

PRIME Retreat

“Equity in All Efforts”

Monday, March 18, 2013

8:30 a.m. – 1:00 p.m.

I. OVERVIEW

On March 18, 2013, the members and staff of the PRIME Steering Team met for planning retreat. The overarching purpose of the session was to generate answers to this Focus Question:

“Considering all that we have learned and where we stand right now in pursuing PRIME’s goals, what do we need to do to sustain and build on PRIME’s accomplishments in the years ahead?”

This report articulates the answers to this question generated by a review of the PRIME’s accomplishments and products, and dialogue generated by questions meant to elicit the lessons learned, work still to be accomplished, and the assets needed to support the work. Answers to these questions are provided in Section IV of this report. Answers to the Focus Question are provided as “findings” in Section V, which begins on page 9. Findings will be reviewed and validated at a future meeting of the Steering Team.

The retreat concluded with an evaluation of the Steering Team. Doak Bloss facilitated the planning process (development of recommendations for sustaining the work of PRIME). Tom Reischl facilitated the Steering Team evaluation activity (see Section VI).

II. PARTICIPANTS

Participants in the retreat included the following:

Julie Allen	Shurooq Hasan
Stan Bien	Brenda Jegede
Renee Canady	Allison Krusky
Alethia Carr	Courtney Lawler
Becca Coughlin	Holly Nickel
Elizabeth Kushman	Carol Ogan
Paulette Dobyne Dunbar	Denise Reinhart
Brenda Fink	Tom Reischl
Derek Griffith	Sheryl Weir

III. PRIME ACCOMPLISHMENTS AND PRODUCTS

Process: After a review of PRIME's three core objectives, participants were asked to name PRIME's primary accomplishments and products over the past year, and accomplishments anticipated prior to the end of the W.K. Kellogg Foundation grant. Four accomplishment/products were discussed in detail, and summarized below. In the interest of time, remaining products and accomplishments were listed but not explored in depth. Products anticipated by the end of the grant period (November 2013) were also listed.

PRIME's Three Core Objectives

1. Develop a replicable workforce training and practice model that incorporates social justice and the elimination of racism in both organizational policy and practice to be used as a strategy for eliminating disparities in health outcomes, related to infant mortality in Michigan.
2. Use a state/local partnership network to codify effective efforts that undo racism and improve infant health in Michigan. Share local lessons learned statewide and disseminate experience of Michigan communities that inform this work and improve effective engagement of stakeholders in policy-making decisions.
3. Identify a sustainability quality assurance process that recognizes social determinants of health in policies, program models and practices, allocation formulas and/or program accreditation review. This should include public documentation of health status data and stories of African Americans and American Indians in Michigan.

Accomplishments and Products Discussed in Detail

1. Increased Dialogue on Equity Issues (Goals 1 and 2)

- Within MDCH, personnel are routinely engaging in conversations about equity and justice that they would not have previously. This impression was voiced by several participants. Staff members are using tools and methods from the workshops and the website to initiate and maintain dialogue on issues that were difficult to address before.
- An important element of this accomplishment is the adoption of common language and concepts that enable people to address phenomena that were sidestepped or ignored in the past. This allows people to avoid some of the misunderstandings that might otherwise occur because of their trepidation about discussing issues of race and racism explicitly.

- One positive consequence of this increased dialogue is that people from other parts of state government are now talking about equity and the health impacts of oppression and privilege.
- Participants acknowledged that the “common language and concepts” must be reiterated often in order to keep the dialogue alive. Also, they are likely to require translation for some groups and people who have not been involved in the training and workshops provided by the project. The development of a shared language for discussing these issues will likely be an ongoing process.
- It was noted that PRIME did not focus on the development of a common language early in project, and that it took a considerable amount of time and energy to develop it, but it was essential to moving forward. It is hoped that the evaluation of the initiative will provide insights into how this can be accomplished more quickly. ???

2. *Website* (Goals 1, 2, and 3)

- The PRIME website summarizes what PRIME is and provides resources and tools for advancing health equity work and educating a broader audience on health equity (definitions, videos, etc.). It provides information on PRIME’s accomplishments and Local Learning Collaborative member updates and lessons learned.
- Analytics on use of the website will be available in a weekly report from Google. Use was highest when the Website was completed in January, 2013. A plan is in development to increase the awareness and use of the site.
- The website is a tangible thing that can benefit people who are not directly involved with the project.
- Participants acknowledged that ideally the website would serve additional functions that it does not serve now, particularly the dissemination of best practices and a forum for focused discussion on important equity issues and challenges. Ideally, it would serve as a link for public health professionals to share and build on each other’s efforts to implement health equity principles in daily practice.

3. *Local Learning Collaborative* (Goal 2)

- The collaborative consisted of local health departments, Healthy Start grantees, and other community based organizations that had experience implementing equity into their work. Prior to being invited to participate on the LLC, these entities participated in a MDCH Health Equity Conference and Infant Mortality Summit in 2008. Members participated every six weeks in face-to-face meetings

or conference calls during which they shared information about their work, challenges, and lessons learned.

- The LLC demonstrated the value of having others to talk to outside of one's usual local partners. An important consideration in continuing the work of PRIME is how to expand this benefit to others. We need to maintain a vehicle whereby the state can share experience and insights with local partners and local partners can share their experience so that it can inform state policy and practice.
- Participants acknowledged that at present only a handful of state personnel are engaged with the collaborative. Ways to expand its influence on the state could be explored.

4. *Learning Labs* (Goals 1 and 3)

- These were developed with the University of North Carolina, University of Michigan and Vanderbilt University as a means of helping staff incorporate equity into their day-to-day practice. It involved three sessions spaced two to three months apart. The first session dealt with background and conceptual information, and the second with a process and tools for developing individual action plans. The third (in April) will include a report by staff on how they are incorporating equity principles into their work. The initial Learning Lab is being conducted with WIC staff.
- The Learning Labs have been difficult work both for participants and facilitators, mainly because there are no established templates for applying the principles of health equity in daily practice. Consequently the process has been very organic, with participants and facilitators learning and building constructs along the way.
- Participants involved directly with the Learning Labs say that many great ideas are being generated, and that the process provides an important opportunity for people to re-imagine WIC processes and practice. Early indications are that "if you give people the opportunity to think differently, they will."
- The ongoing challenge will be how to find ways to support this work in the work place itself. What supports do managers need? What performance objectives should be in place to support this work? What structural needs must be met in order for an equity framework to be sustained in a department or section?
- It is important to recognize that we are simultaneously prompting personnel to adopt a new framework for their work, exploring ways to implement that framework within specific divisions of the department, and developing practical tools to assist others in following a similar path. We should never expect this to be a linear process, or one that unfolds in exactly the same way with every work unit.

- An organizational assessment should occur in order to track not just infant mortality numbers but cultural change and perception of health equity, using “upstream” metrics.

Other Products and Accomplishments Listed but not Discussed in Detail

- Increased political will to address infant mortality and the social determinants of health.
- Project Evaluation: data reports and analysis that can inform similar efforts and aid in refining future work at MDCH.
- Application of the Kitagawa analysis in the Nurse Family Partnership program.
- Organizational assessments (structures that can be routinized within organizations) and metrics that can measure equity (not just for infant mortality).

Products and Accomplishments Anticipated by November 2013

- Completion of the Native American PRAMS survey
- Historical Review of federal and state policies and their connection to infant mortality. It is hoped that this can be used to bolster infant mortality as a political priority.
- A completed Toolkit that will encompass what we learned and effective guidance for others on how they can transform practice. This should include an assessment of what an organization needs to think about when embarking on a similar effort (recognizing that the process will not be the same for every organization, and will probably not be linear).
- Consideration of which parts of the Learning Laboratory should be replicated, and how. What should it look like for other sections, such as Children’s Special Health Care Services?
- Consideration of how to build internal supports, possibly using the Health Equity Steering Committee as a foundation. How do we build our internal capacity to link and maintain personnel who are working on health equity, minority health, health disparities, etc.?

IV. ANSWERS TO SUMMARY QUESTIONS

Process. Participants were divided into small groups to generate answers to a series of questions intended to elicit the information needed to answer the Focus Question. Each question is listed below, with the answers that were generated. (Similar answers from different groups have been consolidated.)

Question 1. What specifically have we learned about doing this work over the past 3 years?

- It is a challenge to keep the focus on the system/institution level versus individual level change.
- The tools/aids/resources need to be made in a way that they are both division specific as well as applicable bureau wide.
- A critical mass of people who are committed is critical, but not impossible. There are groups of people who are showing interest, support and willingness.
- The work takes dedication. It needs to be purposely infused into structures, agendas, etc.
- Both state and local levels need to figure out how to make concepts real, they need to define what is different and what we are doing differently in order to have an affect.
- The process takes time; there is no one easy, magic answer. It is necessary to address all pieces at once; addressing one piece at a time won't be effective.
- In order to advance change, it is important to include those in leadership positions.
- Having a dedicated project coordinator is essential.
- Important to recognize that this is a process and we are developing it together.
- Do not underestimate staff and their ability to contribute.
- We have to take the step to try something different and not be afraid to try something new.
- PRIME is not a single project. The goal is to embed this into our everyday work. It is a change in our thinking.
- This initiative is about changing viewpoints and ways of thinking about our culture.
- Opportunities for staff to express their concerns as they process the information about equity need to be included.

Question 2: Where do we stand, developmentally, in pursuing PRIME's goals? (What remains to be done? What do we want to be true 2 years from now?)

- Discussion is beginning to occur outside of the Bureau of Family and Maternal Child Health; it has begun in places that we have not directly targeted.
- We need to add a focus of health equity in grants and really focus on it. Health Equity needs to stay on the agenda in internal capacity building and the quality assurance process.
- We need to complete the learning labs.
- A more thorough quality assurance needs to be in place.
- Dissemination of LLC lessons needs to occur in order to create more of a two-way

conversation.

- Develop relationships with additional or non-conventional partners. Stake holders should be engaged on mutual goals requires more community outreach.
- The Native American PRAMS survey should be completed.
- The PRIME process needs to be outlined.
- The definition of success or failure needs to be more clearly explained.
- There should be an effort to connect efforts to health outcomes.
- Higher leadership needs to be engaged.
- There needs to be a strategy to deal with attrition.
- Establish a state/local partnership network as a collaboration, requires more development.

Question 3: What assets do we have in place to support the ongoing work of PRIME after the grant concludes?

- Good knowledge base in staff
- Health Disparity Reduction/Minority Health Section (HDRMHS)
- Spark more interested and emerging leaders in this area
- Health disparity reduction law (PA653) to set political agenda
- Relationship with U of M
- Evaluations from prime training
- DCH Health Equity Steering Committee
- Deputy Director and other higher level administration
- Critical mass of staff within BFMCH with a variety of backgrounds
- Communities/LLC
- Intra-departmental collaboration
- Epidemiology and data
- Partnership between academia and people in practice

Question 4: What other assets do we need?

- Funding
- Ongoing political support
- Continue to need/build knowledge in our staff
- Ongoing departmental leadership support
- More resources to go to HDRMHS
- Return on investment analysis that will be valued by higher administration and the governors office
- Strategy to facilitate bi-directional communication between LLC and DCH.
- Forming partnership with UM Public Policy/Law school for policy analysis
- Expanded communication with other states
- Identify what staff divisions are doing after training
- Development of a communication style/structure/approach that is more comfortable to/takes into consideration the cultural uniqueness of all population groups

- Ensure the inclusiveness of all perspectives/regions of the state

Question 5: How can we develop or pursue these assets in the coming months?

- Develop a mechanism of accountability/assignment of responsibility for sustainability of work
- Revitalize Health Equity Steering Committee (MDCH-wide)
- Have joint division meetings
- Expand capacity of others to add to website
- Use information officer, utilize social media and press releases to further dissemination of work
- Provide more workshops and writing up learning lab products
- Develop emerging leaders, invite them onto steering team
- Relationship with University of Michigan Office of Public Health Practice-commune a meeting to plan for the collaboration
- Find U of M faculty or student from HMP and/or joint center to assist with cost analysis (RDI report)
- Build and plan strategies to facilitate bidirectional communication with LLC and DCH into next grant and sustainability plans
- DCH Directors 3MIL discretionary fund
- BCBS fund, investigate through partners and find out how California Endowment did it
- Having an “orientation” (make the case) dialogue with executive leadership in order to garner support and advocacy for the work being conducted
- Build into each program that they dedicate some of their resources to support health equity and disparity
- Bullet point report on success of PRIME to affect funding
- Create a small team to work with J. Olszewski’s new insurance co-op with a 2 prong goal:
 - Provide best practice ideas to reduce health disparities and increase equity to the co-op to meet their goal of meeting health equity criteria of their co-op
 - Identify data points that might be helpful to collect on an on-going basis for decreasing infant mortality and increasing health equity and ask that it be included in the co-ops process of setting up their data collection

V. RECOMMENDATIONS

A structured exercise to answer the Focus Question generated eight recommendations. These recommendations were created by clustering participants' answers to the Focus Question, *“Considering all that we have learned and where we stand right now in pursuing PRIME’s goals, what do we need to do to sustain and build on PRIME’s accomplishments in the years ahead?”* Three of the recommendations are designated “catalytic,” meaning that if they were accomplished they would automatically advance the work of the other recommendations as well. The three catalytic recommendations are presented first. There was no other attempt to prioritize.

The recommendations as presented below are still in draft form. Validation and revision of the recommendations will occur at a future meeting of the Steering Team.

Catalytic Recommendations

1. EQUITY LEADERSHIP DEVELOPMENT: Sustain the transformation process within MDCH and in local communities by identifying and supporting emerging leaders in the discipline of health equity.

Leaders can be drawn from the Steering Team, the Local Learning Collaborative, people within MDCH, and other partners. The structure that was created for the grant should be used as a foundation for ongoing work. We need to identify leaders and champions who can commit to a new, organized effort to promote health equity and its application to public health practice. A new structure for this effort should 1) clearly define who is responsible for what; 2) hold leaders accountable; and 3) recruit additional partners to increase community and state ownership of a health equity framework.

2. DISSEMINATION OF OUTCOMES: Organize the internal and external products of the PRIME initiative in a way that beautifully demonstrates the viability and importance of continuing the work.

MDCH should continue to monitor and track changes occurring within MDCH as a result of this initiative. These changes and other outcomes should be organized into compelling written and visual communications that can be broadly disseminated in order to attract additional support for continuing the transformation process. Products to be organized include but may not be limited to: 1) lessons learned; 2) recommendations to other organizations and agencies interested in transforming practice within a health equity framework; 3) resources lists; 4) identified assets; and 5) executive summaries of PRIME findings.

3. FUNDING: Pursue funding for essential infrastructure needed to sustain current PRIME strategies, with an eye toward embedding the work permanently within the structure of MDCH.

The long-term goal should be to make health equity approaches the norm for all public health practice in Michigan. In the short term, however, we need to assure that there are the personnel and organizational structures in place to continue the efforts that were launched through PRIME. The Steering Team should ascertain what financial resources will be necessary in the next several years to sustain and coordinate the work, and seek funding from a variety of sources to do so. Specific suggestions that were offered within this recommendation were to: 1) create a team specifically charged with pursuing additional funding for PRIME; 2) move quickly to tap the Blue Cross/Blue Shield endowment for support; and 3) fund ongoing activities within the organizational structure of the Health Disparities Reduction/Minority Health Section. Members will also utilize Title V funding to support TA needs around cultural competency training.

Other (Non-catalytic) Recommendations

4. EQUITY IN ALL EFFORTS: Assure that health equity continues to be interwoven into all practices in a highly visible way.

It is important that “equity in all efforts” becomes a reality within MDCH, and that MDCH make this imperative visible to other departments, local communities, and the general public. Within this recommendation, the following suggestions were offered:

- 1) Require that all policies be viewed through a health equity lens, i.e. what groups are potentially marginalized or harmed by the policy?
- 2) Assess the application of health equity in all performance measures and performance reviews
- 3) Push for the inclusion of equity on all departmental agendas
- 4) Provide monthly bullet points tracking the application of health equity concepts in practice
- 5) Share successes and lessons learned with a broad network

It was also suggested to add a link to the PRIME website on the Department’s main webpage. The long-term goal is the merge the PRIME Website with the HDRMHS website.

5. ONGOING TRAINING: Assure that all MDCH staff are oriented to the principles of health equity and ways to apply them.

Continue training of staff with the goal of immersing all MDCH personnel in a culture of equity. This should include the development of a plan to train all new staff, provide training to sections that have not yet been included, and periodically updating

those who have. Consider the outcomes from the WIC staff's Learning Laboratory as a way to best keep staff engaged in the application of health equity principles.

6. RETURN ON INVESTMENT: Develop the “business case” for adopting a health equity framework for all public health practice, and present to government leaders.

In order to sustain this work, partners in the PRIME initiative need to be able to explain to administrative leadership that such a framework has a high return on investment. This argument needs to be articulated in a way that illuminates the positive impact of health equity on health status, economic indicators, and education outcomes. There may be an opportunity to report this in the context of the implementation of the Affordable Care Act.

Members thought the business case for infant mortality, infant health, and lifecourse would be a much stronger argument than a general health equity approach.

7. INCLUSIVITY: Assure the diversity of participants in the ongoing work of PRIME.

Leaders of the ongoing work should be mindful and intentional about increasing the racial and ethnic diversity within the Bureau and in all meetings related to the Bureau's work. They should also engage people at all levels and from multiple sectors of the department.

8. NATIVE AMERICAN PRAMS: Make the administration of PRAMS to Native American mothers a routine practice.

The Pregnancy Risk Assessment and Monitoring Survey has been adapted to be culturally appropriate for Native American mothers. MDCH should institutionalize the use of the survey to monitor and report risk among Native Americans. PRIME should document and share the process used in the NA PRAMS survey.

VI. Steering Team Evaluation

The retreat concluded with the PRIME Evaluator guiding members of the PRIME Steering Team to discuss each member's individual contributions to the PRIME project. Steering Team Members took several minutes to silently reflect on four questions provided by the PRIME Evaluator. These questions included:

1. What Steering Team activities have been the most valuable to you? How was each activity valuable to you?
2. What have you tried to contribute to the success of the Steering Team?
3. In what ways has the Steering Team activities failed to meet your expectations? What work still needs to be done?
4. Should there continue to be a PRIME Steering Team (or something like it) after the Kellogg Foundation funding for this initiative ends?
 - a. What would be the focus of the Steering Team in the future?
 - b. Who would serve on the Steering Team in the future? Are there new leaders emerging from the initial activities of this initiative?

The Evaluator facilitated the evaluation discussion by writing down responses to the questions on a large presentation board, and encouraging discussion among the Steering Team members. Steering Team members listed a wide variety of valuable Steering Team activities. Some of the themes that emerged were professional development and educational activities, the PRIME retreat and opportunities to review evaluation results.

Each Steering Team member also listed what they had contributed to the success of the PRIME project. During this exercise, team members were able to reflect on the diversity of strengths and resources within the PRIME Steering Team.

Steering Team Members had spent the majority of the retreat reflecting on PRIME's goals, and identifying the Steering Team's vision for the remainder of the PRIME project. The Steering Team had a very rich discussion which addressed part of the Evaluation questions. Due to time restrictions, these questions were not re-addressed.

Detailed responses to the evaluation questions:

What Steering Team activities have been the most valuable for you? How was each activity valuable to you?

- Continued learning with Videos
- Like the review of the evaluation results
- Sharing of information and feedback from various members has helped to shape the direction of PRIME.

- Coordination of the project coordinator; without the project coordinator it would be very difficult to manage all the activities. A central person with the knowledge of all the activities is essential to the success of the group.
- Having a variety of experts and people from different backgrounds in the group has helped to expand ideas and generate more discussion on what can be done.
- The trainings provided have been helpful with having a common language. Knowing how to discuss health equity is an essential part of successfully leading the discussion that will get results.

What have you tried to contribute to the success of the Steering Team?

1. Julie Allen – Provided outsider perspective about internal strengths
2. Stan Bien – Feedback, information and ideas as WIC prepared for the learning labs and staff responses to the labs
3. Renee Canady– Provided local health dept. experience; mindful of error of expertise. Balance between privilege and lack of knowing. Building of knowledge we are doing together. Acknowledged that PRIME had engaged leadership (could have been a delegated assignment); Alethia’ s personal commitment of the effort.
4. Alethia Carr – Gave department perspective. Used position to share with group what we can do within the department to move forward; shared insight from funder and related meetings she attends. Brought in information from other groups and shared our information with others. Face of the project.
5. Becca Coughlin –Assisted in making connections with EPI, HDRMH
6. Derek Griffith– Evidence, novelty and difficulty in what we are doing; helped to facilitate engagement with others (UM, UNC). Knowledge in various areas
7. Brenda Jegede – worked to continually move the work forward. Identified when to utilize the expertise of various members
8. Allison Krusky– Conducted thorough evaluation analysis and in timely manner
9. Courtney Lawler– Provided fresh set of eyes. Communication with CSHCS – going thru a major transition and hard sometime to keep on agenda
10. Holly Nickel – Provided general equity resources; shared feedback on learning lab components and what needs to be changed
11. Carol Ogan – Kept track of budget and what we can and cannot do
12. Denise Reinhart – Provided administrative support
13. Tom Reischl – Saw his role as internal evaluator not “outside” evaluator.
14. Sheryl Weir– Contributed to resources section. Helped develop opportunities to integrate work on a broader level

Should there continue to be a PRIME Steering Team (or something like it) after the Kellogg Foundation funding for this initiative ends?

Participants agreed that the group should continue, and would do so by connecting with local groups. PRIME work can be integrated with HESC and that would be essential in allowing PRIME to continue after the funding is done. PRIME needs to be seen as an initiative and not as a program. The focus should also shift to how it can relate to a bigger discussion on equity, beyond (but still including) the current focus of infant mortality.