health Disparities Initiative

Contents

Executive Summary

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

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

This report covers EHDI infant mortality grant activities for the state fiscal year 2025 (FY 2025) from July 1, 2024 to June 30, 2025, the second year of the EHDI 2024-2028 grant cycle. The infant mortality grantees are Leech Lake Band of Ojibwe, Portico Healthnet, and Wilder Foundation (African American Babies Coalition or AABC). Together, they directly reached 1,565 individuals in the 12-county Twin Cities metro area and Leech Lake Reservation, primarily serving African Americans, American Indians, and Latinas/Latinos/Hispanics. Aside from working on individual-level changes such as increasing or improving awareness, knowledge, or behaviors, their programs focused on changes at the organization or community level and addressing broader social determinants of health as the root causes of inequities.

Notable highlights from FY 2025 include 79 families actively participating in the Family Spirit home visiting program, 288 home visits made, 60 children receiving immunizations and well-child checks, 82 fathers completing Fatherhood Teachings and cultural Ojibwe language camps, data sharing agreements with three clinics put in place, referral and reporting processes co-developed with partner clinics, parents learning and practicing healthy and traditional parenting skills, 95% of pregnant people and 99% of newborns successfully enrolled in health insurance, increased utilization of high quality prenatal and postpartum care, and an online resource exchange developed with 1,200 people visiting the website.

EHDI legislation requires that MDH report how the infant mortality grantees used their grant funds, and the amount expended for each use. In FY 2025, 98% of the total award of $656,268 was expended. Out of total expenses, 45.9% were for salaries and fringe, 20.2% for contractual services, 15.6% for supplies, 0.7% for travel, and 3.0% for other expenses. Their indirect cost was 14.6% of total expenses.

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

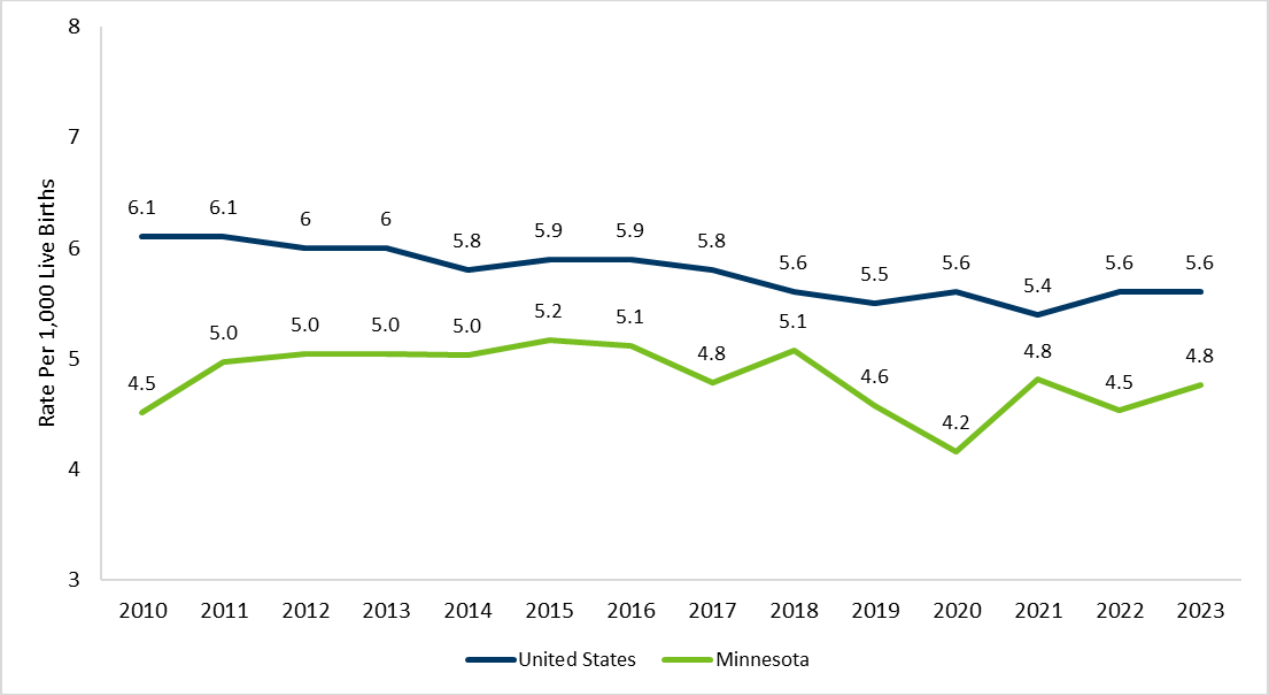
Infant Mortality in Minnesota

Infant Mortality Rates and Disparities

Infant mortality is defined as the death of an infant before their first birthday. The infant mortality rate is measured in terms of the number of infant deaths per 1,000 live births. It is considered a key indicator of maternal and child health, as well as overall societal health. Based on data from the U.S. Centers for Disease Control and Prevention (CDC), Minnesota's infant mortality rate in 2023 rose 4% from the previous year, from 4.5 infant deaths per 1,000 live births in 2022 to 4.7 infant deaths per 1,000 live births in 2023. This means that for every 1,000 infants that were born alive in Minnesota in 2023, five died before their first birthday.

The infant mortality rate in the U.S. exhibited a declining trend from 2010 to 2021, then inched back up in 2022 to 5.6, where it stayed unchanged in 2023 (Figure 1). Minnesota rates were lower than those for the U.S. during these years, and in 2020 reached its lowest rate at 4.2 after peaking in 2015 at 5.2.

Figure 1: Infant Mortality Rates, United States and Minnesota, 2010-2023



Sources: United States rates are from Ely DM, Driscoll AK. Infant mortality in the United States, 2023: Data from the period linked birth/infant death file. Natl Vital Stat Rep. 2025 Jun;74(7):1–20. DOI: https://dx.doi.org/10.15620/cdc/174592. Minnesota rates are from 2023 Minnesota Final Linked Birth-Infant Period Cohort Death File. Minnesota Department of Health.

However, the declining infant mortality rates mask significant disparities. Table 1 and Figure 2 show that in Minnesota for the periods 2012-2016 to 2019-2023, five-year rolling average rates of infant mortality

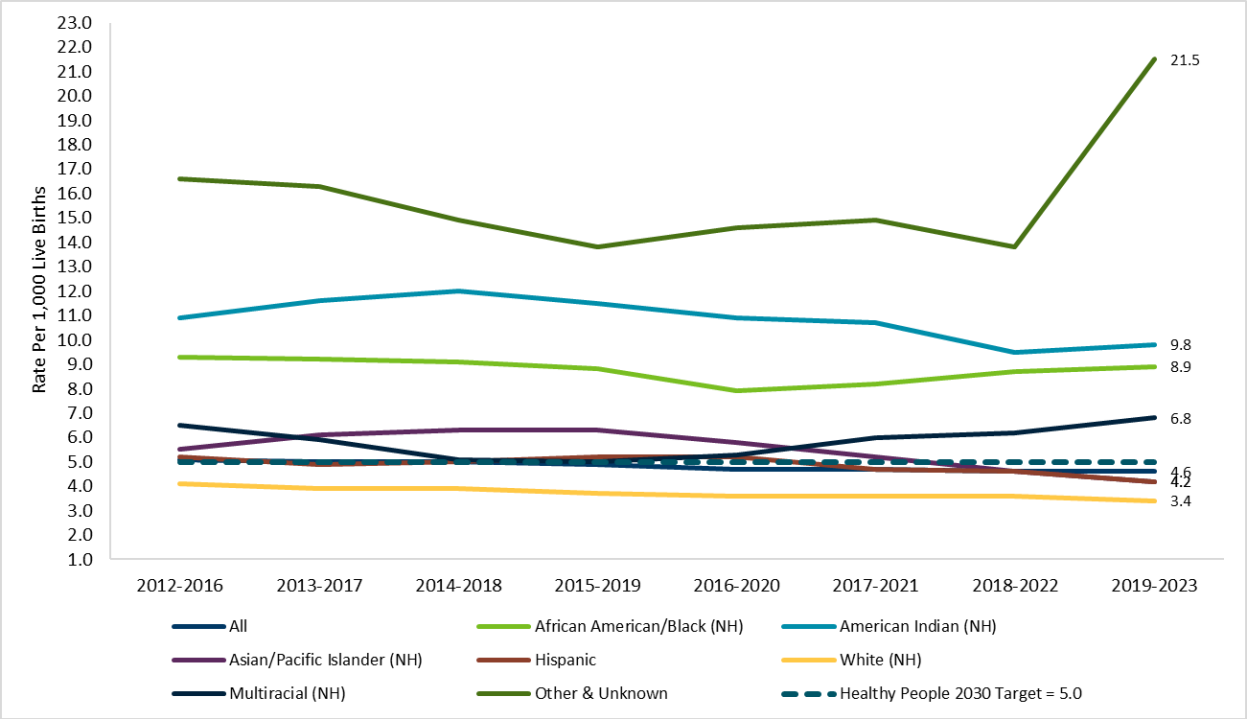
for communities of color are higher than rates for non-Hispanic whites – 9.8 for American Indians, 8.9 for African American/Black, 4.2 for Asian/Pacific Islander, and 4.2 for Hispanics compared to 3.4 for non-Hispanic white. This means that compared to babies who are white, American Indian and African American/Black babies are more than twice as likely to die before reaching their first birthday. Moreover, while the infant mortality rate for all of Minnesota stayed the same at 4.6 for the years 2019-2023 compared to the previous period 2018-2022, and declined for whites from 3.6 to 3.4, the rate increased for American Indian from 9.5 to 9.8 and for African American/Black from 8.7 to 8.9.

Table 1: Infant Mortality Rates (five-year rolling averages) by Maternal Race/Ethnicity, Minnesota, 2012-2016 to 2019-2023

	2012-2016	2013-2017	2014-2018	2015-2019	2016-2020	2017-2021	2018-2022	2019-2023
All	5.1	5.0	5.0	4.9	4.7	4.7	4.6	4.6
African American/Black, Non-Hispanic	9.3	9.2	9.1	8.8	7.9	8.2	8.7	8.9
American Indian, Non-Hispanic	10.9	11.6	12.0	11.5	10.9	10.7	9.5	9.8
Asian/Pacific Islander, Non-Hispanic	5.5	6.1	6.3	6.3	5.8	5.2	4.6	4.2
Hispanic	5.2	4.9	5.0	5.2	5.2	4.7	4.6	4.2
white, Non-Hispanic	4.1	3.9	3.9	3.7	3.6	3.6	3.6	3.4
Multiracial, Non-Hispanic	6.5	5.9	5.1	5.0	5.3	6.0	6.2	6.8
Other & Unknown	16.6	16.3	14.9	13.8	14.6	14.9	13.8	21.5

Source: 2023 Minnesota Final Linked Birth-Infant Period Cohort Death File. Minnesota Department of Health.

Figure 2: Infant Mortality Rates (five-year rolling averages) by Maternal Race/Ethnicity, Minnesota, 2012-2016 to 2019-2023



Source: 2023 Minnesota Final Linked Birth-Infant Period Cohort Death File. Minnesota Department of Health.

The cause of these infant deaths varies by race. Based on 2019-2023 data, the leading causes of infant mortality in Minnesota are prematurity (31.0 % of all infant deaths), followed by congenital anomaly or birth defects (25.6%), other perinatal conditions (15.9%), and sudden infant death syndrome or sudden unexpected infant death (SIDS/SUID) (13.2%). For the same period, the leading cause of infant deaths for babies born to Black/African American, Asian/Pacific Islander, and Hispanic mothers was prematurity, but for American Indian babies, the leading cause of death was SIDS/SUID.

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

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

- Infant mortality rates are higher for U.S.-born compared to foreign-born African American, Asian/Pacific Islander, and Hispanic women compared to whites. This could be explained by the immigrant effect; that is, they initially retain the advantages of healthier lifestyles and food they were used to in their home countries when newly arrived in the U.S. However, these advantages fade over time with socialization, often leading to worsening health due to factors such as stress (discrimination, employment or hiring biases), barriers to care (language, unequal treatment, complexity of healthcare system), and lifestyle changes,

- Infant mortality rates are higher among women who smoke tobacco than those who do not smoke. Among smokers, infant mortality rates are higher among American Indians and more than double among Blacks/African Americans compared to whites.
- Those who experience poverty and thus have less access to adequate health care have higher rates of infant mortality (for example, those on Medicaid).
- Infant mortality rates are generally higher among women with fewer years of education. By race/ethnicity, however, it is striking that rates are still higher among African American/Black and American Indian women even if they have received more years of education than women who are white.

Minnesota Infant Mortality Reduction Initiatives

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

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

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

In 2023, the Healthy Beginnings, Healthy Families Act: Infant Health was established which created additional opportunities for the state to address infant mortality. Work under this act builds equitable, inclusive, and culturally and linguistically responsive systems that ensure the health and well-being of young children and their families by establishing the Minnesota Partnership to Prevent Infant Mortality, and funding statewide grants to improve infant health outcomes. The grants, administered by the Maternal and Child Health Section in MDH's Child and Family Health Division, include Infant Health Tribal Grants (January 2024-June 2025),

Minnesota Partnership to Prevent Infant Mortality: Improving Infant Health Grants (April 2024-July 2025), and Minnesota Innovations in Perinatal and Infant Health Grants (May 2024-June 2028).

Also, in 2023, the Maternal and Child Health Section and the Injury and Violence Prevention Section at MDH were awarded a five-year multi-component grant by CDC to improve case ascertainment, data completeness, and timeliness of sudden unexpected infant deaths (SUIDs) information, under CDC's Sudden Unexpected Infant Death (SUID) and Sudden Death in the Young (SDY) Case Registry. The grant aims to reduce the incidence of SUIDs and address inequities in the state's Black/African and American Indian populations. As part of this grant, MDH has proposed to create Minnesota's first Safe Sleep Collaborative under which all activities related to the grant, including the creation two community action teams—one for the American Indian population and a second for the Black/African American population—created to implement community data-driven strategies to reduce the disproportionate burden of SUIDs in these populations will be housed.

The Health Equity Bureau and EHDI

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

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

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

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

EHDI Infant Mortality Grants

Information in this section was obtained from annual reports submitted by grantees covering the reporting period July 1, 2024, to June 30, 2025 (state fiscal year 2025 or FY 2025).

Infant Mortality Grantees Overview

In FY 2025, three organizations received EHDI funding to implement infant mortality programs: Leech Lake Band of Ojibwe (Family Spirit program), Portico Healthnet (Increase Protective factors for Pregnant Persons & Newborns), and Amherst H. Wilder Foundation (African American Babies Coalition) (Appendix B). Their EHDI programs serve African Americans, American Indians, and Hispanics/Latinos in Minnesota in the 12-county Twin Cities metro area as well as the Leech Lake Reservation.

The infant mortality grantees were awarded a total of $656,268 in FY2025 (includes unspent funds rolled over from FY 2024). Information on how grantees expended these funds is provided in the next section. Grantees worked to address health disparities beyond providing programs that target individual-level changes (such as awareness, knowledge, behavior, or skill). They also focused on broader social determinants of health, such as changing policies, systems, or environments to address the root causes of health inequities.

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

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

Use of Grant Funds

EHDI legislation requires that MDH's infant mortality report include information on specific uses of grant funds and the amount expended for each use. Table 2 shows how the three infant mortality grantees used their EHDI funding in FY 2025.

Table 2: All Uses of Grant and Total Funds Awarded to Infant Mortality Grantees, Fiscal Year 2025

	Salaries & Fringe	Contractual Services	Travel	Supplies	Other	Indirect[a]	Total Spent	Total Awarded[b]
Leech Lake	$93,328	$28,500	$3,456	$92,809	$4,685	$29,615	$252,393	$261,863
Portico	$104,433	$65,100	$686	$6,702	$400	$17,732	$195,053	$197,126

	Salaries & Fringe	Contractual Services	Travel	Supplies	Other	Indirect[a]	Total Spent	Total Awarded[b]
Wilder	$98,123	$36,892	$216	$881	$14,248	$46,919	$197,279	$197,279
Total	$295,884	$130,492	$4,358	$100,392	$19,333	$94,266	$644,725	$656,268
% of Total Spent	45.9%	20.2%	0.7%	15.6%	3.0%	14.6%		

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

[b]Total Awarded includes unspent FY2024 funds rolled over into FY2025.

Salaries and fringe combined were the largest expenses at 45.9% of the total amount spent by the three grantees. They also spent 20.2% on contractual services, 15.6% on supplies, and 3.0% on other expenses, and 0.7% on travel. Indirect costs comprised 14.6% of total expenses.

Contractual expenses included payments to research and evaluation consultants, trainers, a design consultant, a curriculum development consultant, a curriculum writer, and birthing fruition trainers. Travel expenses for mileage and lodging included staff travel to and from grantee meetings, partner meetings, client home visits, and a local conference. Supplies expenses were incurred for technology licenses, computer equipment, technology support, staff phones, refreshments, printing training materials, and office and program activity (craft) supplies. Other expenses included training registration fee, stipends for training and evaluation (e.g., focus groups) participants, childcare for focus group participants, marketing and communications, and freight and shipping. Finally, indirect expenses covered overhead costs such as utilities and rent.

Appropriation Retained for Administrative Purposes

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

Levels of Change, Objectives, Strategies, and Activities

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

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

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

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

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

Objectives

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

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

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

Strategies

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

Activities

Aside from delivering health services, FY 2025 program activities included recruiting program participants, conducting home visiting, conducting trainings and other learning activities, improving service infrastructures (e.g., developing internal or inter-agency referral processes, data sharing agreements, patient consent processes, or report back mechanisms), planning project expansion, developing resources (e.g., curricula or modules, resource exchange platform, BIPOC trainers registry), providing support services (e.g., transportation, appointment scheduling), building and strengthening relationships, holding large public events, and conducting evaluation.

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

Evaluation

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

Program Reach

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

In FY 2025, the EHDI infant mortality grantees directly reached a total of 1,565 individuals (Table 3). This is 322 more than the 1,244 individuals reached in FY 2024, a 26% increase. By priority population, 39% pf individuals reached were Hispanic/Latino/Latine, followed by Native/Indigenous/American Indian (29%), African American (16%), white (11%), and Asian/Pacific Islander (2%).

Table 3. Number of Individuals Directly Reached by EHDI Infant Mortality Grantees by Priority Population, FY 2025

Population / Grantee	Leech Lake	Portico HealthNet	Wilder	All Grantees (% of Total)
African American	0	75	176	251 (16%)
African Immigrant/North African/Middle Eastern	0	0	6	6 (<1%)
Native/Indigenous/ American Indian	459	0	2	461 (29%)
Hispanic/Latino/Latine	0	605	0	605 (39%)
Asian/Pacific Islander	0	30	4	34 (2%)
white	153	15	8	176 (11%)
Multiracial	0	0	10	10 (1%)
Unknown	0	22	0	22 (1%)
All Populations	612	747	207	1,565

Outputs

Outputs and outcomes reported by grantees in their FY 2025 annual report were based on their FY2023-2025 evaluation plans.

Leech Lake Band of Ojibwe

- 79 individuals actively participated in the Family Spirit Home Visiting program.
- Staff made 288 home visits made (52 in-home visits, 76 phone calls, and 91 indirect visits such as the welcome baby ceremony and other events).
- 60 participants went to their prenatal appointments and post-partum appointments
- Staff helped 86 individuals on Medication-Assisted Treatment (MAT) with MAT appointment scheduling and transportation to appointments.
- 60 infants, toddlers, and children received immunizations and attended well-child checks.
- 240 community members (including Tribal staff) attended Family Spirit presentations on SIDS/SUIDS, safe sleep, Fetal Alcohol Spectrum Disorders (FASD), and cultural teachings.
- 23 individuals made hammocks, and 53 families completed baby moccasins and learned the Ojibwe cultural teachings about baby moccasins.
- 82 fathers completed (or participated in) the Family Spirit Model/Fatherhood Teachings.

- 82 fathers participated in seasonal cultural Ojibwe language camps.
- Family Spirit partnered with a new organization called Apple Blossoms and partnered with Sacred Bundle which both offer outdoor immersion programs.
- Family Spirit staff attended Leech Lake Band of Ojibwe Tribal events or meetings.
- 60 participants learned about available resources, how to make appointments for themselves, and how access the medical facilities of their choice.

Portico Healthnet

- Partnered with Riverland Community Clinic, UCare, and Hennepin Healthcare to develop referral and reporting models to support outreach and enrollment for pregnant patients and members.
- Data sharing agreements established with Minnesota Community Care, Riverland Community Clinic, UCare, and Hennepin Health.
- 443 total pregnant person referrals received, and 280 were successfully contacted (63%) .
- 397 out of 420 health insurance applications (94%) submitted for pregnant people resulted in health insurance enrollment.
- 99% of newborn applications submitted resulted in health insurance enrollment.
- In collaboration with Federally Qualified Health Centers (FQHCs), including Riverland Community Clinic, Minnesota Community Care, and Hennepin Healthcare, developed a referral and reporting process to integrate it seamlessly into their Electronic Medical Records (EMR) system.
- With Hennepin Healthcare, co-created a practice for newborn enrollment services at Hennepin County Medical Center (HCMC) for newborns who do not reside in Hennepin County (accounts for approximately 30% of births at HCMC).

Wilder Foundation

- 6 culturally specific experts from community agencies were recruited to provide Host Training, with 6 community organizations partnering with AABC on the recruitment.
- 21 participants completed the Host Training (90% completion), 10 of whom participated in the Host Training reflection/focus group.
- Convened the Safer Birthing Consortium in November 2024.
- A resource exchange was developed and launched as a part of a redesign of the AABC website. AABC promoted the resource exchange at partner convenings and events throughout the year, engaging over 25 partners. Over 1,200 individuals visited the AABC resource exchange based on web traffic data.
- AABC worked with Nicole Fernandez to develop updated Birthing Fruition modules.
- 12 individuals participated in the Birthing Fruition training.
- A survey of Birthing Fruiting training attendees revealed that they were “very satisfied” with the training sessions. All said they felt confident or very confident in providing culturally aware care to pregnant individuals after attending the sessions. The training met their expectations in that they learned about the birthing process, lactation techniques, and how to help new parents breastfeed; they gained knowledge, information, and resources to support expecting mothers; and the training supported their doula training or certification
- AABC hosted the annual two-day Black and Brown Birthing Summit in partnership with 15 organizations and was attended by 156 individuals. In addition, AABC collaborated with Simpson Housing to host a pre-summit training focused on launching the new maternal mental health and domestic violence guide/curriculum, attended by 16 individuals.

Outcomes

Leech Lake Band of Ojibwe

- Family Spirit has had a positive impact on the Leech Lake community. The elders are starting to gather together more, they are spending more time with each other, and are gathering together to feel safe (food safety, physical safety).
- Family Spirit has had a positive impact on tribal leadership or tribal consortiums. Family Spirit is serving as a stable connection for tribal leadership and the community as a whole. When Family Spirit hosts pancake breakfasts, tribal leadership comes and talks; in large tribal events, tribal leadership announces that Family Spirit staff are present, which signals to people that Family Spirit is always here to help.
- Parents are getting the support they need to access pre-natal and post-natal care, well-child visits, and MAT/opiate treatment.
- Parents are practicing healthy, traditional parenting skills. People are cooking more, families are sewing, and the men are fishing and cleaning the fish and learning to cook it. Adults and youth are participating more in traditional ceremonies.

Portico Healthnet

- Enrollment in health insurance of pregnant/post-partum people and newborns increased. From a baseline of 90%, 95% of submitted applications for pregnant people were approved and resulted in health insurance enrollment, and 99% of submitted applications for newborns were approved and resulted in health insurance enrollment.
- Clients' understanding of how to utilize public health insurance during pregnancy and postpartum increased. 96% of clients reported that they understood their insurance better after working with Portico.
- Birthing people and children birth-5 years' utilization of high quality prenatal and postpartum health care increased. 134 out of 217 respondents reported visiting 10 or more prenatal appointments, compared to the recommended 10-15 prenatal appointments for a healthy pregnancy. Also, 41 of 83 respondents whose child has turned 1 reported their child attending 5-6 well child visits in their first year of life.
- The enrollment process for pregnant people and parents of newborns improved according to partners and former clients, but Portico needs more Navigator capacity to scale up efforts and meet the growing need for enrollment assistance for pregnant and new parent clients.

Wilder Foundation

- The medical community increased their awareness of culturally appropriate resources. 100% of Birthing Fruition training session attendees reported that they learned gained knowledge, information, and resources to support expecting mothers.
- The medical community developed increased understanding of postpartum health issues among BIPOC communities. 100% of Birthing Fruition training session attendees reported that they learned lactation techniques and how to help new parents breastfeed.
- Participants were satisfied with the trainings. 100% of survey respondents (49) attending the September 2024 Birth Summit, and 100% of survey respondents (20) attending the December 2024 Community Host Training, said they were satisfied with the training.

Shared Measurement System

A shared measurement system (SMS) is a system of tracking, measuring, and reporting on the collective or shared reach and outcomes that are common across grantees within a priority health area. EHDI first implemented an SMS in FY 2018, marking a critical first step in better understanding the collective impact of the EHDI program. Since then, EHDI has sought ways to better understand and assess outcomes achieved within and across EHDI populations. Due to the COVID-19 pandemic, the SMS was paused in FY 2021 and FY 2022 to allow grantees to focus their energies in addressing urgent COVID-19 related needs in their communities. The SMS was slowly brought back in the current grant cycle. It was introduced to grantees in late fall 2024, selection of shared measures is ongoing, and SMS reporting will start with the FY 2026 annual report.

Level of Change Narratives

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

Leech Lake Band of Ojibwe (LLBO)

Level 1 Narrative: *One client who has since graduated from the Family Spirit program and her husband were both very dependent on drugs and were on the verge of losing their children. We stepped in and helped her understand a bit more about herself and her trauma that had pushed her into using drugs. She didn't know about the trauma and historical trauma within her, why her spirit is standing outside of her body waiting to come in, and the impact of drugs. She decided to go to treatment with her husband and asked a family member to watch their kids. They came home from recovery, got jobs, rented an apartment, and got their kids back. Now she has a steady job, and her husband is going to school and learning construction. The kids are doing well and thriving. No one before had taken the time to talk to them about her trauma and the spiritual side of drugs. We did that for them and helped them get into treatment. Now she is doing awesome. She looks healthy and her children are happy. They continue to go to therapy to help the kids get through what was happening before they became sober. I see her every day and we hug. They call us aunties now. We are the aunties to the whole community. It's an honor.*

Portico Healthnet

Level 1 Narrative: *We would like to share a testimonial from a returning client, who for the purpose of sharing we will call "Toni." Toni was first referred to Portico during her first pregnancy for assistance enrolling in healthcare coverage. On a separate occasion, Toni received assistance from Portico to apply for Emergency Medical Assistance for one of her children after they experienced a medical emergency and Toni needed assistance paying for the cost of care. Recently, one of our most experienced Navigators provided Toni with support enrolling her newborn in coverage. Toni and her family have only been in the United States for a few years and has shared that Portico's support has been critical to their family's stability and wellbeing. Toni also shared that being able to receive these services in her primary language of Spanish has been life changing and she is deeply grateful for our support. Toni is one of many pregnant clients that we had return for multiple appointments to not just obtain coverage for themselves and their newborns, but to receive support for their entire family.*

Level 2 Narrative (Organizational Change): *This past year, our EHDI work has taken a new approach to expanding our service offerings for pregnant people and their newborns. While our focus for enrolling pregnant people in the past has primarily focused on those who were uninsured and getting them into coverage as soon as possible, we have begun to think about bridging the gap for those who already may have some level of coverage and are eligible for expanded benefits during their pregnancy but are not currently enrolled in these benefits. For example, many of the pregnant UCare members we are assisting with enrollments are already enrolled in Medical Assistance but have been identified as not being actively enrolled in the expanded Medical Assistance benefits for pregnant people due to failure to report their pregnancy to their county on a timely basis. We have worked with our partners at UCare to develop processes to reach out to these individuals and explain the importance of reporting their pregnancy in a timely manner to unlock additional coverage benefits for pregnant people. These additional benefits, including medical and dental coverage for pregnant people, provide coverage for the pregnant person for a year after the end of the pregnancy, and provide us an educational touchpoint to prepare for timely newborn enrollment. By connecting pregnant people who are already enrolled in some level of coverage to this additional benefit, we are opening up the conversation about other programs they may be eligible for due to their pregnancy, such as WIC benefits and health plan incentives. As Portico's health literacy content for pregnant persons is released in Year 3 and 4 of the EHDI grant, it will increase the number of pregnant Minnesotans who gains to this valuable information. This new approach helps us not only better assist those who are uninsured, but those who are also underinsured and may not be aware, for example pregnant persons who are eligible for Medical Assistance for secondary coverage. Supporting this outreach, Portico is developing a web landing page focused on educating pregnant women on their expanded eligibility for Medical Assistance and/or the value of reporting pregnancy early when already encouraged in Medical Assistance. This webpage will include brief explainer videos (translated), frequently asked questions, links to supporting information and services, and a scheduling link for assistance by an MNsure Navigator with these steps.*

Wilder Foundation (African American Babies Coalition or AABC)

Level 3 Narrative: *AABC has dedicated the past year to driving change through policy and institutional efforts as well as direct services for incarcerated mothers. In the first year, AABC collaborated with a mother and doula who had given birth while incarcerated and relied on her own mother to care for her children during her sentence. At the end of that year, AABC hosted a workshop titled "Experiences of Birthing While Incarcerated," bringing together mothers, doulas, and community members to share stories from a mother's perspective. Moving into the second year, AABC aimed to gather more data to strengthen its system change program by supporting mothers in facilities and the community. Partnering with Wilder Research, they developed a survey to collect insights from mothers who had given birth while incarcerated. The goal was to use this information to create a guide for policy and institutional changes, focusing on challenges such as isolation, loss of connection with their children, postpartum depression, and the lack of mental health resources both in facilities and in the community. However, as inquiries from mothers in the community were limited, AABC shifted its focus to the caregivers supporting these mothers during their incarceration.*

To enhance their efforts, AABC hired a consultant with extensive experience and community connections. She has provided valuable insights on supporting the guide, which now focuses on caregivers of mothers who gave birth while incarcerated. The guide has taken time to develop, and Nicole has observed a lack of community support for both caregivers and mothers after their release. Based on her research and conversations, Nicole noted, "Most agencies, including the Department of Corrections (DOC), offer minimal mental health and resource support for these mothers." With Dr. Tolefree's assistance, Nicole facilitated two caregiver circles to

gather data for the guide. This resource aims to spark systemic change from an institutional perspective while offering direct services to help communities support mothers during and after their sentences. It will complement AABC's printed curriculum, Birthing Fruition, and integrate into the maternal mental health guide. The guide focuses on addressing the unique challenges mothers face post-incarceration, such as postpartum depression, isolation, and mental health, all viewed "through the lens of the caregiver."

Conclusions

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

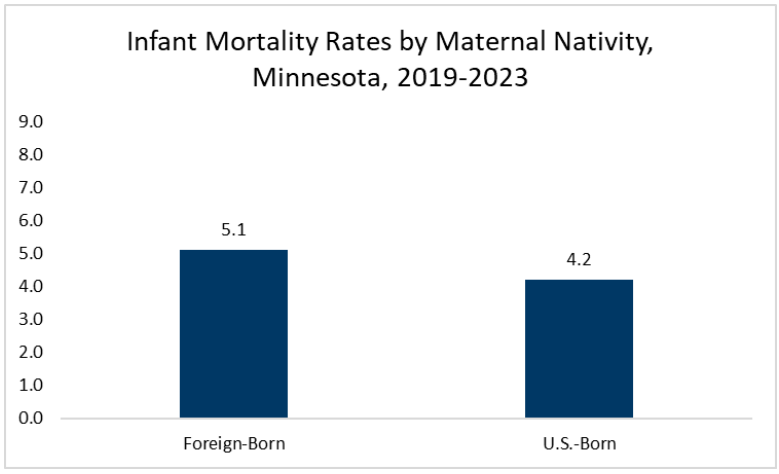
U.S. infant mortality rates have been gradually declining in the last two decades, reaching their lowest between 2018 and 2021. In Minnesota, infant mortality rates have exhibited a similar downward trend. Additionally, Minnesota's infant mortality rates are generally lower than the national rate and most states. Despite this seemingly rosy picture for the state, the health gaps between whites and populations of color and American Indians remain. If Minnesota is to advance health equity, the state must pay attention to inequities in social and economic factors which are the key contributors to health disparities and are what need to change. The EHDI infant mortality grantees are doing just that.

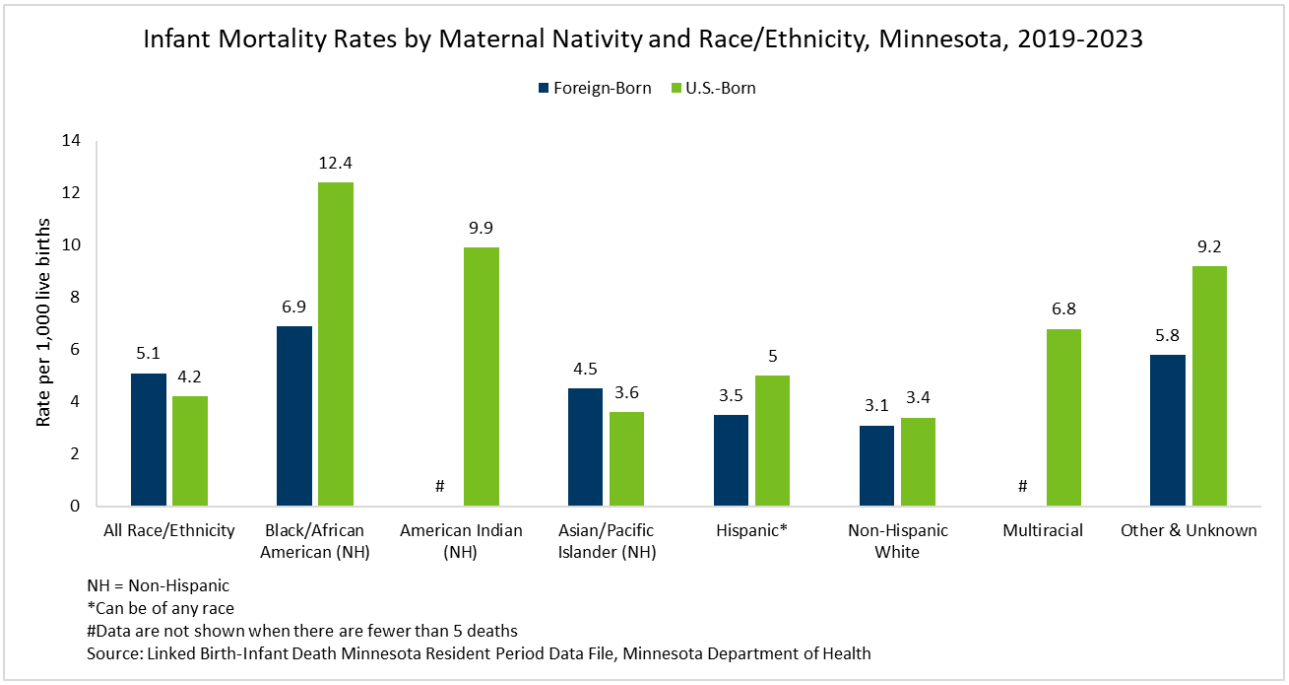
Information gathered from infant mortality grantees in FY 2025 indicate that EHDI is making significant contributions towards the goal of reducing infant mortality disparities. The infant mortality grantees are serving populations most impacted by infant mortality disparities, African Americans, American Indians, and Latinas/Latinos/Hispanics. In FY 2025, they directly reached 1,565 individuals through their activities. This number will increase by thousands more if indirect interactions are counted, for example, people reached through social media and tabling at community events. Examples of accomplishments in the first year include providing home visiting services to 79 families, making 288 home visits, helping 60 children receive immunizations and well-child checks, 82 fathers completing Fatherhood Teachings and cultural Ojibwe language camps, establishing data sharing agreements with three clinics, co-developing referral and reporting processes with partner clinics, parents learning and practicing healthy and traditional parenting skills, successfully enrolling 95% of pregnant people and 99% of newborns in health insurance, helping clients access high quality prenatal and postpartum care, and developing an online resource exchange already accessed by 1,200 people.

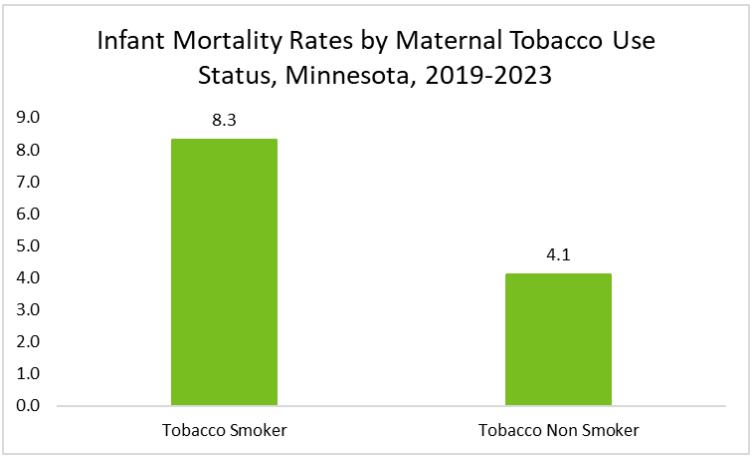
Strategies they successfully employed include increasing health care access; addressing protective and risk factors contributing to infant mortality; developing resources on healthy birth outcomes; empowering the community by forming a community advisory committee for their grant program; utilizing community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

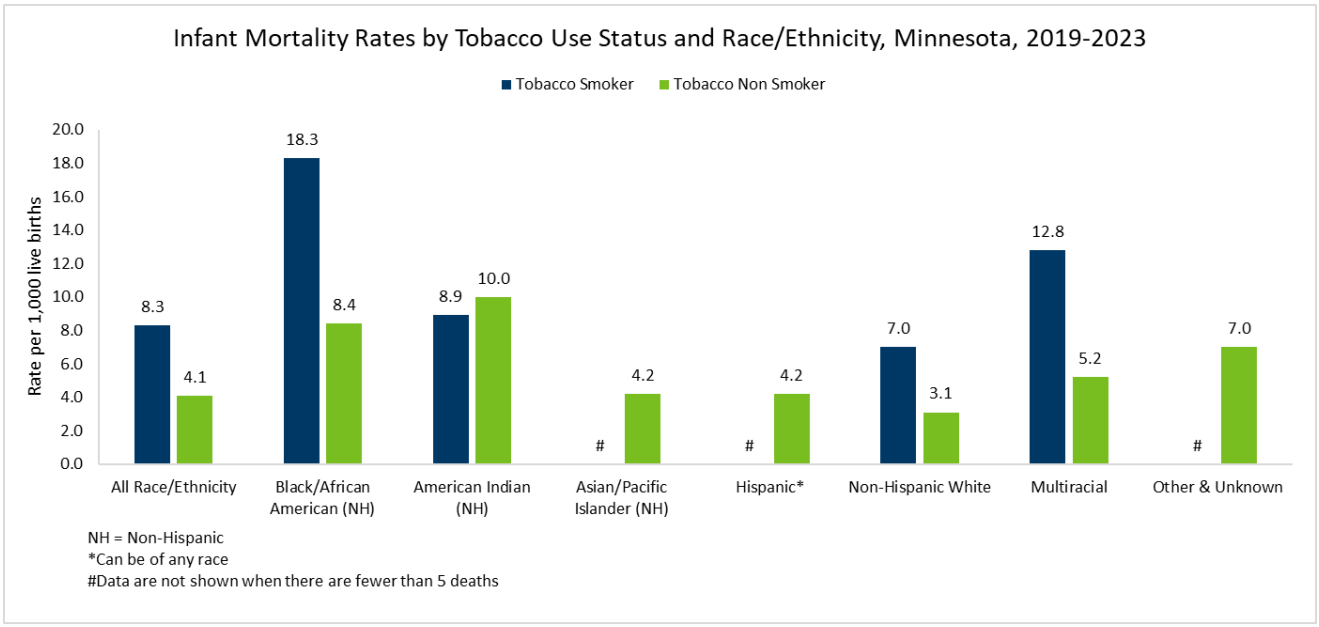
EHDI, in partnership with MDH and the Minnesota State Legislature, is committed to making an impact on infant mortality disparities and inequities through the efforts of grantees. This work is a worthy and critical investment in the current and future health of Minnesotans.

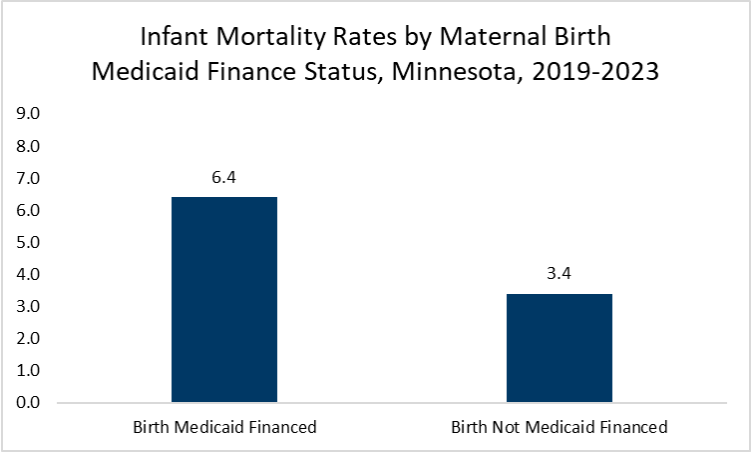
APPENDIX A. Infant Mortality Rates and Selected Social Determinants of Health, Minnesota

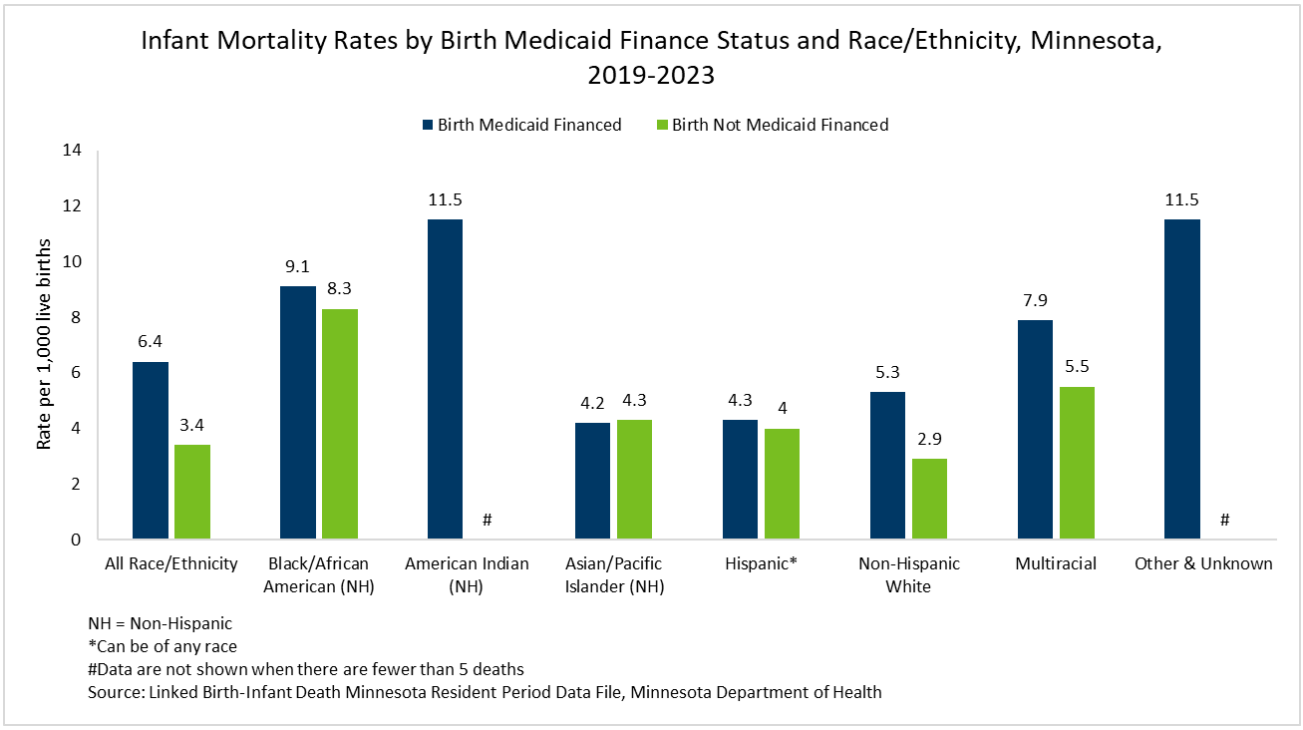


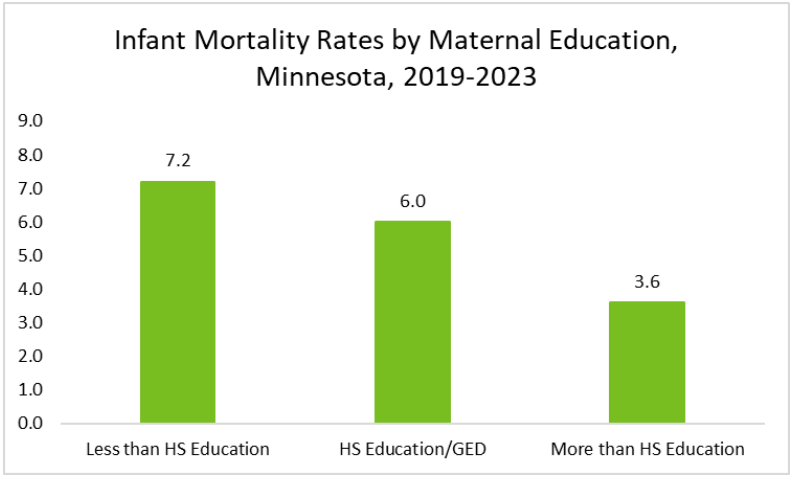


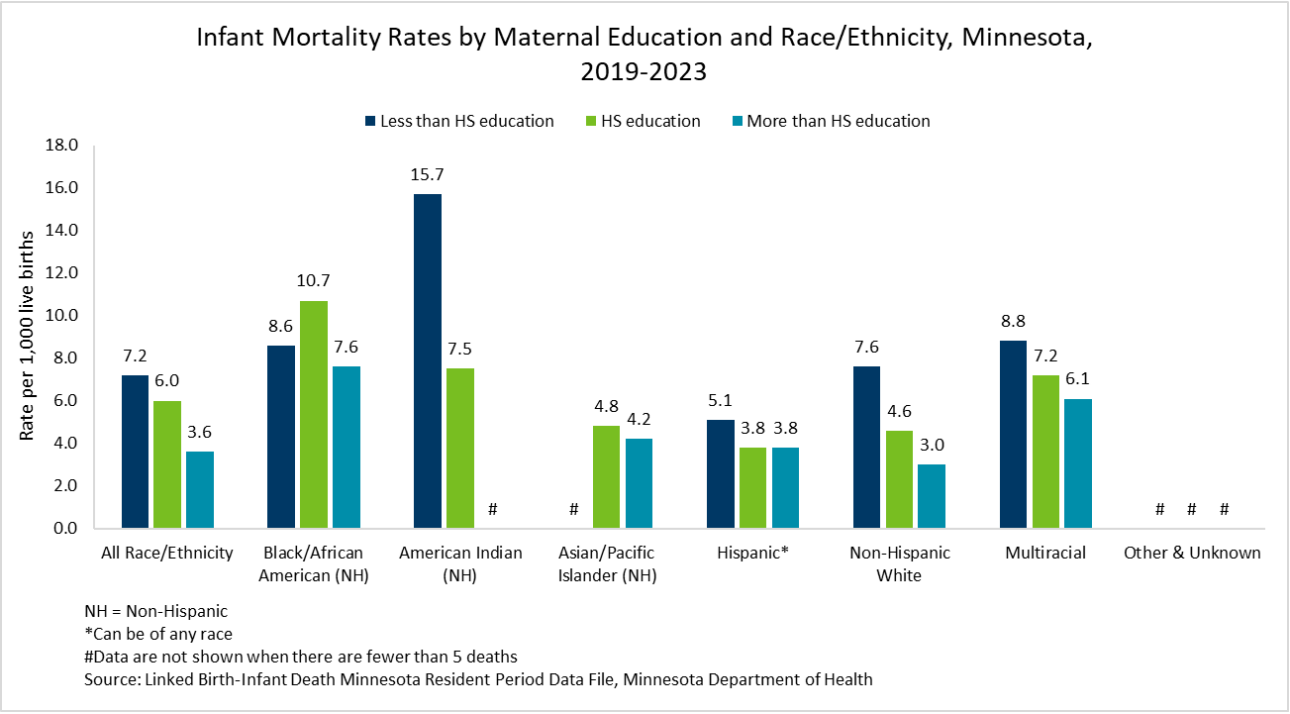

Infant Mortality Rates by Maternal Tobacco Use Status, Minnesota, 2019-2023
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
8.3
4.1
Tobacco Smoker
Tobacco Non Smoker


Infant Mortality Rates by Tobacco Use Status and Race/Ethnicity, Minnesota, 2019-2023
Tobacco Smoker
Tobacco Non Smoker
Rate per 1,000 live births
20.0
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
8.3
4.1
18.3
8.4
8.9
10.0
#
4.2
#
4.2
7.0
3.1
12.8
5.2
#
7.0
All Race/Ethnicity
Black/African American (NH)
American Indian (NH)
Asian/Pacific Islander (NH)
Hispanic*
Non-Hispanic White
Multiracial
Other & Unknown
NH = Non-Hispanic
*Can be of any race
#Data are not shown when there are fewer than 5 deaths


Infant Mortality Rates by Maternal Birth Medicaid Finance Status, Minnesota, 2019-2023
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
6.4
3.4
Birth Medicaid Financed
Birth Not Medicaid Financed


Infant Mortality Rates by Birth Medicaid Finance Status and Race/Ethnicity, Minnesota, 2019-2023
Birth Medicaid Financed
Birth Not Medicaid Financed
Rate per 1,000 live births
14
12
10
8
6
4
2
0
6.4
3.4
9.1
8.3
11.5
#
4.2
4.3
4.3
4
5.3
2.9
7.9
5.5
11.5
#
All Race/Ethnicity
Black/African American (NH)
American Indian (NH)
Asian/Pacific Islander (NH)
Hispanic*
Non-Hispanic White
Multiracial
Other & Unknown
NH = Non-Hispanic
*Can be of any race
#Data are not shown when there are fewer than 5 deaths
Source: Linked Birth-Infant Death Minnesota Resident Period Data File, Minnesota Department of Health


Infant Mortality Rates by Maternal Education, Minnesota, 2019-2023
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
7.2
6.0
3.6
Less than HS Education
HS Education/GED
More than HS Education


Infant Mortality Rates by Maternal Education and Race/Ethnicity, Minnesota, 2019-2023
Less than HS education
HS education
More than HS education
Rate per 1,000 live births
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
7.2
6.0
3.6
8.6
10.7
7.6
15.7
7.5
#
#
4.8
4.2
5.1
3.8
3.8
7.6
4.6
3.0
8.8
7.2
6.1
# # #
All Race/Ethnicity
Black/African American (NH)
American Indian (NH)
Asian/Pacific Islander (NH)
Hispanic*
Non-Hispanic White
Multiracial
Other & Unknown
NH = Non-Hispanic
*Can be of any race
#Data are not shown when there are fewer than 5 deaths
Source: Linked Birth-Infant Death Minnesota Resident Period Data File, Minnesota Department of Health

APPENDIX B. EHDI Legislation

2025 MINNESOTA STATUTES

Eliminating Health Disaprities 145.928

Subdivision 1. Goal; establishment.

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

Subd. 2.State-community partnerships; plan.

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

Subd. 3.Measurable outcomes.

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

Subd. 4.Statewide assessment.

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

Subd. 5.Technical assistance.

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

Subd. 6.Process.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) reflects racially and ethnically appropriate approaches; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) reflects racially and ethnically appropriate approaches; and

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

Subd. 9.Health of foreign-born persons.

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

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

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

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

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

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

Subd. 10.Tribal governments.

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

Subd. 11.Coordination.

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

Subd. 12.Evaluation.

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

Subd. 13.Reports.

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

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

Subd. 14.Supplantation of existing funds.

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

Subd. 15.Promising strategies.

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

APPENDIX C: EHDI Infant Mortality Grantees Program Description, Population and Geography Served, FY 2025

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

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

APPENDIX D: EHDI Infant Mortality Grantees Levels of Change, Objectives, and Strategies, FY 2025

Leech Lake Band of Ojibwe (Family Spirit)

Level 1: Health Promotion/Direct Service

- Objective 1A: Improve pregnancy outcomes
    - Strategy 1A.1: Increase access to prenatal medical care, decrease substance use during pregnancy and throughout the family life cycle; Increase Well-child visits and healthcare
    - Strategy 1A.2: Address risk factors contributing to Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death (SUID) promoting safe sleep.
- Objective 1B: Fathers develop a healthy lifestyle to support family wellbeing
    - Strategy 1B.1: Promote Traditional Ojibwe Beliefs, practices, and family values as well as other belief systems
    - Strategy 1B.2: Address risk factors contributing to Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death (SUID) promoting safe sleep.
- Objective 1C: Family Spirit Program and the LLBO community members improve recruitment, retain new resources, and improve relationships with all communities in and surrounding the LLBO territories.
    - Strategy 1C.1: Create and attend various group meetings to support the participants of the LLBO Family Spirit Program and relationships within and surrounding the LLBO territory.

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

Level 1: Health Promotion/Direct Service

- Objective 1A: Increase protective factors against infant mortality.
    - Strategy 1A.1: Increase enrollment of pregnant people residing in target markets into health insurance so they can access timely prenatal care.
    - Strategy 1A.2: Enroll newborns into health insurance.
- Objective 1B: Expand service model to address at least one additional protective factor for preventing infant mortality.
    - Strategy 1B.1: In collaboration with partners and community, identify additional protective factors pregnant people and newborns need to decrease infant mortality. Level 2: Organizational/Institutional Change

Level 2: Organizational/Institutional Change

- Objective 2A: Develop a customizable service model designed to increase protective factors for pregnant persons and infants facing health disparities in targeted communities.
    - Strategy 2A.1: Lead the development of a community-based network for sharing best practices in increasing protective factors for pregnant persons and newborns facing health disparities.

- Strategy 2A.2: Identify and prioritize additional communities experiencing disparities in infant mortality rates and create plan to expand pregnant persons and newborn enrollment assistance project.

Wilder Foundation (African American Babies Coalition)

Level 2: Organizational/Institutional Change

- Objective 2A: Participating black and indigenous community members increase their knowledge of healthy birthing, including how to advocate for and access high quality perinatal care for black birthing mothers who are incarcerated.
    - Strategy 2A.1: Provide culturally affirming birthing education and training to African American and indigenous community members on the effects of incarceration and how social disparities affect birthing people and their families.
- Objective 2B: Increase number Black and Brown Perinatal Navigators (Doulas) who are trained and equipped to provide navigation and support to black and brown birthing people who have experienced incarceration.
    - Strategy 2B.1: Provide doula and birthing navigation training to African American and indigenous birthing people after incarceration.
- Objective 2C: Participating institutional partners will increase their capacity provide culturally sensitive perinatal services to African American and indigenous birthing people and their families.
    - Strategy 2C.1: Develop and curate a culturally specific knowledge and resource exchange focused on healthy birthing and postpartum outcomes for African American and indigenous mothers and families.
    - Strategy 2C.2: Train healthcare workers and community members to provide culturally sensitive and appropriate care to black and indigenous birthing people and their families experiencing the effects of incarceration and/or post-partum depression.

Level 3: Root Causes/Conditions for Health

- Objective 3A: System of care for black and brown birthing people is more culturally responsive and integrated.
    - Strategy 3A.1: Host gatherings and events for healthcare workers, childcare providers, social service staff, and policy leaders to disseminate best practices centered on black and indigenous maternal and infant health.

References

Centers for Disease Control and Prevention. (2023). *CDC-RFA-DP-23-0006: The Sudden Unexpected Infant Death (SUID) and Sudden Death in the Young (SDY) Case Registry — Instructions* (Package ID PKG00280374) [PDF]. Grants.gov. Centers for Disease Control and Prevention National Center for Chronic Disease Prevention an Health Promotions

Centers for Disease Control and Prevention. (2024, September 17). *SUID and SDY Case Registry*. Sudden Unexpected Infant Death and Sudden Infant Death Syndrome

Ely DM, Driscoll AK. Infant mortality in the United States, 2023: Data from the period linked birth/infant death file. Natl Vital Stat Rep. 2025 Jun;74(7):1–20. DOI: Infant Mortality in the United States, 2023: Data From the Period Linked Birth/Infant Death File.

Minnesota Statutes § 145.928 (n.d.). *Eliminating health disparities.* Minnesota Office of the Revisor of Statutes. 2025 Minnesota Statute 145.02 Eliminating Health Dispartities

Minnesota Department of Health. (2023). *2023 Minnesota Final Linked Birth-Infant Period Cohort Death File* [Data set]. Minnesota Department of Health. For a Healthy Minnesota

Minnesota Department of Health. (2024, December 20). *Healthy Beginnings Healthy Families: Infant Health*. Healthy Beginnings Healthy Families: Infant Health

Minnesota Department of Health. (2025, October 16). *Infant Mortality Reduction Initiative*. Infant Mortality Reduction Initiative