DEPARTMENT OF HEALTH

Perinatal Health Strategic Plan

CREATED BY THE PERINATAL SUBCOMMITTEE OF THE MATERNAL AND CHILD HEALTH ADVISORY COMMITTEE

Perinatal Health Strategic Plan

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Executive summary

The perinatal health strategic plan was created through the Perinatal Subcommittee, an initiative through the Innovations for Maternal Health Outcomes in Minnesota (I-MOM). The five year I-MOM grant is funded by the Health Resources Services Administration (HRSA) and was awarded to Minnesota Department of Health (MDH) in 2022. The subcommittee is a subgroup of the Maternal and Child Health Advisory Committee and is a multidisciplinary, diverse, and community-led group, supported by MDH. This partnership between the subcommittee and MDH is grounded in co-creation and community ownership and design.

The strategic plan focuses on perinatal health disparities in the Black, American Indian/Indigenous, and rural communities, in addition to highlighting recommendations from ten main topics:

- Education and training requirements
- Diverse workforce
- Accountability
- Health care systems, policies and practices
- Advocacy, policy, and legislation
- Culturally responsive data practices
- Assess to substance use disorder and mental health services
- Funding for substance use disorder and mental health
- Screenings and prevention
- Care for people who are incarcerated

Starting in October 2025, three community action teams were formed to implement the strategic plan recommendations over the next two years of the grant.

Background

Perinatal Health in Minnesota

Minnesota has one of the highest levels of health outcomes and life quality in the nation. It also has one of the highest disparities for health outcomes for Black, American Indian/Indigenous, and other people of color, according to the Cost of Health Inequities in Minnesota Report (PDF). While Minnesota's maternal health outcomes appear better than national averages, deep disparities reveal implicit biases, inequalities in access, gaps in quality of care, and the effects of structural racism.

From 2019-2023, 16.4% of babies born to Black women and birthing people were born at low birth weight compared to 7.9% of babies born to foreign-born Black mothers. The overall rate of low birth weight in Minnesota during that time was 7%. U.S.-born Black mothers also experience the highest rate of preterm births, at 15.9% between 2019-2023, compared to 9.4% overall in the state (Minnesota resident final birth file, 2019-2023).

U.S.-born American Indian or Alaska Native mothers/birthing parents had the second highest rate of preterm births at 13.7%. Meanwhile fewer U.S.-born American Indian or Alaska Native mothers started prenatal care in the first trimester (57.2%), compared to 83% across all Minnesota mothers from 2019-2023 (Minnesota resident final birth file, 2019-2023).

Between 2013 and 2023, 18 Minnesota counties have lost or reduced hospital birth services, according to the Rural Health Care in Minnesota: Data Highlights Chartbook. According to the MDH's Division of Health Policy, increases in pre-term births have been associated with the loss of hospital birth services in rural areas. It also means birthing people in rural Minnesota need to travel farther distances to receive obstetric services. Patients living in rural zip codes travel roughly 42 minutes to seek maternity and neonatal care, compared to 23 minutes on average across the state (Minnesota Hospital Discharge Database, 2020-2022).

The perinatal health strategic plan focuses on the Black, American Indian and Indigenous, and rural communities because of these stark health disparities.

Perinatal Subcommittee

The mission of I-MOM and the subcommittee is to align and strengthen the implementation of innovative, data-driven, community-informed and supported perinatal health programs to improve outcomes for communities experiencing the highest rates of disparities (Black, American Indian, other populations of color, new immigrants, refugees, and rural).

The vision of the subcommittee is to:

- Create a statewide perinatal strategic plan and create action-oriented workgroups that focus on improving perinatal health outcomes.
- Align efforts of the multiple committees that are working perinatal health across Minnesota.
- Review current structures and initiatives in order to sustain the subcommittee's work beyond the current HRSA funding.

Starting in January 2023, a diverse network of members was recruited to the subcommittee. MDH focused on ensuring representation from rural, Black, and American Indian and Indigenous families. The subcommittee is comprised of 13 members representing the following:

- Maternal and Child Health Advisory Committee
- Maternal Mortality Review Committee
- Minnesota Perinatal Quality Collaborative
- Community members from the Black, American Indian and Indigenous, and rural communities
- Health professionals, including obstetricians, midwives, pediatricians, behavioral health, community health workers, doula, etc.
- Urban Indian community members
- Health care system representatives
- Payers and insurance representatives
- Non-profit and community-based organizations
- Local and state agencies (Local public health and Department of Human Services)
- Birthing people
- Social workers
- Family home visitors
- Parents and caregivers

One key charge of the subcommittee was to create a strategic plan. Rather than starting from scratch, the subcommittee was committed to building off and aligning with existing efforts. Over the past several years, there have been multiple state, county, and community level initiatives on infant and maternal health that have produced recommendations. Instead of asking community members once again what they wanted to see in a perinatal health strategic plan, the subcommittee and MDH contracted with an external consultant to review 10 reports to better understand what suggestions have already been made to the state to decrease perinatal health disparities. After months of prioritization, adapting, and editing, the subcommittee created a draft list of recommendations.

Community feedback phase

In the winter of 2024 and the spring of 2025, the subcommittee and MDH published a survey and partnered with three community organizations to host listening sessions in order to gather feedback on the strategic plan recommendations. The survey was open to the public and 164 responses were submitted. Five community listening sessions were hosted with the Black community, American Indian and Indigenous community, and with community health workers. Four of the five listening sessions were done in the metro area, and one was done in Northwest Minnesota. The crucial insight gained from survey responses and listening sessions were incorporated into the strategic plan.

Please note that these recommendations are reflective of the wisdom and expertise of subcommittee members. While MDH played a supportive role, they are not responsible for the creation of this content.

Focus values and considerations

The subcommittee will proactively promote and collaborate with community organizations and health systems over the next two years to advance equity, justice, and systemic changes in perinatal care. Focus is especially needed where existing systems do not fully support the desired experiences and outcomes for Black, American Indian and Indigenous communities, and rural communities.

- **Promote strategies**: Emphasize that the subcommittee's role is to actively promote strategies rather than merely adopting them. This highlights the proactive nature of the committee's work.
- **Collaborate**: Stress the importance of collaboration with community organizations and health systems. This aligns with the need for working alongside existing entities, as discussed in the small group discussions.
- **Advance equity and justice**: Highlight the overarching goals of advancing equity and justice in perinatal care.
- **Drive systemic change**: Emphasize the subcommittee's role in influencing systemic changes within the health care and social services systems to address disparities and improve perinatal health experiences.
- **Encourage community involvement**: Reflect the call to action by actively involving those who are doing the work.

Anti-racism statement

In the subcommittee’s commitment to anti-racism in perinatal health for the Black and American Indian and Indigenous communities, they vow to actively resist and dismantle systemic barriers while advocating for equitable access to quality care. This involves addressing institutionalized discrimination and biases, recognizing historical trauma, and prioritizing policies, resources, training, and effective interventions that center the needs of marginalized communities.

The subcommittee’s goal is to create a future where every woman and birthing person, regardless of race or ethnicity, receives the support and care necessary for optimal perinatal health outcomes and experiences. Anti-racism is embedded throughout the recommendations presented in the strategic plan.

Target population statement

These recommendations focus on communities who identify as Black, American Indian and Indigenous, and rural because these communities face the highest perinatal health inequities.

However, not every community has representative data and people hold intersectional identities. Therefore, this was designed to be a living document that can be tailored to best suit a communities' need.

Recommendations

The first part of the strategic plan outlines recommendations for the Black, American Indian and Indigenous, and rural communities in Minnesota. These recommendations are grounded in the value that traditional wisdom and community leadership are essential to decreasing perinatal health disparities in these communities and should be the framework in which action steps are implemented. Although the recommendations are distinct to each community, areas of overlap among the recommendations underscore the intersection of these communities.

Reducing perinatal health inequities in Black communities

- Acknowledge and respect cultural practices and the historical trauma that Black communities have faced.
- Require that health systems and government systems confront structural racism and criminalization in perinatal care. Document barriers to licensure and employment for community-based practitioners. Identify racially disparate treatment patterns in health care institutions, and support training programs that go beyond cultural competency to address structural harm and historical context.
- Provide education and training to postpartum doulas within the Black community, focusing on care collaboration, advocacy, and certification as doulas. Ensure that Black educators of color are hired for these trainings. Develop specific strategies such as scholarships, outreach programs, mentorship opportunities, and culturally relevant marketing materials to encourage the Black community to attend such trainings and pursue certifications.
- Establish and fund training programs where Black community members can affordably gain training for perinatal mental health community health workers, peer recovery specialists, and/or doulas, or other similar roles.
- Train young advocates to support the health of Black babies. Offer opportunities for economic growth and teach community members how to participate in making policies. For example, hosting community events advocating for change, providing training to community members on policy making such as how to draft and sponsor bills, how bills become laws, and rally around issues impacting Black communities when legislation in session.
- Recognize and support fathers, caregivers, and partners in perinatal health, both at the individual and policy levels.
  - Create new and expand existing initiatives that prioritize the role of fathers in Black perinatal health.

Reducing perinatal health inequities in American Indian and Indigenous communities

- Expand definitions of perinatal care to include American Indian and Indigenous knowledge systems (ceremonial practices, kinship-based caregiving, land-based healing, and traditional birthing knowledge).
- Establish avenues for hospitals and health systems to allow for American Indian and Indigenous cultural practices alongside the western medical system.
- Require health systems to treat emotional and psychosocial safety as primary health outcomes evaluated during perinatal care. Patient-reported experience measures (PREMs), narrative data, and story-based evaluation tools should be integrated into monitoring and accountability processes.
- Require that health systems and government systems acknowledge and confront structural racism and criminalization in perinatal care.
  - Document barriers to licensure and employment for community-based practitioners. Identify racially disparate treatment patterns in health care institutions, and support training programs that go beyond cultural competency to address structural harm and historical context.
- Conduct responsive data practices. Honor community research protocols such as consultation with Tribal authorities and/or elders, timely return of data, community feedback loops, and action- oriented strategies with community accountability measures.
- Conduct culturally sensitive data collection and research that centers Tribal data sovereignty, community driven data practices, and data disaggregation.
- Provide education and training to postpartum doulas within the American Indian and Indigenous community, focusing on care collaboration, advocacy, and certification as doulas. Ensure that American Indian and Indigenous educators are hired for these trainings. Develop specific strategies such as scholarships, outreach programs, mentorship opportunities, and culturally relevant marketing materials to encourage the American Indian and Indigenous community to attend such trainings and pursue certifications.
- Establish and fund training programs where American Indian and Indigenous community members can affordably gain training for perinatal mental health community health workers, community health representatives, peer recovery specialists, and/or doulas, or other similar roles.
- Encourage the development and support of Missing and Murdered Indigenous Relatives regional and state offices, fostering collaboration between state and Tribal communities.

Reducing perinatal health inequities in rural communities

- Expand local perinatal support services.
  - Increase access to certified nurse-midwives, certified professional midwives, and community-based doulas to provide consistent prenatal, labor, and postpartum care in underserved areas.
  - Create training and scholarships for rural residents to become perinatal mental health workers, peer recovery specialists, or doulas, ensuring care providers reflect and understand their communities.
  - Fund mobile midwifery and doula programs to travel directly to maternal care deserts, providing at-home or community-based support.
  - Partner with Tribal health and local health departments to incorporate traditional and culturally grounded birthing practices, when desired by families.
- Integrate behavioral health and substance use services.
  - Embed behavioral health providers into prenatal and postpartum care teams so mental health and substance use services are part of routine care rather than separate systems.
  - Expand access to medication-assisted treatment and culturally relevant recovery programs tailored to pregnant and postpartum individuals.
  - Provide stigma-reducing education to both providers and communities to encourage early help-seeking.
- Enhance telehealth and remote monitoring.
  - Invest in broadband infrastructure to ensure consistent telehealth access across rural Minnesota.
  - Equip clinics and home visiting programs with devices for remote fetal heart rate monitoring, maternal blood pressure tracking, and glucose testing, especially for high-risk pregnancies.
  - Integrate telehealth visits with local care coordination so abnormal results trigger timely interventions.
  - Expand insurance coverage for telehealth prenatal, postpartum, behavioral health, and lactation visits.
  - Train both patients and providers to use remote monitoring tools effectively, addressing technical and confidence barriers.
- Leverage phone-based education tools.

  - Deploy plain-language, culturally relevant mobile applications with prenatal and postpartum information tailored to rural realities. Make it user friendly and free so that all residents can access it.
  - Include interactive features like appointment reminders, symptom trackers, breastfeeding support modules, and safe sleep guidance.
  - Ensure accessibility for varying literacy levels and provide content in multiple languages, including American Indian and Indigenous languages where applicable.
  - Promote adoption through WIC, community health workers, and home visiting programs, and integrate secure messaging for direct patient-provider communication.
- Require behavioral health training for rural providers.
  - Mandate specialized training in perinatal mental health and substance use disorder care for all rural maternity care providers, including primary care physicians, nurses, midwives, and doulas.
  - Cover core competencies such as screening for postpartum depression, anxiety, and perinatal substance use; trauma-informed care; and culturally responsive treatment.
  - Provide ongoing virtual continuing education to reduce travel burden for rural providers.
  - Establish mentorship and peer-support networks linking rural providers to specialists in psychiatry, social work, and addiction medicine.
  - Normalize behavioral health screening as part of every prenatal and postpartum visit to encourage early identification and treatment.

The second part of the strategic plan outlines topic-based recommendations that apply to all three of the above target populations.

Education and training requirements

Implement ongoing education and training requirements for health systems, organizations, individual care teams, state agencies, and law enforcement about bias, trauma, social determinants of health, and culturally respectful care through a person-centered approach.

Action steps:

- **Cultural sensitivity**: Develop culturally sensitive policies for mandatory training modules that are required educational components for clinicians.
- **Discrimination and systemic racism**: Provide health care providers and care teams with annual, required anti-bias training to address discrimination and systemic racism in health care. The trainings will be co-created with communities most impacted and will focus on how racism is perpetuated, bias, trauma, and culturally respectful care and will recognize and address both conscious and unconscious biases in health care delivery. Trainings on trauma-informed care should consider:
  - What are providers doing to ensure they deliver trauma-informed care?
  - What training is provided? What ongoing support is there for employees?
  - Identify ways to address and improve the culture of the organization to be equitable and anti-racist.
  - Review internal policies, procedures, and practices.
  - Mission statement, values, commitment to anti-racist organization, working to address internal and external issues.
  - Is there a feedback process for clients to provide input or suggested improvements?
- **Bias**: Conduct training and education by recognizing and addressing both conscious and unconscious biases in service delivery, including but not limited to health care providers, social service providers (social workers, family home visitors, etc.), and community service providers. Implement systematic changes addressing root causes of bias and discrimination, holding both systems and individuals accountable.
- **Law enforcement**: Train law enforcement on working with women and birthing people (mobile crisis unit instead of incarceration).

Diverse workforce

Diversify the health care workforce in medical systems, health care centers, medical schools, nursing schools, and midwifery schools, particularly by increasing the number of American Indian and Indigenous, and Black doctors, midwives, doulas, nurses, social workers, community health representatives and community health workers, and cultural advocates. Support education and training for minority health care professionals. Develop and support alternative pathways to careers in culturally specific health care fields (e.g., cultural healers).

Action steps:

- **Funding**: Pass legislative measures to fund health care workforce programs that include mentorship and support once in those roles. Funding includes creating programs that connect people for better education opportunities, aiming to build a more diverse group of health care workers who can serve women and birthing people across the state.
- **Education**: Implement a process for certifications and licensure of non-western trained health professionals to be able to practice in the United States.
- **Training for community members**: Provide economic development opportunities and training for community members on policymaking processes and engagement.
- **Community leadership**: Provide funded internships, apprenticeships, and understudy opportunities for future leaders. Restructure or assign leadership to have cultural accountability partners or coaches.

Accountability

Enhance personal and professional accountability for equity in health care.

Action steps:

- **Accountability for professional conduct**: Audit documentation for bias (i.e. racism, colorism, tokenism, sexism, ableism, classism, homophobia etc.) and weaponizing of charts. For example: collect stories or surveys from patients upon discharge about bias experiences or acts of racism. Include audits as part of performance reviews, salary increases, promotions, etc.
- **Licensing**: The renewal of licensure for health care providers includes an audit of documented encounters (i.e. acts of racism). For example, if a health care professional has "x" number of encounters, their recertification will be impacted by a probationary action as determined by the corresponding professional association (i.e. American Medical Association).
- **Incident reporting**: Establish anonymous reporting mechanisms for women and birthing people on the perinatal journey to report bias incidents. Ensure protection against retaliation for those who report. Connect people for collective action by facilitating listening sessions and providing updates on corrective measure taken to support individuals who have experienced trauma.
- **Psychological, cultural, and emotional safety**: Hold the system accountable to create a safe space for affected communities and providers to speak up without harm or repercussions. Establish a process to address the concerns raised.
- **Racism integrated into risk assessment**: Include an ongoing assessment of racism within the regular risk assessment conducted by providers. Take caution when including race as a factor in the risk assessment.

Health care system policies and practices

Ensure that health care systems take responsibility for making changes in policies and practices to remove bias, racism, and discrimination in health care.

Action steps:

- **Rules and laws**: Create rules and laws to eliminate the disparities in the health of mothers and babies, especially focusing on the needs and cultural understanding of Black, American Indian and Indigenous, and rural communities.
- **System change strategies**: Modify rules around giving birth in prison, make sure Medicaid covers support from doulas, and make it easier for people to understand and use their insurance.
- **Data reporting**: Require providers, health systems, and health plans to report maternal depression health care effectiveness data and information set measures.
- **Strengthen perinatal programs and training**: Improve access to health care professionals, money, and resources to help with programs focused on the health of mothers and babies (e.g. strengthening community health worker curriculum to include content and training on maternal and child health topics including perinatal health, especially on substance use disorder, mental health, self-advocacy, and options for a combined childbirth educators, community health worker, doula certification).
- **Tools and data**: Provide and require anti-racism tools to be standardized in health systems (pilot strategies such as patient reported experience measure of obstetric racism or Irth app within a health system and lead evaluation within health system and individuals receiving care.

Advocacy, policy, and legislation

Improve birthing outcomes in health care systems (including clinicians and nursing staff) for Black, American Indian and Indigenous, and rural women, birthing people, and children through advocacy, policy, and legislation. Adapt community and relational standards based on feedback and expectations.

Action steps:

- **Advocacy in care coordination**: Fund cultural advocates to provide culturally sensitive care coordination.
- **Expand definition of care providers**: Expand the utilization and scope of practice of community health workers as trusted messengers that can be integral to continuity of culturally sensitive care. Develop systems of support for these health workers to receive reimbursement and conduct visits outside of medical or clinic office settings.
- **Protect families**: Promote policies that support keeping families intact, especially when women and birthing people are seeking treatment for adverse mental health conditions, substance use disorder, or while incarcerated.
  - **Child welfare system**: Advocate for child welfare reform to address racial disparities in child removal and use alternative resources (e.g., early childhood and infant mental health specialists). Respect and reclaim culture to protect children and families. Increase the number of American Indian and Indigenous, and Black foster parents to promote the best interest of the child and to promote stability and security.
  - **Prison policy**: Reform prison policies to increase support for women and birthing people, and their families, while incarcerated – including improved and mandated breastfeeding and chestfeeding policies, increased time allowance and space to engage with family members, and whole family mental health and wellbeing services.
  - **Substance use disorder treatment**: Establish more family treatment programs for substance use disorder that allow children to remain with their caregiver while completing treatment.
  - **Community advocates**: Support individual and family healing by increasing and promoting the use of community advocates.
- **Comprehensive community engagement**: Integrate community engagement throughout the legislative processes, including policy development and planning, data collection and analysis, and dissemination and evaluation.
- **Meeting needs to make participation possible**: Develop systems of support through funding and policy to meet the needs of community members to access services and engage in systems-level work, including transportation, child care, and compensation for time/expertise.

- **Violence prevention**: Prevent violence against Black and American Indian and Indigenous women, birthing people, and children by advocating for policies, support programs, and resources such as:
  - Advocate for public safety measures to reduce over-policing in Black and American Indian and Indigenous communities.
  - Push for state and local organizations to recognize and describe racism as a form of violence.
  - Invest in measures to identify and assess intimate partner violence during prenatal care and postpartum periods.
  - Revise policies at homeless shelters to accommodate women and birthing people.

Culturally responsive data practices

Create data practices that are culturally sensitive and co-created with communities.

Action steps:

- **Perinatal-related data**: Expand public health data strategies to include substance use, alcohol use, mental illness, and intimate partner violence before, during, and after pregnancy.
- **Intersectionality and agency**: Recognize people may identify in multiple communities and elevate autonomy for those that identify as such or who have historically not participated in reporting.
- **Awareness**: Empower communities by raising awareness and confronting systemic issues, ensuring a better understanding of how racism impacts perinatal health outcomes and patient experiences.

Access to substance use disorder and mental health services

Improve access to culturally responsive substance use disorder and mental health care services, particularly with providers who have specific training in perinatal mental health and wellbeing.

Action steps:

- **Substance use disorder and mental health services**: Improve treatment and prevention programs for substance use disorder and mental health issues during and after pregnancy through culturally responsive approaches and integrated care.
- **Trauma-informed, culturally responsive services**: Increase accessibility of trauma-informed and culturally responsive programs, including substance use disorder and crisis mental health services and general referral services for individuals in crisis.
- **Reimbursement**: Establish pay for perinatal community health workers/peer recovery support, like current policies with doulas, such as Medicaid reimbursement and sustained grant funding for community programs.
- **Qualified professionals**: Increase the number of providers with credentials in perinatal mental health/reproductive psychiatry through Postpartum Support International and other organizations, through outreach and education support at local higher education institutions, health care organizations, and community programs.
- **Hotline**: Support funding for a statewide perinatal mental health hotline, like other states, and spread awareness and use of the hotlines through community outreach and communications materials.
- **Crisis mental health services**: Increase availability of crisis mental health services in the perinatal period through outreach and funding support to health care organizations and community programs.

Funding for substance use disorder and mental health

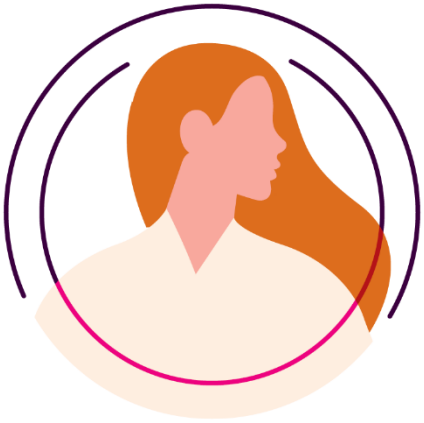
Increase funding in federal, state, and local levels for communities disproportionately impacted by substance use disorders and mental health conditions to fund efforts that address impacts on women and birthing people.

Action steps:

- **Funding for community organizations**: Innovate funding to support community-led organizations to develop trauma-informed, culturally responsive models of care for harm reduction and safety, focused on cultural empowerment and culturally responsive care.
- **Training**: Increase available funding from federal sources to enhance training for diverse workforces related to mental health, wellness, and substance use disorder.
- **Buprenorphine**: Provide funding to increase the number of providers that are trained, competent, and confident prescribing buprenorphine, the prescription used for opioid addiction to reduce cravings and withdrawal symptoms, in women and birthing people. people.
- **Funding flexibility**: Increase the amount of funding to communities that is flexible, accessible, and sustainable.
- **Remove barriers** to receiving and renewing funds for non-traditional applicants.
- **Navigating funding**: Provide training to community members on how to navigate and access government dollars.
- **Simplifying funding applications**: Minimize barriers for communities to access government funding opportunities through simplified and culturally responsive grant application processes and notifications of funding opportunities.

Screenings and prevention

Improve screenings and preventions for perinatal health to make them consistent and non-biased.



Action steps:

- **Education**: Expand educational efforts to include substance use, alcohol use, mental illness, and intimate partner violence before, during, and after pregnancy. Utilize networks of community health workers, doulas, peer support specialists, and recovery coaches.
- **Screening and referral**: Provide holistic care for perinatal health and improve screening and referral processes to address intimate partner violence, substance use disorder, and mental health during pregnancy and postpartum periods.
- **Reimbursement**: Reimburse for screening outside of global prenatal care payment.

Care for people who are incarcerated

Enhance support for women and birthing people who are incarcerated.

Action steps:

- **Culture and language**: Consider the cultural and linguistic diversity of women and birthing people who are incarcerated.
- **Addressing the needs of pregnant people who are incarcerated**: Address the unique challenges faced by women and birthing people who are incarcerated, calling for improved health care services, support, and accommodations.
  - Access to medication assisted treatment and prenatal, postpartum, and preventative care.
- **Access** to community health worker/doula/peer recovery specialist, home visitors.
- **Bi-directional, continuum of care support** for re-entrance to community.

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