PRIME

Practices to Reduce Infant Mortality through Equity

Recommendations for State Public Health Departments

Lessons learned for transforming public health through equity education and action

Michigan Department of Health and Human Services
Bureau of Family, Maternal and Child Health

Additional information about PRIME can be found at www.michigan.gov/dchprime and in the following publications:

Practices to Reduce Infant Mortality Through Equity: A Guide for Public Health Professionals

PRIME Program Outcomes: Perspectives on Changes in Organizational Policies and Practices

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INTRODUCTION

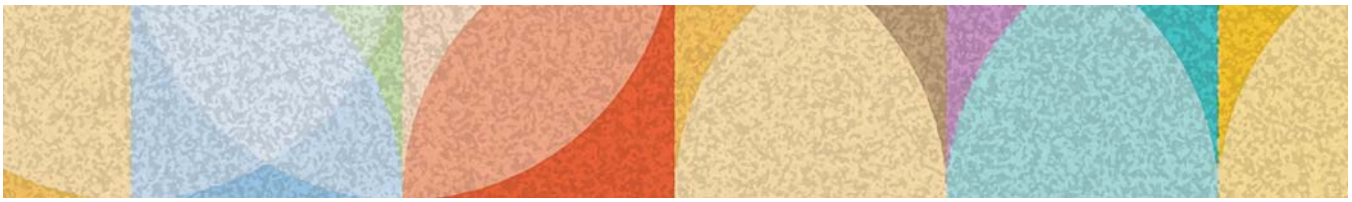
Achieving health equity for all citizens is a goal of public health work within Michigan and across the country. Health equity has been defined as "the principle underlying a commitment to reduce—and, ultimately eliminate—disparities in health and in its determinants, including social determinants."[1] Health disparities are the metric used to measure progress toward reaching this goal of ensuring that all citizens have a fair opportunity to reach their potential.[2] Through its focus on transforming public health through equity education and action, the **Practices to Reduce Infant Mortality Through Equity** (PRIME) initiative has led efforts to change policies and practices within the state health department to ensure that Michigan residents have opportunities for their best health status.

The PRIME initiative was funded by the W. K. Kellogg Foundation from 2010–14 to focus on the unique needs of a state health department to help them more effectively promote health equity. PRIME was designed to enhance the capacity of the Michigan Department of Community Health (MDCH)* Bureau of Family, Maternal and Child Health (BFMCH) to reduce racial disparities in infant mortality between African Americans and Whites and between American Indians and Whites in Michigan. PRIME was designed to create a state public health practice model that would help to both reduce racial disparities in infant mortality and promote health equity in the state. The initiative has focused on three specific goals:

- Develop a training model and resources that promote the understanding of how institutional racism affects policies and practices and that help to eliminate racial disparities in infant mortality.
- Use the state and local partnership networks to work to eliminate racial disparities in infant mortality.
- Establish a sustainable quality improvement process for these efforts within the BFMCH.

Practices to Reduce Infant Mortality through Equity: Recommendations for State Public Health Departments highlights the context, rationale and model of PRIME, as well as lessons learned and recommendations that may be pertinent to other states interested in carrying out state-level efforts to promote health equity. More information about the specific methods used for equity education and action can be found in *Practices to Reduce Infant Mortality through Equity: A Guide for Public Health Professionals*, which is available at the PRIME website at www.michigan.gov/dchprime. The PRIME website also includes a copy of the project evaluation report titled, *PRIME Program Outcomes: Perspectives on Changes in Organizational Policies and Practices.*

*In April 2015, the Michigan Department of Community Health and the Michigan Department of Human Services were merged to form the Michigan Department of Health and Human Services. Because the information in this publication describes events that took place prior to that development, the departmental title of MDCH is used throughout.



THE CONTEXT FOR PRIME

The Role of the Michigan Department of Community Health

MDCH, which was one of 18 departments of the state government, was created in 1996 by consolidating the Department of Public Health, the Department of Mental Health and the Medical Services Administration, the state's Medicaid agency. (The Office of Drug Control Policy and the Office of Services to the Aging were later consolidated with MDCH.) The department, which was one of the largest in the state government, was responsible for health policy and management of the state's publicly-funded health service systems. It included approximately 3,100 employees and planned to provide services to approximately 2 million Michigan residents during the current year.[3] **The mission of MDCH was to protect, preserve and promote the health and safety of the people of Michigan with particular attention to providing for the needs of vulnerable and under-served populations.**

MDCH and its Health Disparities Reduction and Minority Health Section (HDRMHS) have been national leaders in outlining a strategy to guide state-level efforts to reduce health disparities (see, for example, the *2010 Michigan Health Equity Road Map*).[4] In 2004, the department designated HDRMHS to enhance its existing efforts to improve the health of minorities in the state. HDRMHS also serves as the monitoring entity for the 2006 Minority Health Bill (Public Act 653), which mandated that the State of Michigan "develop and implement a structure to address racial and ethnic health disparities in this state."[5] The mission of HDRMHS is to provide a persistent and continuing focus on eliminating health disparities in Michigan, with the goal of ensuring that policies, programs and implementation strategies are culturally and linguistically tailored to significantly reduce the mortality and morbidity rates of these populations. The section also collaborates with state, local and private sectors to advance and implement health promotion and disease prevention strategies.

The MDCH Bureau of Family, Maternal and Child Health, which led PRIME's initial efforts, was responsible for policies and programs targeted to improving the health outcomes and quality of life of Michigan's children, women and families. These responsibilities included assessing needs of children, women and families, recommending policy, and promoting and developing best practices and service models. The three divisions of BFMCH include the Women, Infants and Children Division, the Children's Special Health Care Services Division, and the Division of

Family and Community Health. The Division of Family and Community Health is responsible for areas including perinatal health, reproductive health, infant health, adolescent and school health, oral health, lead poisoning prevention and home visiting.

Connecting Infant Mortality & Health Disparities

Disparities in infant mortality rates among racial groups within Michigan are significant. When PRIME efforts began in 2010, the rate of infant mortality for Whites was 5.5 deaths per 1,000 live births, while the rates for African Americans and American Indians were 14.2 and 10.5, respectively. Despite increased attention and concern about racial disparities in infant mortality, the ratio between African American/White infant mortality has increased the last 40 years. In 1970, the African American/ White 3-year average infant mortality ratio was 1.65 and in 2012 it was 2.45—showing a widening in the gap between African American and White infant mortality rates.[6] These disparities have remained relatively constant for the past decade. Between 2000 and 2012, the 3-year average African American/White infant mortality ratio slightly decreased from 2.95 to 2.6 and the American Indian/White 3-year average infant mortality ratio slightly increased from 1.92 to 2.13.[7]

Addressing these gaps has called for deeper understanding about health disparities—differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust.[8,9] Health disparities are health

"To reduce infant mortality and prevent infant deaths, MDCH is working to understand the contributing life issues from a historical, social and cultural perspective using a conceptual framework called Life Course Theory. This framework explains the origin of poor pregnancy outcomes and the disparities in infant mortality through a population based focus that is rooted in social determinants and social equity."

State of Michigan: Infant Mortality Reduction Plan (August 2012) (p. 8) [10]

outcomes that occur in groups that have systematically experienced greater obstacles to health based on their race, ethnicity or other characteristics—including obstacles linked to discrimination and exclusion.[11] Differences that meet these criteria are significant because they involve patterns that are potentially modifiable through changes in policies and other types of interventions. Within Michigan, racial disparities in infant mortality between African Americans and Whites and between American Indians and Whites have been identified as meeting these criteria, and BFMCH is responsible for developing, implementing and overseeing efforts to address these disparities.

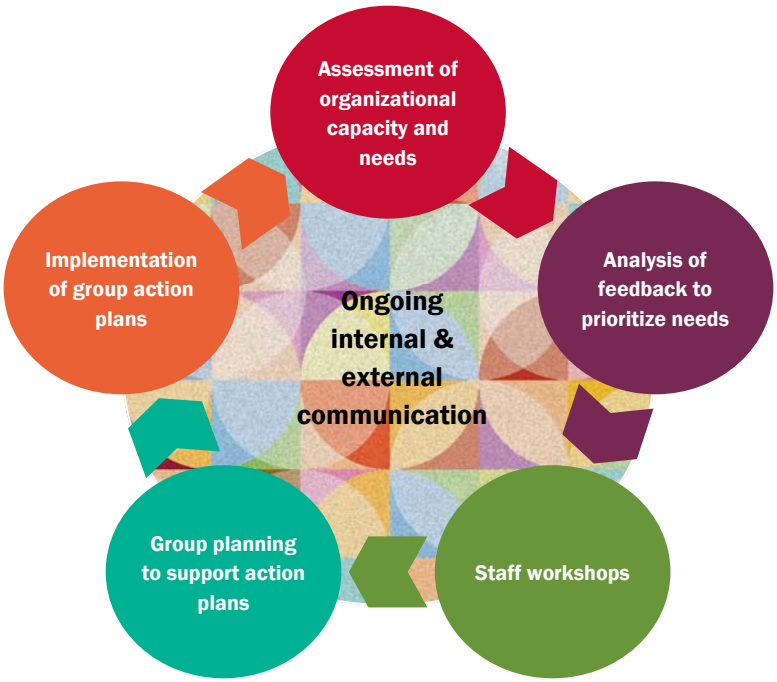
Despite the previous efforts of MDCH and HDRMHS around these issues, several challenges have persisted, including a lack of clarity about the different roles of state and local health departments in addressing these issues, and the limited availability of resources and staff capacity for doing so. Other challenges have included the absence of direction within public health guidelines and a lack of clarity related to strategies that are appropriate for the state's position within the public health system. Through its focus on equity education and action for change, the PRIME initiative was designed to address a fundamental and ongoing question for MDCH: **What does BFMCH need to do differently to reduce racial disparities in infant mortality beyond what it does to address infant mortality in general?**

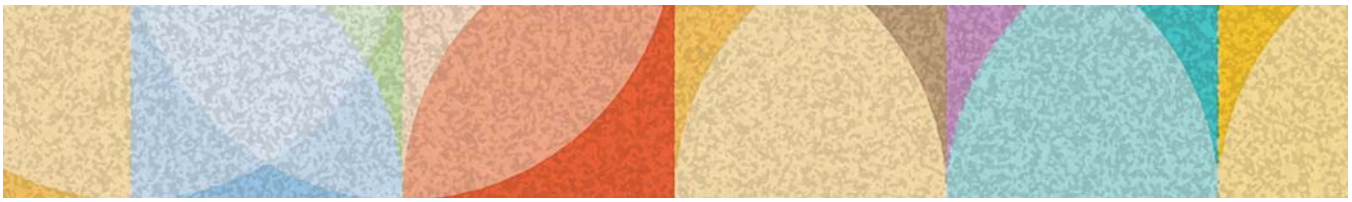
THE PRIME INTERVENTION MODEL

PRIME was designed as an organizational capacity-building intervention that moved beyond one-time or short-term educational efforts toward action resulting in cultural and organizational change. As illustrated in Figure 1, the intervention components included a baseline assessment of individual, group and organizational areas for growth, as well as workshops and trainings designed to help staff members understand the conceptual basis of PRIME, explore assessment findings, and build a common vocabulary for exploring issues of equity. These sessions focused on raising awareness about the relationship between racism, discrimination and health disparities, and the root causes of social and health inequalities at the personal, interpersonal, institutional and cultural levels.

These experiences also provided a foundation for more effective communication and interactions with MDCH colleagues in and outside of the department, and included an explicit goal to directly link the application of staff members' new knowledge to their professional roles, responsibilities and tasks as state-level public health practitioners. (For more information about the specific methods of PRIME, refer to *Practices to Reduce Infant Mortality through Equity: A Guide for Public Health Professionals,* which is available at the PRIME website at www.michigan.gov/dchprime. The guide also includes a listing of key concepts and definitions used within the PRIME efforts.)

Figure 1. PRIME intervention model





LESSONS LEARNED & RECOMMENDATIONS

Dismantling institutional barriers to reducing health disparities—and doing so in ways that transform organizational culture and practices—requires commitment, efforts and strategies from multiple levels of a state health institution. The following information highlights some of lessons learned throughout the PRIME initiative, as well as recommendations for doing this work. (Additional lessons learned and reflections about the PRIME effort are included in the two companion pieces available at the PRIME website at www.michigan.gov/dchprime: *Practices for Reducing Infant Mortality through Equity: A Guide for Public Health Professionals* and *PRIME Program Outcomes: Perspectives and Changes in Organizational Policies and Practices.*)

Context Matters: The Perfect Storm of Opportunity & Leadership

Making significant change within complex systems like health institutions is often facilitated by factors such as visionary leadership and good timing. Change is not equally likely to happen at any time; there are times when events happen within and outside of an organization that increase the likelihood that health equity efforts will be seen as timely, important and particularly relevant. In Michigan, one of the most important contextual factors that paved the way for PRIME was that progressive and visionary leadership within BFMCH pursued external funding from the W. K. Kellogg Foundation. This departmental request coincided with a philosophical shift within the W. K. Kellogg Foundation in which the foundation established funding priorities to focus on equity, children ages 0-8, and infant mortality. As a result, the BFMCH director pursued funding for MDCH to create an initiative to reduce health disparities in infant mortality between Whites and African Americans and between Whites and American Indians. Within the vision outlined in the funding proposal was the need to bring together a broad array of constituents, including local health department leaders, tribal leaders and representatives, community organizations, academic partners and expert consultants who could complement the expertise of the MDCH staff.

In 2011, Governor Rick Snyder created Michigan's dashboards to provide a visual assessment of the state's performance in key priority areas including economic strength, health and education, value for money government, quality of

life, and public safety.[12] Within the dashboards, the governor identified infant mortality reduction as one of the state's top health improvement goals. This action significantly raised the profile of infant mortality as a state level priority.

Also in 2011, MDCH convened a variety of stakeholders across the state—including staff and partners involved with PRIME—to develop Michigan's Infant Mortality Reduction Plan. The plan was intended to provide strategies to "strengthen Michigan's ability to create an environment for every Michigan citizen to be a healthy, productive individual, and have children that are born at the right time, in the right place, who become healthy productive adults."[13] A key strategy within the plan recommended weaving awareness of and attention to the influence of social determinants of health—as well as the findings of the PRIME initiative—into all of the plan's other strategies.

All of these factors—the leadership from BFMCH, the changes in the W.K. Kellogg Foundation's priorities, the investment of the W.K. Kellogg Foundation in PRIME, the Governor's inclusion of infant mortality in the state performance goals dashboard and the infant mortality reduction plan—represent transformational vision, leadership and influence that was instrumental in positioning this innovative work.

Innovation Matters: If you do what you've always done, you'll get what you've always got

Prior to PRIME, there were few, if any, state level models that existed to promote health equity and reduce health disparities. The majority of the work on health equity across the nation and within Michigan had been done at the county, city and neighborhood levels. Michigan had been working on infant mortality for many years, implementing the recommended initiatives of the time without significant change in infant mortality or the disparity gap between African American and White infant deaths.

The initial proposal submitted to the W. K. Kellogg Foundation focused on improving access to care, preconception and interconception health but did not address the state health department policies and practices that exacerbate racial disparities and reflect institutional racism. Because the foundation had philosophically shifted to a different lens on matters of health disparity, the W.K. Kellogg Foundation staff challenged the BFMCH leadership to think more deeply and innovatively about how to craft their proposal to address racism as a fundamental cause of infant mortality and health inequities. Growing recognition at the foundation and elsewhere stressed the importance of recognizing and addressing racism as a

fundamental cause of infant mortality and health inequities. Doing so would require a change in health practice at multiple levels—requiring MDCH to build a proposal focused on addressing ways that racism functioned in its policies and practices, interpersonal interactions and relationships, and day-to-day job roles and functions. To find this innovation, BFMCH looked outside of the health department to an academic partner to help shape and realize this vision. Ultimately, the PRIME proposal built from previous conceptualizations of institutional racism and initiatives to dismantle institutional racism.[14,15,16] PRIME was designed to specifically focus on addressing racism at the organizational and institutional levels of public health practice.

Departmental Connections & Allies Are Fundamental

No one bureau or section within MDCH worked in isolation—and recognizing the need to connect with significant allies across the department was essential for the complex work of PRIME. Within MDCH, allies were initially identified within BFMCH, the Health Disparities Reduction and Minority Health Section, and the Lifecourse, Epidemiology and Genomics Division. Additional departmental connections were made over time, and representatives from across the department participated on the PRIME Steering Team, Intervention Work Group, Evaluation Work Group and Native American Ad-Hoc Data Work Group. These cross-departmental contributions were particularly important for addressing—and potentially challenging and changing—departmental policies and practices. These units, however, also worked with university-based subject matter experts, the Inter-tribal Council of Michigan, local public health departments and external consultants to shape PRIME into an organizational capacity building intervention.

Identify & Build Capable & Engaged Leadership

Leadership at all levels of an organization is essential to addressing health inequities. In order for PRIME to be successful, it was vital to recruit and retain a capable and strong project manager to oversee the day-to-day operations of the initiative. It was also important for the managers and leaders throughout BFMCH to be engaged effectively to address health disparities. As part of this process, it was essential to initially identify those who were committed to deepening their learning about the issues (and who might be willing to take some risks)—and then to build the cohort from there. This required that these leaders have a clear understanding of the department's role in these issues, as well as the ability to identify gaps in resources and services that exist between local jurisdictions within the state. In addition, leaders needed to become adept at recognizing the optimal timing for pursuing efforts to achieve health equity.

Provide Staff with What They Need

One of the most important lessons to be learned from an intervention like PRIME is that staff members have the capacity to apply information about health equity and new skills to their work—*if they are provided with tools, opportunity and encouragement.* When health equity principles are incorporated into staff members' daily practice, meetings, decisions and considerations, the principles are more likely to be sustained and institutionalized. Regular meetings with staff to review key concepts and terminology helped to keep an ongoing focus on equity. It was essential to set and regularly revisit expectations, timelines and the scope of the work in order to avoid unrealistic expectations. It was also important that staff hear regularly from those in leadership about the importance of addressing these issues, and that staff recognize the commitment of leaders in doing their own deep and authentic work related to these complex issues.

Be Prepared for Pitfalls & Roadblocks

There are a range of potential criticisms, critiques and threats that can impede and undermine public health practice efforts to pursue health equity—and it is important to prepare staff, administrators and others to address them. To prepare for these kinds of pitfalls and roadblocks, the BFMCH director, in consultation with the project's university-based subject matter expert and with other leaders in PRIME, identified the following areas:

- It is important to communicate some key concepts with staff upon initiating an effort like PRIME. This includes helping staff recognize that public health practices to address health equity will not be accomplished in a short time period. Staff must also realize that they won't receive a "road map" to follow to accomplish the goal of achieving health equity in infant mortality. Efforts like PRIME require staff to work together to co-create institutional goals and the strategies that need to be implemented to achieve their goals.
- It is critical to appreciate and communicate that health equity, racism and related issues are complex and sensitive topics. Leadership must be prepared to deal with substantive differences in how people understand the terms and their implications. Because these are emotionally charged topics, project leadership needs to be equipped to respond constructively to the emotion and resistance that will be natural reactions from some staff. Moreover, leaders should anticipate and create opportunities to address negative reactions and be prepared to respond to push-back. It's important to keep in mind that negative reactions from staff—particularly from those who are White—aren't uncommon as they grapple with ways that racism has been perpetuated

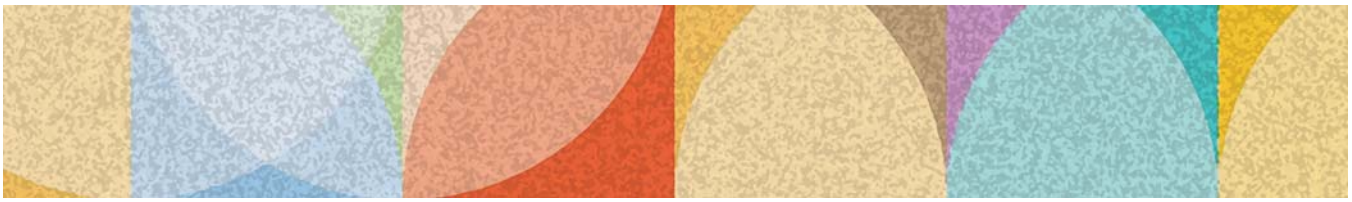
through the actions of individuals *and* through institutional practices and policies. Leaders must be willing to "stay the course" and articulate the value and importance of understanding that these life issues do exist and it is the responsibility of those in public health to address them.

- Focusing on specific racial and ethnic groups may be especially problematic for some staff. Create educational opportunities that provide them with an explicit rationale (as well as clear data) for focusing on improving the health of specific population groups.
- Use data consistently to inform the process and focus the work. Having evaluation data to document the process and impact of public health practice to address health equity is essential to demonstrating why this work is needed, beneficial and relevant over time. In order to sustain this work, it is essential to measure the positive impact of health equity on health status, economic indicators and education outcomes, not just the processes and aspects of organizational change.
- Develop the "business case" for adopting a health equity framework for all public health practice, and present the case to government leaders. The business case for infant mortality, infant health and a life-course approach is likely to be a much stronger argument for some audiences than a moral argument about health equity.
- Avoid "mission creep"—that is, expanding the scope, focus and goals of the project into areas that were not part of the original plan. Create methods for regularly assessing efforts to ensure they reflect the plan's vision and components.
- Understand that the history and structure of your organization will shape what you can and cannot do. The organizational culture will play a key role in determining the organizational readiness to use certain vocabulary, incorporate specific strategies and address particular issues.
- Assure open and frequent communication as part of creating a supportive environment. Ongoing communications from and among those in leadership positions about the importance of addressing these issues is paramount. While many staff and decision-makers may view efforts like PRIME as an "add-on" to the everyday work of a public health institution, leaders must consistently emphasize the value of using these efforts to change the ways that institutions carry out their missions and ways these changes can ultimately benefit all of us.

- Connect with an array of like-minded people doing this work. Leaders in efforts similar to PRIME should build a diverse pool of team members and collaborators—including those who have been most affected by health disparities—with expertise and experiences needed for addressing the complexity of health equity issues. PRIME sought the experience and expertise of the organizations represented on the Local Learning Collaborative and the Steering Team.

"It's important to recognize that the PRIME effort involves a major shift in daily operations and practices within a state health department and requires persistence and patience for change. Early on, I foolishly estimated this change could happen in three years. In hindsight, I now say it takes approximately a decade to make the level of change needed to modify a public health agency into one that understands equity and consistently operates in a manner that promotes and supports equity."

Alethia Carr, Former Director
Bureau of Family, Maternal and Child Health
Michigan Department of Community Health



NEXT STEPS FOR PRIME

PRIME was designed to create an organizational capacity-building model to reduce racial disparities in infant mortality and to promote health equity in the state of Michigan. The PRIME intervention model was designed to optimize the role of the state health department for promoting health equity—and this has required the creation of processes for organizational and cultural change that are intentional, clear and transparent to those inside and outside the organization.

A key next step for PRIME efforts is to determine how best to build the capacity of the Michigan Department of Health and Human Services (MDHHS) to expand to other areas, to train new staff and to be self-sustaining. An additional one-year grant was secured from the W.K. Kellogg Foundation in 2014 to develop a plan to implement the PRIME Intervention Model in other MDHHS divisions (Epidemiology, Chronic Disease, Behavioral Health and Medicaid). PRIME will also identify and address the technical assistance needs of BFMCH staff to fully implement equity work plans that were developed in the project. Finally, PRIME will continue to partner with HDRMHS to develop mandatory online equity training for MDHHS staff and specific curriculum for executive leadership in the department. These efforts will assist in developing quality improvement processes to sustain the efforts in PRIME. The PRIME team seeks to determine how best to institutionalize the changes that have occurred and to maintain the momentum of change within the BFMCH. As PRIME goes forward, the team is committed to extending beyond the exclusive focus on infant mortality to determining how these principles and lessons apply to other health disparities, ultimately contributing to the elimination of health disparities within BFMCH and beyond.

REFERENCES

[1] Braveman, P. (2014). What are health disparities and health equity? We need to be clear. *Public Health Reports, 129*, 5-8.

[2] Braveman, P. A. (2006). Health disparities and health equity: Concepts and measurement. *Annual Review of Public Health, 27*, 18.1-18.28.

[3] Michigan Department of Community Health. (2015). *About the Michigan Department of Community Health.* Retrieved from http://www.michigan.gov/mdch/0,4612,7-132-63157_51216-6391--,00.html

[4] Michigan Department of Community Health, Health Disparities Reduction and Minority Health Section. (2010). *Michigan health equity roadmap.* Retrieved from http://www.michigan.gov/documents/mdch/MI_Roadmap_FINAL_080310_revised_WEB_VERSION_329422_7.pdf

[5] State of Michigan. House Bill 4455, Section 2227 (2006). Retrieved from http://www.michigan.gov/documents/mdch/Public_Act_653_190873_7.pdf

[6] Division for Vital Records and Health Statistics, Michigan Department of Community Health (2014). *Number of infant deaths, live births and infant death rates by race, 1970-2013.* Retrieved from http://www.mdch.state.mi.us/pha/osr/InDxMain/Tab2.asp

[7] Division for Vital Records and Health Statistics, Michigan Department of Community Health. (2015). *Live births, infant deaths and infant mortality rates by race, Michigan residents 2000–2013, Preliminary 12 Months Ending in March 2014, Michigan Residents.* Retrieved from http://www.mdch.state.mi.us/pha/osr/Provisional/InfantDeaths2013.asp

[8] Carter-Pokras, O., and Baquet, C. (2002). What is a "health disparity"? *Public Health Reports*, 117(5), 426-434.

[9] Whitehead, M. (1992). The concepts and principles of equity and health. *International Journal of Health Services, 22*(3), 429–445. doi:10.2190/986L-LHQ6-2VTE-YRRN [access restricted]

[10] Michigan Department of Community Health (August 2012). *State of Michigan: Infant Mortality Reduction Plan.* Retrieved from http://www.michigan.gov/documents/mdch/MichiganIMReductionPlan_393783_7.pdf

[11] U.S. Department of Health and Human Services, Healthy People 2020. (2014–15). *Disparities.* Retrieved from http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities#6

[12] State of Michigan (2015). *Mi Dashboard: Measuring Michigan's performance.* Retrieved from https://midashboard.michigan.gov/

[13] Michigan Department of Community Health (August 2012). *State of Michigan: Infant Mortality Reduction Plan.* Retrieved from http://www.michigan.gov/documents/mdch/MichiganIMReductionPlan_393783_7.pdf

[14] Griffith, D.M., Yonas, M., Mason, M., & Havens, B. (2010). Considering organizational factors in addressing healthcare disparities: Two case examples. *Health Promotion Practice, 11*(3), 367-376.

[15] Griffith, D.M., Mason, M., Yonas, M., Eng, E., Jeffries, V., Plihcik, S., & Parks, B. (2007). Dismantling institutional racism: Theory and action. *American Journal of Community Psychology, 39*(3-4), 381-392.

[16] Griffith, D.M., Childs, E.L., Eng, E., & Jeffries, V. (2007). Racism in organizations: The case of a county public health department. *Journal of Community Psychology, 35*(3), 291-306.

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