Annual Evaluation Report

for

Practices for Reducing Infant Mortality through Equity (PRIME)

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# Annual Evaluation Report for Practices for Reducing Infant Mortality through Equity (PRIME)

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## Acronym List

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ALC</td>
<td>Action Learning Collaborative</td>
</tr>
<tr>
<td>BFMCH</td>
<td>Bureau of Family, Maternal and Child Health</td>
</tr>
<tr>
<td>BRFSS</td>
<td>Behavioral Risk Factor Surveillance System</td>
</tr>
<tr>
<td>CLAS</td>
<td>Culturally and Linguistically Appropriate Services</td>
</tr>
<tr>
<td>CSHCS</td>
<td>Children’s Special Health Care Services Division</td>
</tr>
<tr>
<td>DFCH</td>
<td>Division of Family and Community Health</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>FISMA</td>
<td>Federal Information Security Management Act</td>
</tr>
<tr>
<td>HDRMH</td>
<td>Health Disparity Reduction and Minority Health</td>
</tr>
<tr>
<td>HESJ</td>
<td>Health Equity and Social Justice (workshops)</td>
</tr>
<tr>
<td>HHS</td>
<td>(US Department of) Health and Human Services</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
</tr>
<tr>
<td>ICHD</td>
<td>Ingham County Health Department</td>
</tr>
<tr>
<td>IRB</td>
<td>Institutional Review Board</td>
</tr>
<tr>
<td>ITCM</td>
<td>Inter-tribal Council of Michigan</td>
</tr>
<tr>
<td>IVAN</td>
<td>Infant Vitality Network</td>
</tr>
<tr>
<td>LLC</td>
<td>Local Learning Collaborative</td>
</tr>
<tr>
<td>MAPP</td>
<td>Mobilizing for Action through Planning and Partnerships</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health (epidemiology unit)</td>
</tr>
<tr>
<td>MDCH</td>
<td>Michigan Department of Community Health</td>
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<tr>
<td>MI</td>
<td>Michigan</td>
</tr>
<tr>
<td>NACCHO</td>
<td>National Association of County and City Health Officials</td>
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<td>NACDD</td>
<td>National Association Chronic Disease Directors</td>
</tr>
<tr>
<td>NCS</td>
<td>National Children’s Study</td>
</tr>
<tr>
<td>PEDIM</td>
<td>Partnership to Eliminate Disparities in Infant Mortality</td>
</tr>
<tr>
<td>PPOR</td>
<td>Perinatal Periods of Risk</td>
</tr>
<tr>
<td>PRAMS</td>
<td>Pregnancy Risk Assessment Monitoring System</td>
</tr>
<tr>
<td>PRIME</td>
<td>Practices for Reducing Infant Mortality through Equity</td>
</tr>
<tr>
<td>REACH</td>
<td>Racial and Ethnic Approaches to Community Health</td>
</tr>
<tr>
<td>SAS</td>
<td>Statistical Analysis System (statistical analysis software)</td>
</tr>
<tr>
<td>SDOH</td>
<td>social determinants of health</td>
</tr>
<tr>
<td>UMSPH</td>
<td>University of Michigan School of Public Health</td>
</tr>
<tr>
<td>UR</td>
<td>Undoing Racism (workshops)</td>
</tr>
<tr>
<td>WCHD</td>
<td>Washtenaw County Health Department</td>
</tr>
<tr>
<td>WIC</td>
<td>Woman, Infants and Children (program)</td>
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</tbody>
</table>
Annual Evaluation Report for Practices for Reducing Infant Mortality through Equity (PRIME)

1. PRIME Project Activities

The project leaders for the Practices for Reducing Infant Mortality through Equity (PRIME) project introduced the project logic model to key staff and other stakeholders at the first meeting of the project’s Steering Team. The logic model (see next page) provides a visual summary of the goals and action objectives for the PRIME project and the resources (inputs) needed to accomplish project goals.

The project goals are listed in the logic model as project outcomes. The short-term outcomes include:

- Increasing knowledge of Michigan Department of Community Health (MDCH) staff,
- Producing a tool kit and model curriculum for other state health departments,
- Changing policies in the Bureau of Family, Maternal and Child Health (BFMCH) to reduce racial disparities in infant mortality (IM),
- Increasing efforts to monitor social determinants of health (SDOH) in Michigan,
- Increasing efforts for continuous quality improvement and public sharing of measurable outcomes related to racial equity and health equity, and
- Improve partnerships between BFMCH and local health departments and community-based organizations to reduce racial disparities in infant mortality (IM).

The activities to accomplish these goals and the activity outputs (metrics for monitoring project activities) are also listed in the logic model. The project activities include infrastructure development such as hiring a project coordinator, reviewing current policies and practices, and conducting social justice orientation assessments within MDCH. Other activities focus on curriculum and program development including revising existing models and curricula, creating a tool kit and curriculum on social determinants of racial disparities, and writing reports (green paper, white paper) to present reviews and solicit feedback. The final activity involves direct training of staff within MDCH and other local health departments and community-based organizations. This report summarizes the project activities (guided by this logic model) and our efforts to evaluate the project’s activities and outcomes during the project’s first year.

Structural Developments

The PRIME project established a project Steering Team along with two workgroups (Evaluation and Intervention). The Steering Team is composed of several partners: Michigan Department of Community Health (MDCH), University of Michigan, Ingham and Wayne County Health Departments, Inter-tribal Council of Michigan, Nimkee Memorial Wellness Center and The Corner Health Center (see Appendix A). To increase group cohesion, each group presented the Steering Team with an overview of their agency.
Within the first months of operation, the PRIME Steering Team developed outcome and process goals, a work plan, and a logic model. The PRIME Steering Team increased its capacity by hiring a project coordinator. The project coordinator provides overall support, coordination and communication for the PRIME project and oversees implementation of the project work plan and contractual agreements. The PRIME Steering Team adopted a Consensus Decision Making approach. With this method, all team members provide input for decisions. This method encouraged discussion and ultimately increased group cohesion among the Steering Team members. Additionally, the Steering Team developed operating values and agreed upon responsibilities and expectations of members (see Appendix A).

One of the PRIME project’s goals included increased collaboration with the community. In January 2011, the Local Learning Collaborative Workgroup which consisted of the Bureau of Family, Maternal and Child Health Director, Project Coordinator, two health departments and one Community-based Organization was formed. The Workgroup created guidelines for a Local Learning Collaborative (LLC). The first meeting of the LLC was held in May 2011. The LLC includes twenty three community partners (see Appendix A). The purpose of the LLC is to share local work in undoing racism and health equity with other organizations and stakeholders throughout the state. A main goal of the LLC is to develop a dissemination plan to share their work. The LLC prepared a pre-conference session at the 2011 Michigan Premier Public Health Conference. Additionally, the project contracted with ten agencies on the LLC to gather information on the undoing racism and health equity work they have completed in their local communities. Some agencies utilized funding to pay for staff and travel costs to participate in the LLC meetings. Others used the funding to compile reports on work addressing racial equity and health disparities in infant mortality; to conduct community outreach and education sessions to raise awareness about health disparities in infant mortality; and to provide assistance to maternal and child clients with transportation assistance, educational opportunities and tangible items.

**Steering Team and Workgroups Activities**

The PRIME project established four work groups to plan and implement the primary project activities. The four work groups are:

- Intervention Work Group
- Native American Ad-Hoc Data Work Group
- Evaluation Work Group
- Local Learning Collaborative

These work groups met separately and reported their progress to the project leaders and the Steering Team. A summary of the Steering Team meetings and the work group meetings including meeting dates, number of attendees, and primary topics discussed are provided on the next page and subsequent pages.
Capacity Building

Training

The PRIME project invested in training MDCH staff, community partners, and Steering Team members. During the first year, the PRIME project hosted two training workshops for MDCH staff and community partners serving on the LLC.

The People’s Institute’s for Survival and Beyond (from New Orleans) facilitated the first workshop titled, “Undoing Racism.” The Undoing Racism (UR) workshops focused on institutional and structural racism, racial privilege and internalized racism. MDCH staff who attended were primarily Non-Hispanic Caucasian or Non-Hispanic African Americans. A majority reported attending previous workshops or trainings on health disparities, undoing racism, or health equity (see Appendix B).

The PRIME Evaluation workgroup also held focus groups with MDCH UR participants. Focus group participants reported a growth in knowledge, and a desire to increase collaboration with community members (see Appendix C).

The Ingham County Health Department facilitated the second workshop titled, “Health Equity and Social Justice.” The Health Equity Social Justice (HESJ) workshop presented information on target and non-target groups, the four levels of oppression and change, and health equity. The HESJ workshop provided several opportunities for role playing and small group discussions. Attendees were primarily Non-Hispanic Caucasian or Non-Hispanic African Americans (see Appendix D).

The PRIME project invested in the evaluation of the quality and outcomes of the trainings. Participants completed pretests and posttests for each workshop. These tests measured changes in knowledge and understanding of selected competencies, along with confidence to identify racism. MDCH staff who attended the Undoing Racism (UR) workshop reported significant increases in 11 of 12 self-rated competencies to define and identify various racial disparity/health equity components. The competencies that improved included defining institutional and cultural racism and explaining social determinants of racial health disparities. The only competency that did not increase was the ability to ‘identify policies and practices in the Michigan Department of Community Health that address racial health disparities’. The MDCH staff who attended the HESJ workshop showed significant increases in knowledge for 8 of 12 content knowledge questions. Significant increases in knowledge were not seen on questions regarding unearned privilege, the social justice framework, differentiating health equity and health disparities, and defining racism at the institutional level (for a summary of all trainings, see Appendix E).
## PRIME Team Meeting Summaries

### STEERING TEAM (22 members)

<table>
<thead>
<tr>
<th>Meeting Dates</th>
<th>Number of Participants</th>
<th>Meeting Objectives</th>
</tr>
</thead>
</table>
| September 17, 2010  | 13                     | ● Provide project status update  
● Discuss evaluation metrics  
● Draft 2010-2011 work plan  
● Discuss updated Perinatal Periods of Risk (PPOR) analyses  
● Highlight Michigan counties with high infant mortality  
● Share internal workgroup updates |
| October 7, 2010     | 15                     | ● Share project status update  
● Presentations  
  ○ Women, Infants and Children Division (WIC)  
  ○ Children’s Special Health Care Services Division (CSHCS)  
  ○ Division of Family and Community Health (DFCH)  
  ○ Health Disparities Reduction and Minority Health Section (HDRMH) |
| October 25, 2010    | 15                     | ● Provide project status  
● Discuss project name  
● Review steering team operating principles/values and decision making  
● Discuss roles and responsibilities  
● Discuss 2010-2011 work plan |
| November 19, 2010   | 19                     | ● Share project status update  
● Select project name  
● Review steering team operating principles/values and decision making  
● Provide overview of Ingham County Health Department (ICHD) Health Equity and Social Justice workshop  
● Internal workgroup updates  
● Discuss next action steps |
| December 3, 2010    | 16                     | ● Give project status update  
● Share project name (Practices to Reduce Infant Mortality Through Equity, PRIME)  
● Review steering team operating principles/values and decision making  
● Discuss training/curriculum plan  
● Share evaluation plan  
● Discuss future meeting logistics |
| January 10, 2011    | 21                     | ● Give project status update  
● Review final draft of operating principles/values and decision-making  
● Share Inter-Tribal Council of Michigan – Native American health equity concerns  
● Share dissemination ideas for PRIME project  
● Give internal workgroup updates |
<table>
<thead>
<tr>
<th>Meeting Dates</th>
<th>Number of Participants</th>
<th>Meeting Objectives</th>
</tr>
</thead>
</table>
| January 24, 2011   | 17                     | • Share project status update  
• Discuss work plan revisions  
• Discuss dissemination ideas  
• Give internal workgroup updates |
| February 28, 2011  | 16                     | • Give project status update  
• Provide update on Undoing Racism training  
• Share CDC Health Disparities & Inequities Report  
• Report from National Association Chronic Disease Directors (NACDD) Meeting  
• Share updates on Way County-Detroit Infant Mortality report  
• Provide internal workgroup updates |
| March 21, 2011     | 17                     | • Share project status update  
• Discuss budget and work plan  
• Update group on undoing racism training  
• Share information on Inter-tribal Council of Michigan (ITCM) Statewide Consortium  
• Discuss internal workgroup updates |
| April 4, 2011      | 14                     | • Discuss ongoing reactions from staff that attended Undoing Racism trainings  
• Discuss the next steps identified in the ad-hoc group meeting on Native American data  
• Discuss HDRMH involvement with CLAS/Cultural Competency Training  
• Discuss updates from the workgroups |
| April 18, 2011     | 12                     | • Discuss HHS strategies to address health disparities  
• Discuss updates from the workgroups |
| May 16, 2011       | 17                     | • Learn about Applied Research Center and their activities involving structural racism  
• Learn about Washtenaw County Health Department (WCHD) trip to Boston and what they learned  
• Discuss updates from workgroups |
| June 6, 2011       | 15                     | • Updates on the next steps identified in the ad-hoc group meeting on Native American data  
• Updates on work within DFCH to identify racial disparities  
• Discuss HDRMH involvement with CLAS/Cultural Competency Training  
• Discuss updates from the workgroups |
| June 17, 2011      | 11                     | • Share project status updates  
• Discuss steering team work plan  
• Discuss project coordinator interview and selection |
<table>
<thead>
<tr>
<th>Meeting Dates</th>
<th>Number of Participants</th>
<th>Meeting Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 18, 2011</td>
<td>16</td>
<td>• Share updates on the next steps for gathering Native American data.</td>
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<tr>
<td></td>
<td></td>
<td>• Share updates on work within DFCH to identify areas to focus for potential work changes.</td>
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<tr>
<td></td>
<td></td>
<td>• Discuss ICHD Workshop/schedule with MDCH staff &amp; PRIME.</td>
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<tr>
<td></td>
<td></td>
<td>• Discuss MI's Partnership to Eliminate Disparities in Infant Mortality (PEDIM) Action Learning Collaborative grant and collaboration with PRIME.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Discuss updates from the workgroups.</td>
</tr>
<tr>
<td>August 22, 2011</td>
<td>15</td>
<td>• Update on the ICHD Health Equity Social Justice Workshop</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Review and update the workplan.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Budget review and discussion on Year Two Goals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Discuss updates and next steps from the workgroups.</td>
</tr>
</tbody>
</table>
## INTERVENTION WORKGROUP (7 members)

<table>
<thead>
<tr>
<th>Meeting Dates</th>
<th>Number of Participants</th>
<th>Meeting Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 18, 2010</td>
<td>5</td>
<td>- Discussion of project focus&lt;br&gt;- Review PPOR presentation&lt;br&gt;- Review activities and initiatives of health departments in the U.S.&lt;br&gt;- Share potential training components</td>
</tr>
<tr>
<td>November 17, 2010</td>
<td>6</td>
<td>- Discuss the need to develop a data driven process to address health inequities&lt;br&gt;- Review PPOR data for African-Americans</td>
</tr>
<tr>
<td>December 3, 2010</td>
<td>6</td>
<td>- Review meeting minutes (11/17/10)&lt;br&gt;- Discuss possible training organizations for MDCH staff</td>
</tr>
<tr>
<td>December 15, 2010</td>
<td>6</td>
<td>- Discuss training/curriculum development&lt;br&gt;- Review the Ten Essential Public Health Services&lt;br&gt;- Discuss the involvement of national leaders in infant mortality&lt;br&gt;- Discuss the development of a training institute&lt;br&gt;- Discuss work plan revisions</td>
</tr>
<tr>
<td>January 19, 2011</td>
<td>7</td>
<td>- Review meeting minutes (12/15/10)&lt;br&gt;- Discuss Native American data needs&lt;br&gt;- Share updates on MDCH trainings/consultations&lt;br&gt;- Discuss MDCH/DFCH infant mortality plan&lt;br&gt;- Share dissemination ideas for PRIME work</td>
</tr>
<tr>
<td>February 2, 2011</td>
<td>6</td>
<td>- Review meeting minutes (12/15/10)&lt;br&gt;- Discuss MDCH Trainings&lt;br&gt;- Review Green Paper&lt;br&gt;- Share PRIME Toolkit Components</td>
</tr>
<tr>
<td>February 28, 2011</td>
<td>5</td>
<td>- Review Meeting minutes (2/2/11)&lt;br&gt;- Share Maternal and Child Health (MCH) epidemiology unit demographics/position description/annual reviews&lt;br&gt;- Discuss PRIME work on Native Americans&lt;br&gt;- Discuss PRIME Toolkit Components (evaluation/data needs)&lt;br&gt;- Discussion with Dr. Murray&lt;br&gt;- Discuss Undoing Racism Training</td>
</tr>
</tbody>
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## INTERVENTION WORKGROUP (7 members)

<table>
<thead>
<tr>
<th>Meeting Dates</th>
<th>Number of Participants</th>
<th>Meeting Objectives</th>
</tr>
</thead>
</table>
| April 6, 2011       | 9                      | • Discuss undoing racism workshops  
  o Meeting with managers  
  o Response team  
  o Newsletter  
  o Safe places  
• Present additional training opportunities  
  o ICHD Health Equity Social Justice  
  o VISIONS  
  o Challenging Racism  
  o Healing Racism |
| May 18, 2011        | 6                      | • Discuss Bureau Family, Maternal and Child Health organizational assessment  
  • Review Title V objectives  
  • Discuss Applied Research Center presentation  
  • Provide update on ICHD’s HESJ |
| June 27, 2011       | 7                      | • Present Native American Resources Google Map  
  • Title V application announcement  
  • Green Paper Review  
  • Discuss Ingham County Health Department (ICHD) Health Equity Social Justice Workshops (HESJ) |
| July 27, 2011       | 9                      | • Review meeting minutes  
  • Share Google Map of Native American Resources  
  • Present structure of Green Paper  
  • Discuss dissemination work  
  • Discuss ICHD Health Equity Social Justice Workshop  
  • Title V Objectives |
| August 26, 2011     | 7                      | • Review meeting minutes (7/27/11)  
  • Discuss PRIME budget and outstanding work plan items  
  • Additional technical assistance and student support to MDCH  
  • Discuss PRIME Local Learning Collaborative Website  
  • Review MDCH Organization Assessment  
  • Discuss Blue Ribbon Panel on National Experts  
  • Dissemination options of PRIME work  
  • Identification of other trainings  
  • Input for green paper outline  
  • Discuss PRIME Retreat |
<table>
<thead>
<tr>
<th>Meeting Dates</th>
<th>Number of Participants</th>
<th>Meeting Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 28, 2011</td>
<td>7</td>
<td>• Review past meeting minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Discuss MDCH Assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Update on green paper</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Discuss DFCH health disparities work</td>
</tr>
<tr>
<td>Meeting Dates</td>
<td>Number of Participants</td>
<td>Meeting Objectives</td>
</tr>
<tr>
<td>---------------</td>
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<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>March 28, 2010</td>
<td>9</td>
<td>● Discuss Native American data needs and updates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Share internal workgroup updates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Discuss CLAS/Cultural Competency Training</td>
</tr>
<tr>
<td>June 2010</td>
<td>6</td>
<td>● Share project status update</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Discuss Native American data needs</td>
</tr>
<tr>
<td>Meeting Dates</td>
<td>Number of Participants</td>
<td>Meeting Objectives</td>
</tr>
<tr>
<td>----------------</td>
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</tr>
</tbody>
</table>
| October 5, 2010| 5                      | ● Discuss prospective members of evaluation workgroup  
● Share primary tasks and objectives of the workgroup  
● Discuss training and outcomes |
| November 12, 2010| 8                      | ● Review minutes (10/5/10)  
● Share infant mortality data and data limitations  
● Review PRIME project purpose and goals  
● Discuss how data will be used for trainings and policy development |
| December 2, 2010| 8                      | ● Give Pregnancy Risk Assessment Monitoring System (PRAMS) presentation and hold discussion  
● Review of infant mortality data  
● Discuss process evaluation |
| February 18, 2011| 7                      | ● Review meeting minutes (1/25/11)  
● Data collection & evaluation for Undoing Racism Trainings  
● Use of PPOR to improve MDCH policies & procedures  
● Discuss steering team meeting evaluation |
| April 11, 2011 | 5                      | ● Share pre/post test analysis for the Undoing Racism workshop |
| May 27, 2011   | 5                      | ● Share updates on Undoing Racism workshop data  
● Future meeting dates and meeting objectives |
| June 27, 2011  | 6                      | ● Review ICHD Health Equity Social Justice training dates  
● Share Undoing Racism pre/post test results  
● Share updates on the Division of Family & Community Health (DFCH)  
● Review PRIME evaluation requirements  
● Future meeting dates and logistics |
| July 20, 2011  | 6                      | ● Review meeting minutes (6/27/11)  
● Review results of Undoing Racism workshop with statistical explanation  
● Discuss ICHD Health Equity and Social Justice Evaluation  
● Discuss PRIME reporting and evaluation requirements |
| August 24, 2011| 4                      | ● Review meeting minutes (7/20/11)  
● Provide Undoing Racism Focus Group updates  
● Provide ICHD Health Equity and Social Justice survey feedback  
● Discuss PRIME stakeholder evaluation  
● Review Kellogg grant application evaluation requirements |
<table>
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<tr>
<th>Meeting Dates</th>
<th>Number of Participants</th>
<th>Meeting Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 22, 2011</td>
<td>6</td>
<td>• Review Undoing Racism Focus Group Results</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Review ICHD – Health Equity Social Justice Pre/Post Test Results</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updates on MDCH Survey and the Stakeholders’ Evaluation</td>
</tr>
<tr>
<td>October 4, 2011</td>
<td>6</td>
<td>• Review draft of process evaluation online survey</td>
</tr>
<tr>
<td>October 10, 2011</td>
<td>6</td>
<td>• Review draft of process evaluation online survey</td>
</tr>
</tbody>
</table>
### LOCAL LEARNING COLLABORATIVE

<table>
<thead>
<tr>
<th>Meeting Dates</th>
<th>Number of Participants</th>
<th>Meeting Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 7, 2011</td>
<td>6</td>
<td>- Discuss ideas for goal 2 for the PRIME project</td>
</tr>
</tbody>
</table>
| February 28, 2011| 5                      | - Comment on existing proposal  
- Invitation to present at Michigan Premier Public Health Conference  
- Undoing Racism trainings |
| March 18, 2011   | 4                      | - Discuss LLC composition and future invitations  
- Meeting logistics  
- Review goals and objectives of LLC |
| March 25, 2011   | 20                     | - Introduce PRIME vision, goals and objectives  
- Undoing Racism workshop invitation  
- General discussion on participation and meeting logistics |
| May 12, 2011     | 14                     | - Introduction and overview of PRIME goals and objectives  
- LLC members discuss their current involvement and lessons learned  
- Dissemination ideas  
- Meeting logistics and agenda topics |
| July 21, 2011    | 13                     | - Review previous meeting minutes and follow up items  
- LLC member updates  
- Invitation to attend Health Equity and Social Justice workshops  
- Discuss PRIME LLC Contracts  
- Share dissemination ideas  
- Meeting logistics and agenda topics |
| August 31, 2011  | 13                     | - Review previous meeting minutes (7/21/11)  
- Share ideas for Michigan Premier Public Health Conference Pre-Conference Session  
- Discuss PRIME LLC Contracts  
- Share future meeting dates and agenda topics |
- Discuss ideas for dissemination  
- Discuss PRIME Local Learning Collaborative Contracts  
- Highlight remaining PRIME meeting schedule |
Internships

The PRIME project provided internships to three graduate students. Interns gained experience working with community groups, attended meetings and created program profiles. Two summer interns created program profiles for the Division of Family and Community Health (DFCH) and for the PRIME Local Learning Collaborative (LLC). These profiles have been used as an initial assessment of the DFCH and local community agencies. The profiles contain information on existent programs addressing racial and ethnic disparities, the goals and objectives and what, if any connection, do these programs have with infant mortality reduction. A third intern worked for four months with the PRIME LLC. The intern assisted the PRIME LLC in preparing materials for the Michigan Premier Public Health Conference. One intern created and presented a poster at the pre-conference session at the Michigan Premier Public Health Conference. Student interns also attended the Steering Team and workgroup meetings. In addition, the PRIME project has hired two graduate research assistants. One graduate student research assistant worked on the development of Native American resources. A second graduate student compiled information on local and state organizations which were doing work on racism, health equity and health racial disparities. Specifically, what work had these organizations done and how they did it. Three interns and one graduate assistant participated in the Health Equity and Social Justice workshops.

Intervention Development

The PRIME Intervention workgroup focused on three main projects. These projects include the planning of two workshops, the development of the program intervention and a toolkit. The workgroup also began to indentify components for an organization assessment that would assist in identifying staff needs that will need to be addressed in the intervention. The PRIME Steering Team identified evidenced-based programming to guide intervention components.

Curriculum development

Beginning in May 2011, the Intervention workgroup began the planning process for a PRIME green paper. The goal of the PRIME green paper is to review strategies and theoretical approaches to guide the reduction of infant mortality. The outline for the PRIME green paper began in June 2011 and a draft was completed in September 2011. The PRIME green paper serves as a framework to develop an intervention for MDCH.

Toolkit

The PRIME Intervention workgroup began discussing potential toolkit components in February 2011. The Intervention workgroup is continuing to develop the toolkit. The toolkit will contain resources regarding organizational assessment, workshops/trainings, ongoing training and ancillary activities (e.g., suggested documentaries). The toolkit will be used in conjunction with the PRIME Steering Team model for reducing infant mortality.
Organization Assessment

In August 2011, the workgroup began discussions with the University of Michigan Health System Program for Multicultural Health staff to draft an organization assessment for the BFMCH. Some assessment categories include: program development, employee engagement, community outreach, monitoring and evaluation, and staff development. Results of the assessment will be used to focus the intervention to address staff needs.

Data

The PRIME project identified the need for more thorough data reporting methods for the Native American community. The PRIME project developed a Native American Ad-Hoc Data workgroup to address this concern. Several Steering Team members, including those from groups representing the Native American community, focused on survey methodology to improve data collection efforts. The PRIME Native American Ad-Hoc Data workgroup decided to use the Pregnancy Risk Assessment Monitoring System (PRAMS) survey instrument and oversample the Native American population of Michigan.

In addition, Health Disparities Reduction and Minority Health (HDRMH) discussed the possibility of oversampling Native Americans in the 2011 Behavioral Risk Factor Surveillance Survey (BRFSS). Two MDCH epidemiologists worked on statistical modeling of Perinatal Periods of Risk (PPOR), Pregnancy Risk Assessment Monitoring System (PRAMS), and Behavioral Risk Factor Surveillance System (BRFSS) data on Native American and African American populations.

The Native American Ad-Hoc Data Workgroup is currently drafting a Native American specific survey. Questions on racism and social determinants of health are being added to the survey. Next steps include the addition of tribal health centers within the communication strategy to aid in data collection.

Communication

MDCH Staff

The PRIME Steering Team has made communication with MDCH staff a priority. The Intervention workgroup regularly provides feedback to both MDCH managers and staff regarding the PRIME project. Within MDCH, the Division of Family and Community Health (DFCH) managers have been primary contacts. As a result of the PRIME communications, the DFCH managers have considered utilizing the Applied Research Center equity assessment as a tool to address racial disparities. The DFCH planned staff meetings to discuss health disparities. Additionally, DFCH created a report of the staff meetings which included discussions on health disparities and the life course perspective. There has been increased communication and awareness among MDCH staff regarding the racial disparities in infant mortality rates as a result of the PRIME project.
Dissemination of Results and Presentations

In December 2010, MDCH issued a press release announcing the grant funding from W.K. Kellogg and the goals and objectives of the project. The release was shared in the Gongwer News Service, The Michigan Chronicle, and the Bureau of Family, Maternal and Child Health Director was interviewed by Central Michigan University’s radio station.

Beginning in May 2011, members of the PRIME Steering Team collaborated with the State’s Infant Mortality Steering Committee to plan the 2011 Michigan Infant Mortality Summit. The purpose of this summit was to disseminate best practices, share assessments, identify strategies and engage community agencies to reduce infant mortality.

During the summer of 2011, the PRIME Local Learning Collaborative (LLC) began to compile information on all of their work in undoing racism and health equity into one document. The LLC shared this information at a preconference session at the Michigan Premier Public Health Conference in October 2011. In addition, the LLC has begun to draft a dissemination plan that will include a web-based component.

2. State Policy and Practices Review

The Intervention workgroup has focused on understanding the current curricula and trainings (national and local) that is available in the areas of racism, health equity and social justice. The group consist of members from Bureau of Family, Maternal and Child Health, Health Disparities Reduction and Minority Health, University of Michigan, and Ingham County Health Department. The group has also engaged in identifying state reports and policy documents to understand the association between state policies & maternal/child health care outcomes.

The list of documents include:

- Michigan Health Equity Roadmap, June, 2010
- Michigan Environmental Justice Plan, December, 2009
- MDCH Strategic Diversity Plan, June, 2010

The Health Disparities Reduction and Minority Health Section is the MDCH lead for monitoring and reporting on the Department’s efforts to eliminate racial and ethnic health disparities per the Michigan Public Act 653. In this capacity, the Health Disparities Reduction and Minority Health Section conducts an annual survey to assess Department activities and effort towards this goal. The 2011 report development is currently underway. PRIME will also assess how this survey and results can assist in efforts to improve health outcomes in Michigan.
3. Collaboration with MDCH Epidemiologists, Local Health Departments & Community-Based Organizations

The PRIME project included collaborative efforts with MDCH epidemiologists to build MDCH’s capacity to assess and monitor infant mortality rates for African Americans and Native Americans. In the project’s first year most of the effort focused on conducting analyses of infant mortality cases for Michigan and Michigan counties using the Perinatal Periods of Risk (PPOR) method. MDCH epidemiologists produced reports with the results of Perinatal Periods of Risk analyses of infant mortality for Michigan and Michigan counties. They also created visual displays and tables of Perinatal Periods of Risk analyses of infant mortality for Michigan and Michigan counties for the MDCH data book.

As mentioned above, PRIME members, MDCH epidemiologists and the Inter-Tribal Council of Michigan are drafting a Pregnancy Risk Assessment Monitoring System (PRAMS) survey specific for Native Americans to be completed in 2012. This approach will use an alternative method to collect data from vital records. An infant will be classified as Native American if the race of the infant, mother or father is recorded as Native American.

In addition to the effort to document infant mortality rates using the PPOR method, the epidemiologists provided assistance to MDCH staff with other study-related activities and pertinent to National Children’s Study Data Core and PRIME. They also contributed to MDCH reports of relevant Maternal and Child Health (MCH) Epidemiology Unit activities (e.g., State Systems Development Initiative, Annual MANCS Report) and made presentations of the National Children’s Study (NCS), in cooperation with the Environmental Division at MDCH. They also helped identify seminal and international work on harmonization of health data and in the area of child health, children health studies (e.g., participated in presentations of the Congress of Epidemiology, Montreal, 2011 - however, at no cost to the NCS/PRIME project).

The epidemiologists also attended events to help generate ideas about improving efforts at MDCH and other state agencies. They represented the PRIME project at MDCH Epidemiology Unit meetings and other epidemiology events to learn from other MCH epidemiologists. They attended the Division of Genomics, Perinatal Health and Chronic Disease Epidemiology staff meetings and the annual Division Day. They also attended Institutional Review Board (IRB), Health Insurance Portability and Accountability Act (HIPAA), Infomatics, Federal Information Security Management Act (FISMA) and other training as required by job duties.

Finally, the epidemiologists engaged in professional development activities. They attended Michigan and national epidemiology seminars, workshops, conferences and other epidemiology and statistics events. They received training in the PPOR framework and methodology as well as in other areas and software (Statistical Analysis System - SAS) pertinent to job duties. And they received training in emerging scientific developments as they relate to NCS and child health to perform NCS and PRIME job duties.
In an effort to share local lessons learned that undo racism and improve infant health, the PRIME Local Learning Collaborative (LLC) was established in March 2011. Representatives from Local Health Departments, Healthy Start Projects and other community organizations that have worked in their local community to address racism, health equity and disparities make up the LLC. The intent of the LLC is to disseminate their experiences with other stakeholders throughout Michigan and seek their involvement in shaping the practices and policies derived from the project.

Twenty three organizations make up the PRIME LLC. Initially, agencies were invited to participate on the LLC and share their undoing racism and health equity efforts based on three factors:

1. Participation in the MDCH 2008 Infant Mortality Summit;
2. Healthy Start Programs; and
3. Presenters at the 2010 MDCH Health Disparities Conference.

After a few meetings, four additional health departments were invited to join based on their communities being a part of the initial eleven targeted Michigan communities with the highest African American infant mortality rates. Several of health departments on the LLC have found it necessary to develop initiatives to combat the racial and ethnic health disparities in infant mortality in their communities including:

- Genesee County Health Department has addressed their disparities in infant mortality through a 3-themed approach (Community Mobilization, Enhancing the Baby care System, and Reducing Racism) within their Racial and Ethnic Approaches to Community Health (REACH 2010/REACH US) program since 1999.
- Kent County Health Department began their work in 2005 and has developed and implemented cultural competency training and toolkits for consumers and providers on responding to racism, including information on organization and self assessments, patient rights and health care standards of culturally appropriate care.
- Ingham County Health Department began to facilitate Health Equity and Social Justice workshops to raise awareness of oppression and privilege based on race, class, gender, and other types of difference, and their impact upon community health in 2005.

Several additional LLC member organizations also strive to reduce infant mortality:

- Saginaw County Department of Public Health Infant Mortality Review since 1991
- Kalamazoo Health and Community Services Healthy Babies Healthy Start since 1997.
- Oakland County Health Division Fetal Infant Mortality Review since 2002.
- Jackson County Prenatal Task Force since 2004.
- Detroit/Wayne County Infant Vitality Network (IVAN) since 2005.
- Berrien County Health Department REACH US grant through Genesee County since 2008.
• Washtenaw County Coalition for Infant Mortality Reduction since 2009.

The Bureau of Family, Maternal and Child Health (BFMCH) Director serves as the co-chair of Michigan’s Partnership to Eliminate Disparities in Infant Mortality (PEDIM) Action Learning Collaborative (ALC), one of five projects nationally. CityMatCH, the Association of Maternal & Child Health Programs, and the National Healthy Start Association created PEDIM, with funding from the W.K. Kellogg Foundation, to eliminate racial inequities contribution to infant mortality within U.S. urban areas. Michigan’s ALC consist of a partnership with Michigan’s six Healthy Start Programs and the Michigan Department of Community Health. Several of the ALC members are also PRIME Steering Team and Local Learning Collaborative (LLC) members. Over an 18 month period, the ALC will work to raise awareness about the prevalence of racism and its impact on the disparity in pregnancy outcomes. The efforts of PEDIM and PRIME will work to reinforce each project.

The PRIME Project Coordinator is a member of the Inter-Tribal Council of Michigan’s Statewide Consortium. The Consortium provides guidance for a five-year Centers for Disease Control and Prevention (CDC) Racial and Ethnic Approaches to Community Health (REACH) CORE initiative to reduce infant mortality among Michigan’s Native Americans. Each of the seven Native Healthy Start projects are engaged in the Mobilizing for Action through Planning and Partnerships (MAPP) process to develop community plans that target policy, systems and environmental change to improve maternal and infant health outcomes within the Native American community.

4. Strategies for Addressing Racial Disparities

Dr. Derek Griffith led a team of researchers and MDCH lead staff in reviewing policy and program practice strategies for addressing health disparities in infant mortality and other health problems. Discussions of policy and program practice strategies occurred at most project Steering Team meetings and at meetings of the Intervention workgroup. A writing team deliberated on these discussions and the result of this review was a draft of a “Green Paper” that represented a variety of perspectives on:

a. Racial health disparities in infant mortality.
b. Social determinants of health shaping patterns and persistence of racial health disparities.
c. The specialized roles and responsibilities of a state health department.
d. Existing training and intervention approaches to address racial disparities in infant mortality.
e. Refined goals for the PRIME project.
f. Specific next steps for creating a new strategy to reduce racial disparities in infant mortality in Michigan.

The Green Paper suggested that the MDCH strategy for reducing racial disparities focus on the three core functions and ten essential services of public health. Within this framework, the authors review a variety of staff training models and training curriculum
resources. The Green Paper also includes a variety of intervention strategies to promote staff capacity development to address racial disparities. Finally the paper included an intervention timeline for the PRIME project including organizational assessment, staff training workshops, and creating specific plans for reviewing and revising policies and practices for MDCH.

5. PRIME Staff Training

A major activity of the PRIME project was public health professional staff training for employees at the Michigan Department of Community Health and for local public health and community partners. There were two large-scale training efforts during the project’s first year:

a. The People’s Institute’s for Survival and Beyond “Undoing Racism” 2-Day Workshops
b. Ingham County’s “Health Equity and Social Justice” 2.5-Day Workshops

Both workshops engaged large numbers of MDCH staff and invited partners from local health departments and community-based agencies. A summary of the evaluation of these trainings is provided here and full evaluation reports are attached in Appendix B and D.

The Undoing Racism workshops engaged 158 participants including administrators, program coordinators, program consultants, and clerical/administrative staff from MDCH and local agencies. Most of the participants worked in two MDCH divisions (Family and Community Health; Health, Wellness, and Disease Control).

The Undoing Racism workshop participants were encouraged to participate in an evaluation study of the workshops. The study participants completed pre-training and post-training surveys that assessed self-rated competencies to define key terms (e.g., institutional racism, internalized racism) and to identify social determinants of health disparities and policies/practices that influence health disparities. The analysis of pre-training and post-training ratings demonstrated statistically significant improvements in all but one of the self-rated competencies.

Open ended questions provided the participants with opportunities to report on their experience of the Undoing Racism workshops suggested that several participants were unhappy with their experience because of the style of workshop facilitation and the specific content of the presentation. Despite these mixed reviews, the majority of participants rated the workshop as “very useful” or “extremely useful.” And 74% of the participants would recommend the Undoing Racism workshops to a colleague without reservations.

A selection of MDCH staff members who attended the Undoing Racism Workshops participated in one of three focus group discussions held a few weeks after the workshops. Each focus group discussed responses to 5 questions:
a. Take two minutes and write down your most memorable moment from the Undoing Racism Workshops. Please note what happened and why you think you remembered it.

b. When you returned to work, did you talk to any of your colleagues about your experience at the Undoing Racism Workshop? What did you talk about?

c. The Undoing Racism Workshop facilitators encouraged each of you to learn about different ways to think about racism including "cultural" racism and "institutional" racism. What do those words mean to you now?

d. What are some examples of policies or practices in your work setting that seem to be related to cultural or institutional racism?

e. Can you imagine ways that policies and practices at your work setting could be changed to reduce cultural or institutional racism?

The focus group participants provided a wide variety of responses to each of the questions. The UM evaluation researchers analyzed and classified meaningful responses into general theme groups. The variety of responses may be indicative of the diversity of perspectives and understandings of racism and its effects on health disparities. The PRIME project staff and partners will study the diversity of perspectives expressed in the Focus Group results to plan future training and staff development activities. The results from this analysis are included in our report on the focus groups in Appendix C.

The Health Equity and Social Justice workshops also engaged 87 MDCH staff and local health professionals. Most of the 74 MDCH employees worked in the Division of Family and Community Health and included administrators, program coordinators, program consultants, and clerical/administrative staff.

The participants completed pre-training and post-training surveys to assess improvements in self-rated competencies related to the workshop’s targeted concepts and skills. We also included content knowledge tests on the pre-training and post-training surveys so we could document improvements in knowledge about important ideas and concepts discussed in the workshops.

The results of analyzing changes from the pre-training to the post-training surveys noted statistically significant improvements in all of the self-rated competencies assessed for this workshop. The participants reported the greatest competency improvements in their abilities to understand levels of oppression, analyze case studies within a health equity and social justice framework, and understanding cultural identity across target and non-target groups.

We also noted statistically significant improvements in specific content knowledge for nearly every content area assessed in the knowledge tests. The participants demonstrated the greatest knowledge gains in the areas of identifying
oppressed target groups, cultural levels of oppression, and interpersonal level of oppression.

Responses to open ended questions noted the variety of experiences the participants found valuable at the workshops including the opportunities to learn new ideas and practice new communication skills. The majority of participants rated the workshop as “very useful” or “extremely useful.” And 83% of the participants would recommend the Health Equity and Social Justice workshops to a colleague without reservations.

6. Survey of Key Stakeholders

As part of evaluating the process of engaging key stakeholders for the PRIME project, we developed an online survey for assessing the primary project partners’ views about the development and implementation of the PRIME project. All members of the PRIME Steering Team will be invited to complete the online survey before a day-long retreat at the start of the second project year. The results of the survey will help focus a discussion about how the PRIME project can be improved.

7. Assessing the Use of a Tool Kit and Curriculum

We plan to assess the use of all PRIME project products by other state and local health departments, but the PRIME Tool Kit and Curriculum have not yet been developed. We anticipate that these projects will be ready for distribution by the end of the third project year.

8. Assessment of New Knowledge Acquired

We utilized a method for assessing knowledge acquired at the Health Equity and Social Justice workshops (described above). Participants showed statistically significant (p < 0.001) increases in knowledge for 8 of 12 content knowledge questions (see Table 1). Significant increases in knowledge were not seen on questions regarding unearned privilege, the social justice framework, differentiating health equity and health disparities, and defining racism at the institutional level. Pre-test scores ranged from 7.2% to 81.2%, with post-test scores ranging 44.9% to 97.1%.

9. Monitoring Social Determinants of Health Disparities

Another goal of the PRIME project is to improve and expand the monitoring of social determinants of health disparities with MDCH. The MDCH epidemiologists (Dr. Viola Grigotescu and Dr. Marina Kleinhapel) conducted a comprehensive set of analyses with Michigan birth records using the Perinatal Periods of Risk (PPOR) methods to help discern causes of infant mortality for African Americans and Native Americans in Michigan. Drs. Grigorescu and Kleinhapel completed analyses for the entire State of Michigan and for specific counties (or groups of counties) where relatively large numbers of African Americans and Native Americans lived.

We also engaged in two extended meetings with MDCH who use the Pregnancy Risk Assessment Monitoring System (PRAMS), developed by CDC, in order to identify other
sources of data that could be used for monitoring social determinants of health that are not available on the birth record. Topics addressed in the PRAMS core questionnaire include barriers to and content of prenatal care, obstetric history, maternal use of alcohol and cigarettes, physical abuse, contraception, economic status, maternal stress, and early infant development and health status. Some standard questions provide additional information on topics already addressed in the core questionnaire, including content of prenatal care, contraception, and physical abuse. Other standard questions address different topics, including social support and services, mental health, and injury prevention.¹

We will continue to discuss issues associated with using the PRAMS for monitoring social determinants as well as other methods in the project’s second year. As mentioned earlier in this report, MDCH is currently drafting a PRAMS Native American specific survey. Questions on racism and social determinants of health are being added to the survey.

During Michigan’s 2011 Infant Mortality Summit, there was a focus on social determinants and contributing factors for infant mortality. The action plan that is being derived from the summit will include an emphasis on social determinants across all activities in the work plan.

Finally, a Lifecourse Workgroup (within the Division of Family and Community Health) is engaged in prioritizing which social determinants of health to monitor in their efforts to reduce disparities in health outcomes. Currently, the workgroup is reviewing the health equity data set developed by the Health Disparities Reduction and Minority Health section and the information included in the Health Equity and Social Justice workshop on root causes of health inequities to determine the social determinants to measure.

10. Annual Assessments of MDCH Efforts to Reduce Racial Disparities.

We developed a method to ask MDCH administrative staff and program coordinators to report on their intentional efforts to review and modify policies and practices that could address social determinants of health disparities. At this point the methods include open ended questions on a survey form. The MDCH administrative staff and program coordinators completed this assessment at the start of the second year. Our analyses of responses to these open ended questions will help us identify different types of policies and practices that MDCH staff believe can effectively address social determinants of health. These analyses will be completed in early 2012 and will be used to refine project plans in 2012 and beyond. We plan to conduct a similar survey in September, 2012 to assess policy and procedural changes in MDCH.

¹ From CDC website: http://www.cdc.gov/prams/methodology.htm
Table I. Improvements in Knowledge at the Health Equity and Social Justice Workshops.

*Please circle True or False or Not Sure for the following statements.*

<table>
<thead>
<tr>
<th>Knowledge Question</th>
<th>Correct Answer</th>
<th>n</th>
<th>Pretest</th>
<th>Posttest</th>
<th>p-value</th>
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</thead>
<tbody>
<tr>
<td>1. Men are the “non-target” group for identifying gender oppression and privilege.</td>
<td>True</td>
<td>80</td>
<td>28.8%</td>
<td>83.3%</td>
<td>&lt;.001</td>
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<td>2. The experience of oppression and privilege can change frequently based on our target and non-target group identities.</td>
<td>True</td>
<td>81</td>
<td>64.7%</td>
<td>92.6%</td>
<td>&lt;.001</td>
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<td>3. Nearly everyone experiences some form of unearned privilege, regardless of how hard they work to achieve success.</td>
<td>True</td>
<td>81</td>
<td>60.3%</td>
<td>69.1%</td>
<td>.327</td>
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<td>4. One way health departments can address the social determinants of health is by promoting healthier eating habits.</td>
<td>False</td>
<td>81</td>
<td>38.8%</td>
<td>64.2%</td>
<td>&lt;.001</td>
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<tr>
<td>5. The field of public health developed in response to social injustice brought about by the industrial revolution.</td>
<td>True</td>
<td>82</td>
<td>33.8%</td>
<td>82.4%</td>
<td>&lt;.001</td>
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<tr>
<td>6. The social justice framework for public health practice suggests that health problems are primarily caused by lower-income individuals making bad health choices.</td>
<td>False</td>
<td>81</td>
<td>76.5%</td>
<td>88.2%</td>
<td>.077</td>
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<td>7. The social justice movement in public health is an attempt to shift focus from health inequities to health disparities.</td>
<td>False</td>
<td>81</td>
<td>43.3%</td>
<td>76.1%</td>
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<td>8. The term “health disparities” refers to the underlying causes of “health inequity.”</td>
<td>False</td>
<td>82</td>
<td>27.5%</td>
<td>44.9%</td>
<td>.017</td>
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<td>9. Thoughts, beliefs, and values held by an individual are examples of the cultural level of oppression and change.</td>
<td>False</td>
<td>81</td>
<td>21.2%</td>
<td>69.7%</td>
<td>&lt;.001</td>
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<td>10. The institutional level of oppression involves rules, policies, and practices that advantage one cultural group over another.</td>
<td>True</td>
<td>82</td>
<td>81.2%</td>
<td>97.1%</td>
<td>.007</td>
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<td>11. The personal level of oppression involves actions, behaviors, and language.</td>
<td>False</td>
<td>82</td>
<td>7.2%</td>
<td>49.3%</td>
<td>&lt;.001</td>
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<td>12. Eliminating interpersonal level oppression involves change in community norms and media messages that reinforce stigma and negative stereotypes.</td>
<td>False</td>
<td>81</td>
<td>10.3%</td>
<td>64.7%</td>
<td>&lt;.001</td>
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Appendices
Appendix A: PRIME Steering Team and Workgroups, Operating Values and Decision Making, and Local Learning Collaborative Roster
<table>
<thead>
<tr>
<th>NAME</th>
<th>TELEPHONE #</th>
<th>WORKGROUP</th>
<th>ORGANIZATION</th>
<th>EMAIL ADDRESS</th>
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<td>Alethia Carr</td>
<td>517/335-8922</td>
<td>Intervention/Local Collaborative</td>
<td>MDCH – BFMC</td>
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<td>Carol Ogan</td>
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<tr>
<td></td>
<td>517/241-7186</td>
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<td></td>
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<tr>
<td>Brenda Fink</td>
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<td></td>
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<td>MDCH – DFCH</td>
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<td>Diane Hennessey, Sec’y</td>
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<td></td>
<td><a href="mailto:henneseyd@michigan.gov">henneseyd@michigan.gov</a></td>
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<td>Brenda Jegede, Proj. Coor.</td>
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<td>Disparities</td>
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<td>Holly Nickel</td>
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<td>Virginia Ganzevoort,</td>
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<td><a href="mailto:mhammami@co.wayne.mi.us">mhammami@co.wayne.mi.us</a></td>
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Operating Values

Mutual Respect
Accept and value differences within the steering team. Respect the expertise and contribution of all members towards the project goals. Communicate openly, respectfully and honestly.

Integrity
Adhere in our behavior to the highest ethical and legal standards. Take responsibility and ownership for our actions and behaviors.

Inclusion
Maintain an atmosphere of open communication. Promote active participation in the decision-making process by all.

Excellence
Support and advance the principles of public health and attain the highest quality outcomes in our efforts. Respond with efficiency and effectiveness.

Learning
Expand our skills and knowledge in ways that contribute to our growth. Accept feedback as an opportunity to learn.

Creativity
Encourage innovative thinking and support creative approaches to problem solving. Demonstrate openness to different perspectives.

Accountability
Deliver work that is research-based to the extent possible: including information, materials and programs that are developed, disseminated and evaluated. Establish measurable outcomes.

Cultural Competency
Strive for cultural competency among all steering team members and partners related to the populations we strive to impact.

Partnering
Work with others to enhance effectiveness and to leverage resources.
Steering Team Responsibilities and Expectations

1. Provide leadership and guidance to the overall goals, objectives, and evaluation of the project. Review information and provide feedback and direction on the planning activities.

2. Attend steering team meetings. Prepare for active participation in discussions and decision-making by reviewing meeting materials.

3. Serve on work groups as needed to contribute expertise towards the project goals, objectives, and evaluation.

4. Workgroup chairs will communicate any action points, decisions and final work products to the entire steering team within a reasonable period. Minutes will be prepared and forwarded to steering team members in advance of the next meeting.
   a. Workgroups will be given a specified charge and period of time to fulfill that charge, and will present a final report or recommendations to the steering team for approval at completion of its charge.
   b. The chair may ask persons who are not members of the steering team to serve on workgroups as necessary to fulfill the goals of the project.

5. The Steering Team will review requests to disseminate information about the project and make recommendations to the Michigan Department of Community Health to support or deny requests.

The Michigan Department of Community Health, as the grantee, shall utilize discretion when necessary to employ other methods, such as forming short-term informational groups; convening focus groups; or inviting people to join the steering team or workgroups to accomplish the goals and objectives of the project.
Roles & Contractual Responsibilities

**Michigan Department of Community Health**
Oversight and grant management; Data analysis; expertise in program development, implementation, monitoring and program evaluation.

**University of Michigan School of Public Health**
Evaluation – direct all aspects of the process and outcome evaluation.

Consultation – subject matter experts for the project; direct all aspects of the policy, program and organizational culture assessment; recommend the design and content of the curriculum and assist with the implementation of training; author the green paper and white paper.

**Local Health Departments & Community Partners**
Provide leadership and expertise on effective initiatives addressing racism and mechanisms for involving stakeholders in policy decisions. Facilitate training and evaluation at the local level. Provide local perspective on issues.

**Training Consultant (TBD)**
Train MCH staff using the curriculum that is developed and provide consultation as agreed in the contract.
Disclosure of Conflicts

Members agree to disclose any actual or potential conflict of interests to the Steering Team as they arise or are identified. The Steering Team will evaluate all disclosures and will determine whether further management or elimination of the conflict is required. If required, the Steering Team will develop a plan of action.

Whenever the Michigan Department of Community Health, on behalf of the Steering Team, may purchase from, sell to, borrow from, contract with or otherwise deal with any organization in which any Steering Team member might benefit or is in any way interested or involved, such interest or involvement shall be disclosed in advance to the Steering Team and recorded in the minutes.

Steering Team members with knowledge of a conflict of interest shall be required to disclose the fact that his/her organization has competed or intends to compete for a grant or contract which the Steering Team is also seeking to obtain.

Conflict of Interest – a potential conflict of interest exists whenever personal, professional, commercial or financial interests or activities have the possibility (either in actuality or in appearance) of 1) compromising a member’s judgment; 2) biasing the nature or direction of the project; 3) resulting in a personal or family member’s (spouse, domestic partners and dependents) gain or advancement at the expense of the project.

Conflict of Commitment – a potential conflict of commitment exists when a member’s external relationships or activities have the possibility (either in actuality or in appearance) of interfering or competing with the project’s goals and objectives or with that member’s ability or willingness to perform the full range of responsibilities associated with his or her involvement with the Steering Team.
Consensus Decision Making

Consensus Decision Making strives to take into account everyone’s concerns and resolve them before any decision is made. Encourages an environment in which everyone is respected and all contributions are valued. When concerns remain after discussion, members can agree to disagree by acknowledging that they have unresolved concerns, but consent to the proposed item and allow it to be adopted. All concerns will be recorded in the minutes.

The chair will assure full debate on divisive issues and seek compromises. It is the Chairperson’s responsibility to assure that department goals and priorities are kept in mind during policy debates.

Opportunities to Use Consensus Decision Making:

1. Final Training Curriculum
2. Process to engage local agencies and share their work
3. Toolkit components
4. Green/white papers
5. Other papers/information produced from the project
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<td>ACCESS</td>
<td><a href="mailto:msaid@accesscommunity.org">msaid@accesscommunity.org</a></td>
<td>313/216-2200</td>
<td>6450 Maple St. Dearborn, MI 48126</td>
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<td>Gillian Conrad</td>
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<td><a href="mailto:gconrad@bchdmi.org">gconrad@bchdmi.org</a></td>
<td>269/926-7121 x5249</td>
<td>769 Pipestone, P.O. Box 706 Benton Harbor, MI 49023</td>
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<tr>
<td>Carolyn Rowland</td>
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<td><a href="mailto:rowlandc@detroitmi.gov">rowlandc@detroitmi.gov</a></td>
<td>313/876-4161</td>
<td>Detroit Dept of Health &amp; Wellness Program 1151 Taylor, Bldg. 6 Detroit, MI 48202</td>
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<td>Hannalori Bates Frick</td>
<td>Dispute Resolution Center</td>
<td><a href="mailto:batehs@slu.edu">batehs@slu.edu</a></td>
<td>248/320-3578</td>
<td>110 North Fourth Avenue, Suite 100 Ann Arbor, MI 48104</td>
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<td>810/257-3202</td>
<td>McCree Courts &amp; Human Services Bldg. 630 S. Saginaw St. Flint, MI 48502-1540</td>
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<td>Genesee Co. Health Dept. 630 S. Saginaw St. Flint, MI 48502</td>
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<td>616/331-5838</td>
<td>Cook-DeVoss Ctr for Health Sciences 301 Michigan. NE, Suite 400 Grand Rapids, MI 49503</td>
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<td>616/331-5831</td>
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<td>1169 Oak Valley Dr. Ann Arbor, MI 48108</td>
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<td>734/544-3058</td>
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## PRIME Annual Evaluation Report

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Appendix B: Undoing Racism Workshop Evaluation Report
Analysis of Undoing Racism Workshop Evaluation Surveys

Thomas M. Reischl, PhD

Allison Krusky, MPH

June 27 2011

Workshop Date

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The Undoing Racism workshop was attended by 158 participants, of which 17 were from partner community organizations. There were 152 returned evaluation forms. There were three Undoing Racism workshops; each lasting 2 days.

13. What is your job title?  

(Check one answer.)

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</tr>
</tbody>
</table>
Most program attendees identified themselves as either a Program Coordinator/Specialist or Program Consultant. The remaining participants were either Administration/Management, or Clerical/Administrative Support; with a small portion selecting the Other category.

14. What Division/Section do you work in? (Check one answer.)

<table>
<thead>
<tr>
<th>Main Division</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Valid</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Division of Family &amp; Community Health</td>
<td>52</td>
<td>34.2</td>
<td>37.7</td>
<td>37.7</td>
</tr>
<tr>
<td>Division of Health Wellness and Disease Control</td>
<td>75</td>
<td>49.3</td>
<td>54.3</td>
<td>92.0</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>7.2</td>
<td>8.0</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>138</td>
<td>90.8</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td><strong>Missing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>System</td>
<td>14</td>
<td>9.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>152</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Half of participants were from the Division of Family and Community Health, with a slightly smaller proportion from the Division of Health Wellness and Disease Control.

<table>
<thead>
<tr>
<th>Section</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Valid</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Disparities Reduction and Minority Health</td>
<td>13</td>
<td>8.6</td>
<td>14.6</td>
<td>14.6</td>
</tr>
<tr>
<td>HIV/AIDS Prevention and Intervention Section</td>
<td>21</td>
<td>13.8</td>
<td>23.6</td>
<td>38.2</td>
</tr>
<tr>
<td>Sexually Transmitted Diseases Section</td>
<td>33</td>
<td>21.7</td>
<td>37.1</td>
<td>75.3</td>
</tr>
<tr>
<td>Women, Infant &amp; Family Section</td>
<td>12</td>
<td>7.9</td>
<td>13.5</td>
<td>88.8</td>
</tr>
<tr>
<td>Child &amp; Adolescent Health Section</td>
<td>10</td>
<td>6.6</td>
<td>11.2</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>89</td>
<td>58.6</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td><strong>Missing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>System</td>
<td>63</td>
<td>41.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>Frequency</td>
<td>Percent</td>
<td>Valid Percent</td>
<td>Cumulative Percent</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------</td>
<td>---------</td>
<td>---------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Valid Health Disparities Reduction and Minority Health</td>
<td>13</td>
<td>8.6</td>
<td>14.6</td>
<td>14.6</td>
</tr>
<tr>
<td>HIV/AIDS Prevention and Intervention Section</td>
<td>21</td>
<td>13.8</td>
<td>23.6</td>
<td>38.2</td>
</tr>
<tr>
<td>Sexually Transmitted Diseases Section</td>
<td>33</td>
<td>21.7</td>
<td>37.1</td>
<td>75.3</td>
</tr>
<tr>
<td>Women, Infant &amp; Family Section</td>
<td>12</td>
<td>7.9</td>
<td>13.5</td>
<td>88.8</td>
</tr>
<tr>
<td>Child &amp; Adolescent Health Section</td>
<td>10</td>
<td>6.6</td>
<td>11.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>89</td>
<td>58.6</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing System</td>
<td>63</td>
<td>41.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MDCH participants were spread over 5 work sections, with most employed in the Sexually Transmitted Diseases Section or the HIV/AIDS Prevention and Intervention Section. The remaining participants were housed within the Women, Infant and Family Section, Child and Adolescent Health Section and the Health Disparities Reduction and Minority Health.

15. Are you a person of Hispanic, Latino, or Spanish origin? *(Check one answer.)*

<table>
<thead>
<tr>
<th>Hispanic</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>138</td>
<td>90.8</td>
<td>95.8</td>
<td>95.8</td>
</tr>
<tr>
<td>Yes</td>
<td>6</td>
<td>3.9</td>
<td>4.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>144</td>
<td>94.7</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>System</td>
<td>8</td>
<td>5.3</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Almost all participants were non-Hispanic.

16. What is your race? *(Check all that apply)*

<table>
<thead>
<tr>
<th>Race</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arabic</td>
<td>3</td>
<td>2.0</td>
<td>2.1</td>
<td>2.1</td>
</tr>
<tr>
<td>White</td>
<td>87</td>
<td>57.2</td>
<td>60.8</td>
<td>62.9</td>
</tr>
<tr>
<td>Black or African</td>
<td>43</td>
<td>28.3</td>
<td>30.1</td>
<td>93.0</td>
</tr>
<tr>
<td>American</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>3</td>
<td>2.0</td>
<td>2.1</td>
<td>95.1</td>
</tr>
<tr>
<td>Arabic and White</td>
<td>2</td>
<td>1.3</td>
<td>1.4</td>
<td>96.5</td>
</tr>
<tr>
<td>Black/AA and AIAN</td>
<td>1</td>
<td>.7</td>
<td>.7</td>
<td>97.2</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3</td>
<td>2.0</td>
<td>2.1</td>
<td>99.3</td>
</tr>
<tr>
<td>Hispanic and AIAN</td>
<td>1</td>
<td>.7</td>
<td>.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>143</td>
<td>94.1</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>System</td>
<td>9</td>
<td>5.9</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The majority of MDCH participants were White (61%), with Black/African American (30%) as the next largest group. A select few identified themselves as Asian, American Indian, Arab, or multi-racial.
17. Please list your previous training on health disparities, undoing racism, and health equity:

(51 of 163 training participants did not list previous training)

**Workshops/Trainings/Conferences/Presentations**

- Healing Racism Institute (3 days)
  Calhoun City, Cultural Competence
  CDC, Cultural Competence
  Philadelphia/Kent City

- Ingham County Health Department
  social justice training

- Attended health disparities conference and workshops.

- Family and Community Health Division meeting

- Undoing Racism Workshop Flint MI,
  Health Disparities conference, Program
  Coordination - Health Disparities

- Attended MDCH Health Disparities
  conference in Nov. 2010

- Update conference Ypsilanti Nov. 2010,
  Civil right work 1968, Member activist
  SDS White/Black Panther parties,
  Organizer ML King Day 2003-2007
  MDCH

- Workshop at the STD/HIV Health
  Disparities conference

- Dr. Lee - MSU, Detroit 2009 a g
  (Diversity training), 2009 cultural
  competency etc- Do Renee Canady

- Health Disparities conference x 2,
  Training at Bureau level, Training at
  Division level

- Undoing Racism, Middle Passage,
  Institutes for Healing Racism, Visions
  Inc., Ingham County Social Justice
  workshops

- Disparities training yearly, Diversity
  training

- Health Disparities conference 2008,
  Annual HIV/STD conference 2008,
  2009, 2010

- Training at the Couidance Center in
  health disparities in the Native
  American/African American
  communities. Training at affirmations
  sensitivity training for working with
  LBGQT community.

- Diversity training, Health Disparities
  conference

- Division training on diversity and racism
  this past two years (Dr. Lee from MSU).
  16 years in HIV and substance abuse
  with multiple trainings/workshops in
  cultural competency, diversity and race
  as it applies to public health services.

- MDCH online trainings, MDE-MEAP-
  unbiased type test writing

- A myriad of trainings over a 26 year
  career.

- MDCH training (3)

- Division meetings with these topics as
  the focus

- ICHD- Health Equity- Social justice

- Participated in Ingham County Health Department's Health Equity Circle Training (4 days), participated in MDCH Chronic Disease and Injury Control Division's sponsored trainings including viewing the "Unnatural Causes" video series

- Trainings at National Health Start Association Spring Conference. MDCH- Infant Mortality Summit ~2007/08. Trainings by Dr. Renee Canady. Breakout sessions by Dr. Lee

- Healing Racism- People’s Institute. Crossroads- Healing Racism

- Poverty Summit, online surveys @ MDCH, Ruby Payne's Bridges out of Poverty

- Unsure- I have participated in several one day trainings on these issues. Unnatural causes video.

- Dr. Lee- MSU, Unnatural causes video- 2008

- Racism and workplace- Indiana (1999), Disparities- Dr. Lee- MSU (2009), Unnatural Causes- MDCH (2008)

- A couple programs offered by MDCH

- Capacity building training with MDCH

- No formal training. Attended many presentations and workshops, including HD Summit and conferences

- Annual diversity trainings

- Presentations at Division meetings, e.g. Strategic planning meetings

- 2008- Video on pregnancy care/outcomes (Unnatural Causes). 2010- Dr. Lee- MSU

- Growing allies facilitator (U of M), School of social work classes/workshops (U of M), Ingham County Health Dept Social Justice and Health Equity training (4 days)

- Have attended several other workshops/division meetings

- Blueprint Task Force 2000 (Access and Equity)

- Yearly for MDCH

- I have worked with the Ingham County Health Dept social justice program for 6 years

- Health Inequity Workshop, Inc. Co.

- Former Undoing Racism training w/ Michigan Dept of Civil Rights

- No specific trainings focused on these topics, however many intervention trainings include discussion of them- also many conference workshops and independent reading

- Attendee at several workshops on racial disparities, cultural competence, have engaged speakers on racial disparities at trainings for which I have oversight and planning responsibility.

- Trainings held with MDCH- Health disparities section, during my work @ HFHS, and trainings with Senior Services- Seattle, WA.
PRIME Annual Evaluation Report

- Presentation given by Bureau Director at
- Health Disparities Meeting (2)
- Health Equity
- Cultural Comp. workshops, Health Disparity trainings, underserved populations
- Health disparities summit, basic racism training thru MDCH, health equity language seminars
- HIV, EPI/CDC (2)
- Many, don't recall titles, ~5
- Various breakout sessions on disparities and social determinants of health through CDC. Viewed Unnatural Causes series.
- Attended Michigan Dept. of Community Health- Health Disparities Reduction and Minority Health's workshops as a capacity building grantee, diversity workshops at community mediation center, and academic courses for MPH degree.
- I have attended other trainings, but I can't remember the names (sorry). Watched Unnatural Causes with a group and discussed. Attended a day-long session as part of a requirement for a Kellogg grant.
- I have had many: 2001- @Kalamazoo Co (H.D.), 2006-@ Kalamazoo Co. HD, 2009- Health Disparities Conference, 2010- Value in Diversity Training, 2011- Value in Diversity Training, there is more...
- Training through DCH Division meeting, Diversity classes through LCC, Currently: Sociology class at LCC
- I have attended several workshops on diversity and health disparity conferences
- Trainings thru Division (speaker from MSU), Unnatural causes, training about poverty (role assignments, "visit" agencies), other 'cultural competence' training over past 15-20 years
- I have conducted, facilitated and educated courses, workshops on race, privilege and oppression
- Introductory to all
- Had some talks at work about the issue
- Books/Video
  - Seen video of Unnatural Causes
- Just readings
- Formal Education
  - Various on-line courses on health disparities
  - MPH in Health Behavior and Health Education at University of Michigan. Completed substantial coursework toward the specialization in Health Disparities by Race, Class and Gender.
  - Training within coursework for BSW and MSW degrees
  - University classes
  - None, college courses
- UMN Social and environmental justice within coursework, addressed health disparities, etc.
## Pretest and Posttest Self-Rated Competencies

*How much do you agree or disagree with the following statements about your level of confidence in successfully conducting these specific tasks?*

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Pretest</th>
<th>Posttest</th>
<th>Paired t-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am confident I can...</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1= <em>Strongly Disagree</em> to 5= <em>Strongly Agree</em>)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Articulate an understanding of <em>racial prejudice.</em></td>
<td>3.97</td>
<td>4.42</td>
<td>7.57*</td>
</tr>
<tr>
<td>19. Articulate an understanding of <em>racism.</em></td>
<td>3.98</td>
<td>4.46</td>
<td>7.82*</td>
</tr>
<tr>
<td>20. Explain racial privilege and power in the United States.</td>
<td>3.76</td>
<td>4.51</td>
<td>11.20*</td>
</tr>
<tr>
<td>21. Define <em>institutional racism.</em></td>
<td>3.63</td>
<td>4.46</td>
<td>11.76*</td>
</tr>
<tr>
<td>22. Define <em>cultural racism.</em></td>
<td>3.60</td>
<td>4.29</td>
<td>9.65*</td>
</tr>
<tr>
<td>23. Identify institutional norms and accepted practices that adversely affect minority race groups.</td>
<td>3.51</td>
<td>4.33</td>
<td>11.41*</td>
</tr>
<tr>
<td>24. Define <em>internalized racism.</em></td>
<td>3.55</td>
<td>4.41</td>
<td>12.23*</td>
</tr>
<tr>
<td>25. Define racial <em>health disparity.</em></td>
<td>3.88</td>
<td>4.40</td>
<td>8.09*</td>
</tr>
<tr>
<td>26. Identify and explain <em>social determinants</em> of racial health disparities.</td>
<td>3.56</td>
<td>4.35</td>
<td>9.62*</td>
</tr>
<tr>
<td>27. Identify policies and practices in the Michigan Department of Community Health that address racial health disparities.</td>
<td>3.15</td>
<td>3.38</td>
<td>2.52</td>
</tr>
<tr>
<td>28. Identify policies and practices that provide guidance in my job duties and that may influence racial health disparities.</td>
<td>3.19</td>
<td>3.55</td>
<td>3.99*</td>
</tr>
</tbody>
</table>

*p < .001
Among Undoing Racism MDCH participants almost all of the self-rated competencies had statistically significant increases. These competencies included increases in understanding of racism, ability to define terminology, and identification of racism practices. Only one competency did not have a significant increase. This competency regarded the identification of policies and practices within MDCH that address racial health disparities.

Workshop Evaluation Questions

12. (part a): In what ways will this workshop help you better address racial health disparities at your job?

Summary: Most respondents reported that this workshop helped them to become more aware and better understand racial disparities. Respondents reported that they would take this knowledge and try to better understand how their position was related to racial disparities. Several respondents indicated that increased communication with community partners and coworkers addressing racial disparities as a method for addressing the issue at their job.

(30 responses)

- More focus on disparities

Increase reports with racial/ethnic outcomes.

As I address child, oral, and adolescent health - disparities will be key focal points.

Identify policies that help 1) Mission statement 2) Strategic Plan and indicators listed. PA 653 that we make a report to legislature every year. MHAC priority populations via needs assessments part of mission statement to (serve all races).

Needs to have continual work and support.

- Greater understanding

Help me be more willing to accept there are racial health disparities because I did not understand previously.

I know that there are social determinants behind racial health disparities that are critical.

Where ever possible UNDO racism

To begin to articulate how social determinants and racial health disparities go together

First, identify contributor to health disparities

Continue to look at how institutions contribute to the disparities
To better understand the problem.

Better understanding of history.

Keep learning and sharing the correct history.

By providing a history of racism

History of racism and how institutions have created and sustained racism in the US.

Understanding white privilege, listening and trying to change policies that promote racism

It will help me understand the distrust of the institution, even though I feel I am helping.

Examining the use of a food ID and social determinant of health to better understand how these can influence services and practices

Better understanding of impact and issue

- **Improve interactions with others**

Help me to identify influence and how the affect interaction with co-workers and clients.

Communicating with colleagues. Listen and encouraging clients to stand for what they believe and don't be afraid to ask question and speak up

Being more aware of the information that was given will help me in talking to physicians about it.

Will help me look more critically at how we go about building relationships with the communities we work with.

- **Other responses**

If activities are put in place and activated by all.

Great workshop.

Will ask powerful questions. Haven't started yet.

Unknown at this time

I don't have direct involvement but can question results

How we/I employ people.
12 (part b): Please list your ideas of what you could do or would like to do in your job that is different from what you are currently doing.

Summary: The most commonly reported change in work practices regarded including the community within the decision-making process and increased collaboration. Many reported a desire to address racial disparities by making changes in their work practices. Some reported confusion over how to apply what they learned in the workshop to their job. Responses focused on finding the causes of disparities and addressing them by using tools learned in the workshop or through collaboration with colleagues/the community.

(101 responses)

- More inclusive practices (community)

ID approach to issues by getting guidance from the clients we serve. ID the strengths of the population services.

I don't work directly with people but would like to see more community involvement on the advisor groups that I serve on.

More strategic/big picture thinking inclusion of more stakeholders.

Listen to the Wayne Co. community to address our problems in outcomes of infants.

Ask for data (racial/ethnic). Seek ways to gather consumer/community input.

need to get into communities. Need forces to come together. See broader than just programmatic.

Invite more members of the community to advisory meetings to get their voice, look more at cultural competences and health literacy.

I think that this workshop has encouraged me to work with people on a community level- this could be more included in our website.

I would like more community planning work. However, you can't give power to a community without support admin. and knowledge that the communities decision are accepted and supported.

Reach out more to the communities we are trying to serve, seek their involvement in program activities.

I will discontinue prejudging my clients.

No judgment.

Change curriculum or revisit how we instruct information. Have hard conversations with co-workers, friends, self, and family.

Have more contributions with CBO and our Gatekeepers.

I would like to have more inter-action with the community we serve.

Continue our work to ensure that all decisions are made after community input has been facilitated. Expand the HIV prevention community planning process to [unreadable] core services,
STD funding and treatment and viral hepatitis to fully implement the founding principles of community planning. Begin a discussion group to continue to learn and apply structural analysis to our work.

Respect each other’s diversities.

Advocacy for community partnership and empowerment of community members for programming decisions rather than the top-down logic currently in place. Identification of social determinants of inequity as being caused by institutional inequities.

Work diligently to serve my community from the blue perspective, not the red. Remember and act on the fact that I can be an agent of change in my institution and personal life. Work to change or create policies at work that will support, not maintain disparities. Think outside the box.

Use the concepts in the power analysis to create more effective community action teams when doing community developing around infant mortality

To go into every community- everytime and operated without preconceived notions- that’s the only way to be truly effective

Reinforces need to continue to engage the community in program decisions. Reinvigorate exploration of ways to use program funds to address structural/root causes and social determinants to prevent disease

More thought into how we work with local communities in order to be more accountable

Explore systems to better include input and participation from communities.

Expand existing efforts. Move beyond data. Engage nontraditional partners that hold the keys to power in other sectors- and address health disparities through metaleadership approach

Engage community members as advisory members/focus groups

Get communities and the population I work with in my program to participate in how it should be run, coordinated, and/or developed.

Commit to more meaningful involvement of or with our community advisory boards and organizations.

- Improve direct services

Treat folk as individuals.

Empower the community we serve.

Increase community satisfaction surveys.

I believe this workshop will aide in giving better services to clients.

Educate more of the community.

Know how to help residents self help (strengthen) to address diseases in their neighborhood.

I now know that we have both positive and negatives forms of prejudice and that prejudice is something that we all have. Therefore, I will do a better job of not judging the clients negatively when I encounter I will try to focus on the "blue"
part. I will be an active listener and be present, not having/holding internal discussions on my head while someone is trying to talk with/to me.

Staff training, assessment paves analysis of current programs, discussion re: empowerment, removing power from our clients with institutional driven programs

Pay attention to my community of people I serve to find out what barriers they are experience in their lack of follow-up to see that their children's hearing is okay. Then try to remove or mitigate those barriers so they will get their services [?] in a timely manner.

I am the EEO Officer in the department. This information assists me in my role as the EEO Officer with the discrimination and discriminatory harassments complaints. As well as understand the workforce statistics.

- More focus on disparities

Annual review of dates and program accomplishments. Ensure family and programs reach racial and ethnic group - at the risk of by passing traditional institutions

This has increased my understanding of racism and its effect on the disparities. Will try to "look at things outside of the white culture."

Keep data current on race/ethnicity. Encourage more community involvement when addressing programs for populations.

Think about and discuss institutional racism inherent in the services we fund and how we define the parameters of the services- consider racism in how we award those funds

Policy and systems change to reduce health disparities and eliminate racism on all levels. Improve the health outcomes of minorities in the US

Participate in more outreach and education on health and racial disparities

MDCH Division of Wellness should institute and require its staff to continue discussing how they can undo racism in health disparities. Also evaluate how MDCH Division of Health and Wellness has made a change in undo racism or eliminating health disparities

Help getting better care for African Americans by understanding their barriers

- Discuss ideas with coworkers

It's opened questions that I previously didn't even consider - the realm of not knowing what I didn't know is a door that's opened - I also have great colleagues to discuss this with that I didn't know I had before.

Work with local providers and have dialogue.

Speak up more honestly and freely about when either a co-worker or myself is not being treated fairly.

I can make suggestions to those in authority. My job is secretarial so I feel this is one way to begin.

1. I can use the tool/skill of contracts to improve communication and relationships. 2) I can use tool/skill #5 to operate from the "blue" list as opposed
to the "red" to improve my performance. 3) I can research the history presented to learn more.

Encourage other staff members more (refer them to trainings) to under the true underlying causes of health disparities/SDDH

- **New ways of thinking about my job**

It has given me another vocabulary.

Better understanding history behind standards and policies I use daily.

Look at the bigger picture and think outside of the box.

I am able to look at clients in a different light. I can see things as they are and recognize the possible reasons why.

I would like to see the box with race labels removed from the form (some that don't deal with helping disparities) - so we are all treated as people - not races. Get feedback from people in communities about their needs as they see them from inside the community.

Increase awareness of how white individualism focus contributes to white superiority. [Unreadable] awareness of need to be vigilant of how internalized inferiority (among People of Color) and internalized superiority (among Whites) can influence interactions.

Re-examine my program operations to identify racial disparities

By giving me a context of history/institution from which to operate, how I contribute to the history/institution to uphold racism and now that I have a context and knowledge from which to work I can try to do my work differently.

Work on life course perspective ideas in our work.

I will use some of the skills - i.e. group rules, think outside of box red vs. blue poverty [unreadable] especially in thinking about reports.

Create policies which empower people of color. Educated colleagues about institutional racism and urge them to incorporate this knowledge in their own jobs.

- **Improve communication/understanding**

Mainly, I hope this will allows us to work with a better understanding of who each of us is without judgment

Increased awareness, increased two way communications, make sure the people served have a voice in the provision of those services

Gave me more language in which to engage co-workers and community members

Discuss racism and root causes with constituents, (consumers) and partners. Spend more time working in and listening to communities. Participation in this workshop/dialogue should be required of my publically elected official!

1. Have more communication with internal and external partners. 2. Agree on a contract to address issues, 3. Solidify buyin among partners, 4. Ensure accountability of outcomes.

Identify personal biases.
• **Continue current practices**

This workshop has provided some refreshment of ideas and information that I already utilize and practice, and will serve as a good reminder for how best to work in the community.

I can speak more honestly and freely with people in my work and personal life about race and racism.

My program serves all Michigan children—not certain populations, races, or income levels. So, I am not sure that I would change anything.

• **Review current practices**

Review existing programs, initiate policy review of programs

MIHP Reviewers/contract folks should attend

Make sure that the work I do is relevant

Conducting a foot ID, and seeing the impact of disparities on the populations I service.

Check Policy's

Develop add'l contract language

Ideas to work from— but I hope there will be more to help us actualize this-coaching, development of drivers, etc. (eg. implementation science).

Ask about and consider how all policy and procedures in programs I work with will affect racial health disparities

Begin doing work around health disparity trainings

Think about impact of race on our policies and local policies.

To look critically at our planning and funding with the tools learned here.

• **Don’t know what to do**

I don't know.

We never learned about what to do next.

No idea. Just an openness to learn. Don't be quick to think I know everything.

Not sure yet, need to digest it all

• **Listings of ideas**

1. Work with communities around issues of empowerment. 2. Consider "estab. a contract" with our communities that holds us and them accountable

1. Conduct power analysis on the division, section, unit, activities. 2. Involve the community members in all activities of the division. Seriously, take community recommendations to make positive change. 3. Engage with other institutions to assure collaboration and change institutional practices. 4. We already changed missions and developed a new strategic plan. 5. Provide policies

1. Pose questions, reframe history in natural occurrences to undo racism. 2. Stimulate/facilitate dialogue

Form contract, listen, help serve the most need

Function from a framework that: 1. Recognizes truth of existence of white privilege. 2. Acknowledges we do not listen to the voice of the poor in developing policy and procedures.
Identify ways to include input from community!

- **Other responses**

Refuse to answer with my name attached.

Provides backdrop for why things are the way they are and provides context

Note: White stating that there were no wrong answers, some were made to feel their answer was wrong

13. **Describe the most useful or valuable outcomes of this workshop.**

**Summary:** Increased knowledge (history/definitions) along with a deeper understanding of racism were the most frequently reported benefits of attending the workshop. Participants were able to make new connections on how racism affects their daily life. Discussions with colleagues were appreciated. Some reported becoming more self-aware and a desire to make personal/work changes after the workshop.

(124 Responses)

- **New perspectives and ideas**

It opened up discussion and made people confront their own bias.

Understand how history has affected me and my co-workers.

Internalizing the information!

The most useful info I got was about racism and how we judge people without getting to know them.

Learned more history and how important it is to involve the clients/community.

Expanded my knowledge have me thinking about my privilege.

Learning about other people's feelings.

More comfort understanding and discussing my role in racism.

Opened my eyes a bit more. I was real impressed with the foot ID. I didn't realize that structure.

The historical foundation of race and racism was very powerful and informative. Changed a lot for me.

To accept that racism is alive and real. How perception adds to illusion and the history was incredible.

Historical perspective valuable. Thinking of poverty and racism in a different way. Group discussion was interesting.

Power analysis. [2]
The box exercise, history, internalized racism.

Day #2 - breaking down internalized inferiority/superiority and their manifestations was insightful.

The perspective that systems are designed to keep (all) poor people where they are.

The knowledge that in many ways we are all victims of a system that was put in place long ago.

Truly identify racism today as well as the history.

Learned new concepts even though this was not my 1st antiracism event. "Wed talk about daily rejection- was split into separate racial groups at last training"

The awareness of how racism affects everyone and also that everyone has prejudice and those definition are different

Just recognizing the power analysis and the way I view racism

It provided a clear explanation of how racism effects us all, personally and institutionally.

Framework or structure for addressing these issues.

All the aspects of the foot print

Foot prints and how to incorporate change in programs to close the gap in health disparities. My knowledge on racism was enhanced from a historical perspective and how racism is ingrain from a societal perspective. Awareness of being a priveledged class.

Definitions, challenging thinking, understanding of history tools

Getting people to actually think

Getting past the barriers of racism

Framework to discuss structural foundation of racism

Foot print theory

Enjoyed the footprint and power analysis in how you need to work with your communities.

Re-thinking the practices of our institution

Foot ID.

Understanding the importance of community driven focus.

The fact that it was explained that "this isn't personal".

- Increased knowledge/understanding

Racism description.

A better understanding of the history that has created the issues we have today.

Gained a great understanding of the framework in which racism was built and how old conversation can affect change or lack thereof.

Extended knowledge of historical causes of race and racism.

Identify the history of cultural racism.

Gives us a definition of racism so that all of us in the Division can be on same
page and presentation of white privilege helpful.
I better understand racism. I never had a name institutional racism.
The knowledge of the teachers. I learned about topics I had no idea about.
The most useful or valuable outcomes of the workshop is the defining of racism.
Understanding the institutions their origins and why their usefulness may not be effective. How much need [sic] to involve community.
Understanding racism and privilege.
I'm able to have a better understanding of my own perception of racism, racial influenced disadvantage and advantage.
Understanding of the historical origins of "race."
Understanding the difference between "programs" of "institutional change."
Explaining the concept of being white.
The history. [2]
History and understanding racism.
Historical context very helpful.
The definition of racism.
History lesson.
Knowledge gained pertaining to how race began to be institutionalized and structured.
Better historical understanding.
The knowledge of how race was developed and implemented to control the people.
Knowledge. Understanding the whole institution.
The history of racism.
Knowledge base or tools to educate others.
Securing the correct definition of race and racism.
I obtain a great deal of knowledge regarding race and the origin of racism.
Better understanding of history of racism.
Knowing about the history.
The history. The hope in a possible change in ourselves.
Learning what I didn't know I didn't know.
Understanding- institutional and cultural racism (or beginning to understand)
Understanding the history of the influence of govt policy and procedure's, impact on minorities
The definitive description of institutional racism and its impacts on program development
Very resourceful information
Review/understanding of history of race determinants
Better understanding in general
Better understanding of origins and consequences of racism.

Understanding the history of race and interpreting other’s rationale for their behavior

I understand how racism got here
understanding institutional racism

An understanding of the history and institutionalization of racism
how white developed

1. Clear distinction between individual/person racism and institutional racism. 2. Clear description of the specific nature or race classifications [?]. 3. Useful dialogue.

A better and deeper understanding of how the stress of racism effects women of color and it’s contribution to infant mortality

Historical background, the film, group interaction

Better overview of racism
understanding the history of racism and how institutions have sustained racism

Historical part

Educational segment.

● Discussions with coworkers

Very excellent to get together with our own workgroups. History. Emphasis on racial/ethnic vs. just issues.

New openings for conversations with colleagues.

Opened up discussion within the division addressed some historical misinformation which reinforces racism throughout society.

Discussions among participants.

Meeting (many for the first time) and having facilitated discussion around critical issues.

Opening discussions make it easier.

Hope that a constructive dialogue can occur to make changes- understanding that it takes time and patience and cohesive thinking/work

That the division and [unreadable] DCH staff have a common language to discuss racism and a common structural analysis.

Opportunities to hear from peers-> build relationships

Dialogue with co-workers about institutional racism and how white with given

Discussion of internalized racism

● Motivation to change

Motivation to organize and to deliberately work towards undoing racism.

Fear of racism.

Good understanding of what we need to do to UNDO racism

Reenergizing me and giving me ideas and information to reconceptualize my work.

That this may move our division to a more holistic approach
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Awareness, History lesson, some slapping up

- **Self assessment and improvements**

  I feel that personally this workshop is more beneficial than professionally.

  Identifying personal biases that assist in providing services to populations without prior prejudice.

  Impact of my personal image of being "white."

  Understanding my knowledge base is only a dot and being open to the power of listening

  Personal and professional application/understanding of the results of internalized racism. Definition of racism.

  Taking racism from the personal to the institutional. Thinking more about what it means to be white in America.

  I loved all of activities that made us identify what we are doing and thinking that is contributing to racism

  Growth, changing viewpoint

  Expanding our box to open and include others. Development of contracts to discuss issues. Neg thinking = neg. performance and how impacts gatekeeper role

  The fact that I can change my behavior and mindset to better understand where people are coming from and what lead them to this point.

- **Other responses**

  Engaging communities to empower themselves.

  Good - but very - superficial.

  Great talking points.

  All of the tools/skills will be useful in some way when applied to my work/practice.

  Realizing that no matter what I am teaching at home my children will still be faced with institutional racism and will need to counteract it

  History and impact of [left blank]

  I feel everything was useful and valuable

  all
14. How did this workshop improve your specific knowledge or skills you use for your job? Please list the specific areas of knowledge or skill development that improved.

Summary: Learning about the history and definitions of the different types of racism was most frequently reported knowledge improvement. Respondents reported better communication (especially listening) skills. Several respondents had an increased self awareness and were able to identify personal biases after they attended the workshop.

(107 Responses)

- **Knowledge about racism**
  
  Historical race and institution procedures/hierarchy.

  Better knowledge and understanding of racism.

  Helps in navigating bureaucracy that improving awareness of historic levels of institutional racism.

  History/impact of institutional racism.

  I know more about race, privilege, power; and history. Want to read more. Doing workshop again would be great.

  More info on what are the roots of racism.

  Great history lesson.

  Looking at the causes instead of the behaviors of racism was a critical moment in the workshop.

  Brought insight into whys of racism.

  Very interested in internalized racism.

  Much better understanding of history and how to created inequalities and racism.

  Opened up disparity, diversity, racism knowledge areas.

  Knowledge of process of "inferiority."

  Just knowing the historical perspective and the role of U.S. government organizations.

  History.

  Power of analysis.

  Lots of good history of race and supporting institutions and [unreadable].

  Definitions helped me understand the real meanings.

  Defining racism. Specific historical examples.

  Learned a lot about history of race and whiteness and internalized oppression.

  It places the functions of our institutions in a more comprehensive context.
I can have a better understanding of how to identify issues of racism and the source in order to implement ideas that would change it.

Understanding the history.

Understanding what and how discrimination is created.

Social determinants.

I did not know the history at all...I was not very interested in history in grade school and I don't remember learning any of this.

Created a stronger foundation for me to educate others.

Power analyses - critical thinking.

I have an understanding of the workings the institutional system.

Regarding poor and how we perceive poverty. The blue vs. the red.

Knowing the true definition of racism and prejudice.

History of racism and how it started and perpetuated poverty. What racism really means and how its institutionalized.

That there is a history (institutional) behind racism, behavior, preconceived notions etc.

This workshop broadened my knowledge and helped me to learn more about how the social determinants impact health outcomes.

Understanding racism, prejudice, power, cultures, racial privilege, institutional racism, internal racism, etc. It was great. Social determinants, thinking outside the box. Race + Prejudice = Power. Gatekeepers. White - Black.

The role of institutions and how they play a role in addressing programs

Influences and powers that maintain or impact status

Understanding clearer the history of race and how it has impacted how I provide services

History of race development, view of the power analysis

improve my understanding of institutional racism

I continue to learn how one structural components of society affect race relations and health outcomes

Historical perspectives on institutionalized racism and suggestions for addressing it in program operations

Overview of institutional racism

Historical knowledge of the roots of racism

It may help understand some results of data (teen pregnancy=multigenerational)

Historical info, tools for use in job

Clear understanding of individual, cultural, institutional racism
It gave me more knowledge of our history! Firmer understanding of institutional racism, distinctions between racism and bigotry

- **Personal thoughts and biases**

It helped me not to pass judgment on other people. Understanding personal thoughts.

It made me realize that as much as I may think I have an understanding of my personal bias, it goes much deeper.

Increased awareness of personal biases and internalized beliefs and thoughts.

How to not have bias with clients or make generalizations.

To treat everyone equal and listen and respect others.

How I perceive people I work with. Acceptance of self.

Try my best not to prejudice people and their situations.

Acknowledging my own personal prejudices that impact staff and clients.

I do not directly work with the public but the information for my personal life and my for my family is priceless.

To listen and hear. To think vs. thought.

I need to do some more "thinking" about this

Responsibility of leadership. "" of having a voice that is heard

More aware of situations
Making me aware of perceptions that people bring to the table

Improved greatly- especially in the area of thinking outside the box and how I contribute to continued racism that prevents others from obtaining and achieving.

Critical thinking about how my program affect racial groups

- **White privilege**

I'm not sure, other than understandings that many do not have the "opportunities" that I have as a white person ( tho in no way takes into consideration anyone person's personal circumstances, regardless of race).

Being able to express my uncomfortable feelings around white privilege, and being pushed to be uncomfortable.

Increased vigilance of how my white privilege affects my interactions, communications.

The description of the history and the understanding of the development of white privilege will aid my ability to work with local communities to understand racial disparities and address inequity.

Knowledge of the history of white privilege- awareness of impact of culture on our unconscious thinking

around racism, white privilege, the social construction of "race" so much really; can't write it all
- **Communications**

Workshop in part talked and true communication and how to tap community for their strengths - part on communication important; will also help in communicating with co-workers. Listening more, open minded

Improved my understanding of how all people should be heard

Language and resources to drawn upon to discuss and address racism

Effective presentation/workshop leader styles. Ways to address difficult issues.

Listening actively

- **Relationships with coworkers**

Time will tell if I can facilitate change with a supervisor who is not supportive or innovative.

Understanding co-workers life experiences better help to communicate with open mind.

provided tools that I can use with colleagues, partners, stakeholders, constituents to change the way we do work. Empowered to push for a changed institutions and scrutiny of all that state government does

Questions addressed that may ask the client why may need to give more clarification as to why we need this information

- **Improve services**

How to better sense the customers true wants and desires. Having a more open view the things/issues that need to be address to being a "real" change. These areas will help me to think how these systems import the client and how I act as a gatekeeper.

The impact of multiple entities on a poor community

The historical "lessons" were helpful to build on what I know. The session on power analysis can be applied to our office.

My job is result oriented and their concepts in the workshop not as helpful in daily tasks but help me understand long term how to educate effectively.

- **Other responses.**

N/A Comment - excellent workshop.

My creative skills for thinking out the box. My thought process to not do needs assessments and to analyze myself first.

Rethink how we approach intervention development. Rethinking how/why we need to build relationships.

Reminded me of knowledge and skills I have and use in my job.

Skill #1 and #5 will be very helpful. A better appreciation and understanding of DHWDC programs.

My interactions of my [unreadable]

That I need to focus on the trickery that goes on in government and keeps oppressing people
Some use of tools- but I don't feel it really went into application to our work. More on us as individuals, and just starting into institutional change.

Public health focus was great

- None

To be honest, I would have to put more thought into how this can improve my skills except for the awareness that the workshop gave me.

I work with very few whites (2) and I feel that this workshop did not help me. Did not get to skills.

15. In what ways did this workshop disappoint you or fail to meet your expectations?

Summary: Most respondents reported no disappointments. However, those who did frequently reported wanting more time, especially for discussions. The workshop could be improved by including more movement, a comfortable environment, and providing handouts. Some expressed concerns of the facilitators being judgmental.

(114 responses)

- No Disappointments

Did not disappoint.

Met my expectations.

There was no disappointment to me. I went into the workshop with an open mind.

I was not disappointed at all I really enjoyed the training/workshop.

I was not disappointed.

It met my expectations but was lengthy.

It didn't. [3]

I didn't have predetermined expectations, workshop was good.

I loved it all!

None/None!/Not at all/None at all! [22]

N/A [5]

It was fine

Didn't

0, it met/exceeded my expectations

It didn't disappoint me in any way

Can't think of anything
I was not disappointed at all. I'm encouraged my division is moving to recognize the impact of racial disparities.

- **Wanted resources**

  Resources were given verbally instead of in writing.

  Failed to offer useful ways to share this knowledge with others who may not be able/willing to participate in this training.

  Would like much more resource material.

  No documentation.

  No tools to use except conversation.

  No handout.

  It was not a disappointment would have wanted handouts.

- **Wanted more application to work**

  I see how this will benefit myself but it's not clear how it will benefit the organization and it's infrastructure it will benefit client services and how they are provided.

  I never found the connection between my job duties and the information we were provided.

  Workshop was excellent but struggling to see how it will change the agency.

  Not sure enough "connections" were made back to the "job."

  Lacking time for real discussion of next steps.

Once again we received a training that didn't show us how to bring this to our job - "program"

It didn't disappoint; although I always want more tangible solutions or ideas

I would have liked to have heard the steps of organizing

I hope we can implement these ideas/concepts and not have it be just another training or project that does not evolve

See previous (but I don't feel it really went into application to our work )

- **Wanted more discussion**

  Not enough time for discussion

  Lack of opportunity to have more sophisticated/in depth discussion of institutional racism

  I would have liked to have discussion. You had "the choir" (in theory). We all have passion, but need help with steps/direction

  I think some people were let off the hook- by now answering the "uncomfortable" questions- which to me means they will continue thinking inside their own box

  I wish we'd had more time to discuss concepts in small groups, then return to larger groups to discuss further.

- **Wanted more active learning**

  I dread lectures I need involvement.

  Less talk and more interaction between the people these. There was no solution I feel really.
Not enough group interaction.

The trainers did not do a good job facilitating discussion. They often used closed-ended questions in an attempt to spark discussion. They refused to allow there to be silence in the room - which after sparks discussion, they complained about lack of participation - but did not use well researched facilitation techniques to encourage participation.

Just too much sitting made it difficult to keep my energy up

- **Wanted more perspectives**

Focus was too controlled/limited.

I thought it was biased. Presenters put people on the spot, instead of asking for volunteers to answer.

Need to learn more about all cultures.

More in regards to white vs. blacks and not white vs. all.

I heard group members giving honest guesses to a lot of history-based questions, only to be told 'No' or 'that's not it.' That language serves to shut people down, not teach. Reconsider how your language engages or disengages people from discussion.

- **Wanted more time**

I really enjoyed the workshop and I think more time, like another 1/2 days would be helpful to totally digest all of the information.

I would have preferred a third day of the workshop.

Ending was abrupt with participants struggling with where to go.

Excellent information but need time to digest.

Too much information in a short two day span. Wish I had more time to process it all.

We didn't have time to explore the practical application of the concepts

Too short

There wasn't time to get into specifics about proceeding with this in the job, which would have been helpful

Not at all-wish it were longer

- **Wanted less time**

Way too long - lots of pieces that didn't work to end result.

Too long. Didn't start on time - frustrating. Difficult to draw out group for more in depth discussions.

- **Wanted more information**

I would have liked more in depth information the entire first half of the day seemed too basic.

I would have liked an example of an institution that transformed

- **Too much information**

Sometimes too much detail cause me to disconnect to the point being made.

- **Wanted more reflection on process**
I would really like to see more room made for processing a meta conversation of what is happening in the room at the time (i.e. the struggle with the vibe in the room, addressing people [unreadable]).

I wish we had more time to process the emotions related (even as a collective) to racism, etc.

- **Wanted a better presentation**

Far too long for degree of dialouge and discussion. Difficult to follow flipcharts and poor writing in a room of this size. With today's technology, many of the presenters could have improved the delivery of their points with details (they were making points with) and technology is so much a part of learning with today's adults in Powerpoint is easier to refer to and all could see.

Unable to read all the notes from across the room

The teaching technique (quiz/probe for the right answer) was frustrating to me

- **Too negative**

I think most things discussed assumed the worst of everyone/devious intent. Now how to see/want to see things??? Feeling of futility vs empowerment to change things.

We were told there were no right or wrong answers, but by diana's reactions, there were and she made some people uncomfortable by getting in their faces and the rest of us too

Some of the facilitation was heavy handed at times- relying on "authority" ("we've done this so many times..we don't need to explore a particular issue) rather than consistently allowing participants to voice their opinions

It was quite a bit about blame, despite the constant voicing that it was not about that. I don't find this helpful.

At times I felt like there were right and wrong answers to questions and like we were expected to think within the trainers' boxes. I left feeling disconnected between reality and the workshop material.

At times Dianas attitude was very negative

I found it somewhat critical and offensive at times

- **Other responses**

Blah, blah, blah name, book, name, book, blah blah blah you lost me 12 hours ago.

It didn't disappoint me, but I worry about how some messages were delivered and if they will be perceived as they were intended.

A little too much emphasis R/T this country problems vs human kind throughout all history.

We were told the workshop would begin punctually at 8:30 am - but it did not.

So little was discussed on how to address the issue of racism. A short synopsis at the end of the presentation provided a little insight. Way too much time spent on afternoon of second day on history.

A.I would like to have spent more time on clear and tangible ways to address/change racism. B. I was also
disappointed that a participant was allowed to use the n-word in discussion unchallenged by our facilitators or organizational leadership.

I was pleasantly surprised with the info and how it was presented

I had no specific expectations coming in to the workshop.

16. What would have made this workshop more successful?

Summary: Respondents enjoyed group discussions and wanted more time to get into small groups. Increasing the amount of activities to break up the day was also recommended. Respondents were split on the length of the workshop, some felt that the workshop could have been compressed whereas others felt that more time would have been better. Several respondents wished they had materials to take from the workshop, along with ideas to apply to their jobs.

(104 responses)

- **More activities and discussion**
  - to have more activities.
  - More workshop kind of work.
  - Making it more interactive.
  - More action - less sitting - possibly role playing or more group activity.
  - More cross participant discussion opportunities.
  - Sitting for many hours was not good. More tables to sit and would have been helpful when writing. You can do tables in a circle/square.
  - Less all day talk!
  - A little more frequent time out of our chairs.

- **Handouts and resources**
  - An agenda. Also handouts.
  - Handouts.
  - Having printed material that I can take home.

? I did not have any expectations and did not know what to expect

I could hear Diane well on the second day, or others when they made comments.

Food was mediocre. Nice facility. Diana and Muhti = excellent.

more small group discussion and individual reflection

don't yammer on and on and on...16 hours at people.

The experiences that our group shared with each other.

More breakout sessions.

Opportunities for discussion or application of concept

More discussion about how to effect change to combat racism
More resources to take home with us to continue this learning. Incorporate upper level administrators into the workshop with the rest of MDCH employees.

Documentation would be helpful as a lot of information is covered. After 2 days all the information is lumped together.

Handouts
Would love handouts of the information at the end.

Overhead projector, hand outs, reading resource list, required reading(s) prior to training

Hard copies of materials to take away for reference

An agenda and more data from credible sources

Maybe some suggested readings post-training. We could have used codes or birthday or something to match surveys instead of names. Maybe you would get more honest responses?

Have more visual aids: videos, etc.

- More time

Not have a condensed version of workshop to allow for in-depth discussions that are not abbreviated or rushed.

More time, another day.

If we had more time with in the workshop, but also if we had time after to discuss with our co-workers as a "whole."

Wish we could've had that extra 1/2 day to discuss application to current work and institution

More time [6]

Longer

More time and time for group discussion

To have it spread over 3 days and not be as long each day

longer- 3 days

It was just enough time for a training; work wise. But actually it could of been like another day or two and would of been more educational for all

It was a little too much information in a short time. More opportunities to move longer spread out over the course of a year, share w/our programs

- Less time

Shorter?

I day not as long or maybe 3 days broken up to shorten sessions.

Could have been a one day workshop.

One day.

It could have been 3 days (1/2 days).

Shorter- too much material over two long days
Shorter - after certain time you lose your audience. You spoke a lot about it has to come from the community - we work from a state-wide perspective and there isn't much we can do.
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- **More applications to work**
  More time to discuss active steps in our workplace.
  More time to analyze specific application to our work
  Given enormity of topic, it was an excellent [unreadable] building training.
  Need to be on the job follow-up
  See #24A (I would like to have spent more time on clear and tangible ways to address/change racism)
  More time spent on how to deal with the problem and ways to incorporate the changes.
  Great workshop - needs a follow up plan.

- **Workshop room and food**
  More comfortable room. More breaks.
  Temperature control - it's hard to focus and learn when biological needs aren't being met.
  Warmer room. Incorporate more movement.
  More comfortable environment. Chairs terrible for long sessions.
  Good food?
  Wish the chair were better for sitting in. I was in pain most of the training.

- **More about culture/history**
  More discussion about culture
  Would like to talk more about culture, but ran out of time.
  More in depth historical perspective?

- **Presenters**
  Presenters that were so inflexible.
  The trainer could have been more in tuned of where the participants were.
  Every trainer has their own style- their style worked for them. I do feel there were times when participants opinions were not valued because the trainers had been doing this for a while

- **Other responses**
  Historical information presented and power analysis.
  More involvement from the white participants.
  If everyone was more open and honest.

- **Groups**
  Smaller group discussions.
  Smaller groups
  Possibly a smaller group- 40 participants was pretty big, and we may have benefitted from more interaction
  Combining the community w/ health care providers or staff
  I would have liked to work more in smaller groups to address specific issues
  More honesty from participants. It is difficult to ensure a "safe" environment for everyone to be truthful, given the
time constraints. Ideas- separate supervisors and co-workers

More group interaction.

Maybe 1 more small group??

More discussion one on one with the group

Above (I would have liked to have discussion)

- Reorder presentation

Maybe going over what racism is the first day first thing instead of later in the day.

It felt like the first day there was an emphasis on working to change peoples sense of empowerment and engagement because it is more useful/important than changing policies/institutions. And felt like the second day that was switched - that policies hold the real potential for change and changing attitudes wasn't as important. I would have benefitted from an approach that valued each equally at all times.

- No suggested improvements

It was good!

I enjoyed it.

Nothing. [2]

Not sure if it could be done any better.

I thought it was very successful. [2]

Nothing. I enjoyed it.

Nothing I can think of

N/A [5]

No recommendations at this time- I think it was a great workshop

It was wonderful- Thank you!

Not sure; it was a lot to cover among two days but it would have been hard 2 get away for longer.

content and timeframe were appropriate

A great workshop! Don't change it.
On a five-point scale, how useful was this workshop for your work?  

_Circle one answer:_

- 1: Not at all Useful
- 2: A little Useful
- 3: Somewhat Useful
- 4: Very Useful
- 5: Extremely Useful

Mean Rating for the UR Workshop: 3.96  
Standard Deviation: .93

Participants who attended the Undoing Racism workshop rated the usefulness of the workshop at 3.96. This is the same as the mean usefulness rating given of 72 other professional training events.

**Comparison of this Mean Usefulness Rating with Mean Usefulness Ratings of 72 other professional training events:**

![Histogram of Mean_5-Pt_Rating](image-url)
17. If we offered this workshop again in the future, would you recommend it to a colleague?  

**Check one answer:**

- **Response**  
  - ☐ No  
  - ☐ Recommend with reservations  
  - ☐ Recommend with NO reservations

**Percent**  
  - 4.6%  
  - 21.5%  
  - 73.8%

73.8% of the participants would recommend this workshop without reservations. This is below the average percent recommending without reservations at 83 other professional training events.
Follow Up Analyses

Additional analyses were run on the pretest posttest self competency survey questions. The analyses look at the responses of the Undoing Racism Workshop participants based on their selected racial identity and their job title.

Table 1 Summary: Each racial group is improving at a similar rate. There are statistically significant differences between racial groups in regards to how they define cultural racism, and identify institutional norms and accepted practices that adversely affect minority race groups. Otherwise, there are no statistically significant differences between racial groups. One racial group is not changing scores at a faster rate than the other.

Table 1: Competency Rating by Race

<table>
<thead>
<tr>
<th>Competency Rating</th>
<th>Pretest</th>
<th>Posttest</th>
<th>F Tests</th>
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<tbody>
<tr>
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<td>n</td>
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<tr>
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### Competency Rating

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<td>African American</td>
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</table>

**Define internalized racism.**

| White             | 76      | 3.38     | .82     | 4.38   | .58     | 4.28   | 111.68* | 3.10        |
| African American  | 42      | 3.76     | .91     | 4.48   | .59     |        |        |             |

**Define racial health disparity.**

| White             | 75      | 3.80     | .79     | 4.37   | .61     | .54    | 52.62*  | .11         |
| African American  | 42      | 3.90     | .76     | 4.43   | .55     |        |        |             |

**Identify and explain social determinants of racial health disparities.**

| White             | 77      | 3.48     | .90     | 4.25   | .75     | 1.74   | 69.29*  | .22         |
| African American  | 42      | 3.60     | .91     | 4.45   | .63     |        |        |             |

**Identify policies and practices in the Michigan Department of Community Health that address racial health disparities.**

| White             | 77      | 3.18     | .88     | 3.27   | .76     | 2.00   | 4.13    | 1.23        |
| African American  | 42      | 3.24     | .73     | 3.55   | .77     |        |        |             |

**Identify policies and practices that provide guidance in my job duties and that may influence racial health disparities.**

| White             | 76      | 3.11     | .92     | 3.47   | .85     | 1.72   | 12.62   | .01         |
| African American  | 42      | 3.26     | .73     | 3.64   | .85     |        |        |             |

*p < .001

1. Includes only MDCH participants
Table 2 Summary: There is no statistically significant difference between each job title in regards to their rate of change in their scores. There is no difference between job titles in how they responded to the questions over time. All groups are changing scores at a similar rate. However, it is important to keep in mind that the sample size for this analysis is relatively small and to see statistically significant differences, the difference would have to be quite large.

Table 2: Competency Rating by Job Title

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Identify policies and practices in the Michigan Department of Community Health that address racial health disparities.

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Identify policies and practices that provide guidance in my job duties and that may influence racial health disparities.

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<th>Posttest</th>
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*p < .001
1. Includes only MDCH participants.
Appendix C: Undoing Racism Focus Group Evaluation Report
PRIME (Practices for Reducing Infant Mortality through Equity)

Evaluation of the Undoing Racism Workshops

Focus Group Results

Allison Krusky, MPH
Thomas Reischl, PhD

Prevention Research Center of Michigan
University of Michigan School of Public Health

December, 2011
Focus Group Results

The PRIME evaluation research team collaborated with the PRIME managing staff to host three focus groups of Undoing Racism Workshop participants. Each of the three focus groups occurred one month after participants attend the Undoing Racism workshop. The Undoing Racism workshops were held February 14-17, March 21-24, and May 16-19, 2011. Three focus groups were held in the on March 10; April 5, and June 1, 2011. There were 28 focus group participants (7, 9 and 12 respectively).

The purpose of the focus groups was to give a sample of the Undoing Racism Workshop participants an opportunity to reflect on their experience within a few weeks of attending the workshop and to report how they have applied what they learned in the workshop in their jobs at the Michigan Department of Community Health (MDCH).

Methods

MDCH staff who attended the Undoing Racism workshop were recruited to the focus group by the PRIME project coordinator and MDCH managers. The MDCH managers created a list of potential participants emphasizing racial, job classification, unit, and gender diversity.

A PRIME evaluation research team member facilitated each of the three focus groups. Each focus group was asked five questions about the Undoing Racism workshop. The focus groups were recorded and transcribed. A member of the PRIME evaluation research team coded the transcripts. Once all transcriptions had been coded and given themes, the group results were compiled by question.
1. What is your most memorable moment from the Undoing Racism Workshops?

SUMMARY:

MDCH participants in the Undoing Racism workshop most memorable moments were mainly focused on increased awareness or greater depth of understanding of the historical development of racism. There was a wide range of previous awareness, with some workshop lessons overlapping previous knowledge. However, participants commented on the further development of the breadth and depth of their knowledge of racism.

This growth in knowledge was a result of the workshop providing historical examples, using visual aid tools (e.g., movies) and exercises which prompted participants to process their opinions. Participants were able to establish connections between workshop lessons and their own work practices. As one participant reflected,

“And I think that when I, before I went into the training, when I thought about institutional racism, I never thought about public health and MDCH and it potentially contributing to that. And it’s kind of the first time that I was like, ‘oh, that’s some of our programs where we have the best of intentions, you know, might be unconsciously leading to that.’”

These workshops also provided an opportunity to reflect on the participant’s own racial identity, and beliefs. This seemed to spark participants of all racial backgrounds to process ideas which they had previously not done. A participant commented,

“I had a couple, but I think the one that I remember the most was going around the room and talking about what we liked about being white or black … and I think I remember that because it was something I never thought about before.”

Including community members to help develop policies and practices was a welcomed idea by participants. One participant remarked,

“However, towards the end when she was saying this is how it looks when an institution is balanced. You know, we have the community involved, the community and she gave the example of her local community being involved and taking the lead instead of the institutions trying to lead them. And I thought, ‘That’s really cool.'”

There was frustration at not knowing how to proceed with the information given at the workshop. As one participant questioned,

“But then my question to her was, “Ok, how can I take this back- make it practical for me. How can I take this back to my job? How-What are some of the things I can do?”
There were also multiple comments critiquing the facilitation process. It appears that the facilitation style distracted participants making it difficult to focus on the content of the workshop. Participants who felt that the facilitation style was confrontational became defensive. Others mentioned their disappointment in the workshop layout which did not allow for more discussion. Some also felt that their personal opinions were not valued or that the facilitators were not open to other points of view.

COLLATED RESPONSES:

Lessons from History

- But specific to that the documentary talked about housing and how the housing properties were automatically devalued when an African American moved into the neighborhood so to speak. And I found that interesting because it gave me some, a little more context, well really a lot more context to the old phrase, 'Well, there goes the neighborhood.' Well, people could be perfectly good neighbors but there's so much out of your control with something like racism when it's institutionalized.

- I liked the visual depiction that was done of the institutional or organizational structures and how learning more about how that historically was established and that was very helpful to me.

- I was kind of shocked how they didn’t allow black veterans to receive the (inaudible) program after the war.

- They gave a historical account of a woman, um, because of her bloodline she was white by all indications but because of her bloodline her birth certificate reflected that she wasn’t white and all of the things that happened as a result of that.

- I didn’t really know the history and that cleared that up for me. I mean it made me understand better what that meant and where that came from.

- For me it was the history and the documentary as well. Because to me, especially when they talked about the red lining and GI Bill, it just sort of painted a clearer picture of how structural (inaudible).

- For me it was the documentary. I thought that a lot of the historical backing was really interesting.

- just appreciate the overview of the history of how different aspects of government created some of the situations we have today. And the overview of how they defined race and how race played a role in those kind of policy and sort of institutional (inaudible).

Lessons about Institutional Racism

- But they looked like they had some interesting things in terms of the institutions and that’s the part that really is the most interesting for me right now.

- I was pretty familiar with the history and I really think that racism is an
institutional and (inaudible), and I was really happy with the kind of community approach. The sense of power and looking at the community I thought that was very powerful.

- Example of the man that shot his wife. So we had the Caucasian male, I forgot what neighborhood, but somewhere in the city, um, shot his pregnant wife and he informed the authorities that it was a black male who shot his wife. And so the example, was to show how different institutions react, even when you have policies and procedures in place-

- They got the utility company to respond and in this, I guess it was like a project maybe area, they got the utility people to turn off the heat in this building so that all the people would come outside so they could start rounding people up and so it was another instance of, well how do you have a policy and procedure to allow someone to turn off the heat in an entire building? ... that was amazing to me to see how institutions can respond and then also how a community may view institutions.

- However, towards the end when she was saying this is how it looks when an institution is balanced. You know, we have the community involved, the community and she gave the example of her local community being involved and taking the lead instead of the institutions trying to lead them. And I thought, “That’s really cool.”

- And I think that when I- before I went into the training when I thought about institutional racism I never thought about public health and MDCH and it unintentionally contributing to that and it’s kind of the first time that I was like, “oh, what’s some of our programs where we have the best of intentions, you know, might be unconsciously leading to that.”

**Personal Racial Identity**

- I had a couple but I think the one that I remember the most was going around the room and talking about what we liked about being white or black or- and I think I remember that because it was something I never thought about before.

- Mine was the ‘what I like about being white’. And first I was like, I don’t know. I’ve never, nobody’s ever asked me, I’ve never had that.

**White Privilege**

- What I’m remembering is when they went around and pointed to any white person and said, “Are you privileged to be a white person?” And a lot of us white people got a little angry, ‘oh no I’m not privileged, I grew up poor.’ And I had some struggles of my own. Just because my skin is white doesn’t mean I’m privileged. Then after a while you really had to say yes, you know, after you thought about it. You really did have to say yes, as a white person you are probably more privileged than some.

- And it was kind of the same thing you were saying about, “no, I don’t think I’m privileged, we struggled.” Because I didn’t have it in my face to sit there and compare it to but then I
went back and I drove back to Howell and never thought twice about it. You know that was my answer, I can just get in my car and not really think about, do I go there—is that safe? And so for me that was kind of like, wow, that is true, I can just get up and go.

- I was real fascinated by the exercise that started out with the white people what they liked about being white and the other races what do we like about being that race.

- I grew up in Northern Michigan so I didn’t have that moment where {name} was in line and black people were being escorted away and she got services after Katrina.

**Learning from Visual Aids**

- I liked the film as well.

- The first day I think it was, or the second, I don’t remember, anyhow they made a diagram of how the building a neighborhood and how the community comes together and all of the influences and it was just that diagram and I found that fascinating how that impacted a lot of things that took place years ago.

- The first one [memorable moment] was more about the content, I liked seeing the movie on the morning of the second day. Well, that’s when we saw it. I thought that it was really enlightening and it really helped kind of pulled everything together.

**Reframing Experiences**

- And she told about what that felt like as a black woman and it brought back a lot of memories that I had being a teenager in my own white town where we had slave days and it- I think it was a moment where for me it kind of epitomized how a single event can be viewed so differently from different perspectives. It was one of the more thought provoking discussions.

**Applications to MDCH Work**

- I really want to see some movement before I leave. .. But the thing that struck me because of that hope, is when I was still struggling with all time trying to figure out how is this, how are we going to use this to make some changes in our institution?

- And so, I found that fascinating of trying how do we plan for that kind of, in what appears to be an impromptu moment to really push our institution forward and what does that mean for us?

- But then my question to her was, “Ok, how can I take this back- make it practical for me. How can I take this back to my job? How-What are some of the things I can do?

**Criticisms of Workshop Facilitation**

- And she said, “well, we’ll learn about that.” Well, we never did learn about that. She never did give us examples. And, so this was so frustrating for me because here you know I’m spending two days, I want to learn, I want to know how we can change but yet there were no answers. And I just thought, “This is another waste of time.”
And the fact that we have to be unyielding advocates and the question of, “How do you do that?” at the same time as you preserve some of your personal safety. And I don’t mean safe in terms of someone shooting a gun at you, but in terms of growth in the organization. Cause I’ve know people who have been unyielding and they got, they’ve gotten labeled and professionally if they stay in this organization they go nowhere.

She explained that because I’m white I have privilege and because I have privilege that makes me racist. And I was extremely offended by that because that’s not who I am, that’s not how I was raised, I treat, I try to treat everybody as I would have them treat me. And I don’t care what color you skin is, I don’t care what side of the tracks you came from everybody has hard times in life, some people have more hard times than other times. If I am in the presence of someone that is not treating someone correctly by calling them outta their race, by calling them outta their name, by disrespecting them I don’t tolerate it. Not by anybody, not anywhere. And I was offended by that.

It was hard to overcome and think beyond what she was trying to get across as far as institutional racism because she was pretty much in our faces. … and I mean she just really was in our faces did not present it, I thought, I thought presented it inappropriately.

She made a statement that all white people are racist. Whether they know it or not we’re racist. And I think immediately I became defensive and it became clear that whatever I had to say or contribute wasn’t really welcome.

But so there might have been a few personal statements that, that I did have feelings about but I just accepted them as personal statements. Maybe it could be toned down a little bit.

I was surprised that on the, I think it was the second day when we sat down and we had the discussion that there was a kind of a going around and asking the white people first what they liked about being White. And- because I thought that wasn’t particularly effective and it set people against each other.

But I think something that was a little negative about the process is kind of a shut down moment- is at the very, very, very beginning of the training day I don’t remember which of the presenters it was that said, “This is not going to be an opportunity for discussion, that this was – they had done research, this is what they knew about – this was not-it wasn’t going to be a give and take. And I don’t, I don’t particularly- that’s not my style if we’re having a discussion (inaudible) that was kind of a shut down.

And we had a one-on-one discussion about some of the things that were covered in the workshop and I tend to like discussions and it was just nice to have that personal, face-to-face, one-on-one open and friendly discussion with her of the different topics.
2. When you returned to work did you talk to your colleagues about your experience in the workshops? And if you did, what did you talk about?

SUMMARY:

Those participants who spoke with colleagues after the workshop were able to clarify ideas and talk more about the ideas of cultural and institutional racism. Participants spoke with other individuals and also in groups during departmental meetings. One participant described how a long discussion with a colleague helped to digest the workshop’s key ideas:

“We spent like two hours talking about what I thought about the message about all whites are racist, and I don’t know I think it was kind of like unpacking it or something.”

Multiple participants also mentioned debriefing about their critiques of the facilitation style and the workshop as a whole. Those participants who did not speak to others about the workshop mentioned not wanting to bias the incoming groups, felt discomfort speaking about racism, or found that other colleagues were not receptive to speaking about the workshop in critical ways.

Several participants commented on changes which had occurred after the workshop which they attributed to the workshop and/or additional discussions with colleagues. A participant commented,

“So I spent part of this morning trying to read about birth certificates and how race is – how the history of how race is reported on the birth certificate which is I think something that came out of our training … So that’s like a direct result of the training.”

There was discussion also on the facilitation style of the presenters. Some felt that the facilitators could have been more in tuned with the department and its programs. There was frustration over the lack of strategies or tools to take away from the workshop.

COLLATED RESPONSES:

Clarifying Workshop Ideas

- And so it became very helpful to have a broader understanding of sometimes how things get changed a bit to reflect terminology that doesn’t clearly define what’s always going on. So, I did talk about that when I went back to work with a colleague. Who is working on, a different project. That colleague I think listened and incorporated those thoughts into the work that they were doing so I thought that was very helpful.

- We spent like two hours talking about what I thought about the message about
all whites are racist, and I don’t know, I think it was kind of like unpacking it or something.

- But I mean people wanted to vent about the facilitation first and argue that actually we spent one of our unit meetings talking about it, like debriefing as a unit, the training, what we thought. And how we thought we could, you know, integrate it into our work.

**Group Dynamics**

- And the other-I talked with one other person, who actually brought it to me and was giving me their observations of the second training. Where they thought that the second day it seemed more divisive, the second day. Whereas I was sharing with this person that I thought in my, in the session that I was in, that the second day we came together more as a group.

**Did Not Talk to Colleagues**

- Well, I didn’t really talk about cause we were the very first group and I knew the other groups had other people that would go through there. So I didn’t really share.

- I think because there’s so many in our division, personally for me that haven’t attended that I don’t want to give them too much of my opinion because then that would deter them from taking in anything. They would have a prejudgment already and I don’t want that to happen.

- Yeah, I kind of avoided it like that too.

- I think you got to spend some time really processing over time and not- I don’t think you’re doing justice to the workshop if you leave and immediately everything just coming back out I think it’s just, you got to, got to kind of mull it over and really take in, you know, apply it.

**Difficulties Speaking with Colleagues about Racism**

- Well, it’s not a hard conversation for me to have [conversation about experiences at workshop].

- Because the topic itself is just going to automatically make some people feel defensive and it’s going to make some people feel victimized and it’s just not an easy topic to discuss.

- Well, I heard a lot before going because of the group that went before us. And it was all primarily negative and very- I heard that it would make you very- feel like you shouldn’t be proud to be white or they target you and after I found that if you tended to say anything positive those that had said something negative prior to it didn’t want to talk about it anymore.

- It seems like for the people that, I mean I had heard a lot about it too. And I was kind of dreading going and I was relieved that it wasn’t that bad. I mean, like it wasn’t bad.

**Talked with Family Members**

- There was a lot of discussion in my own family.

**Applications to Work at MDCH**

- So I spent part of this morning trying to read about birth certificates and how race is – how the history of how race is reported on the birth certificate which is I
think something that came out of our training. … So that’s like a direct result of the training.

- And behind me is {name} who does the birth certificate stuff. And I heard her on the phone exploring that very thing- … And so she was actually, put that, she had taken another step, I don’t know what power she has to do it but that’s powerful.

- What I appreciated about the training was that it just made me think about what I can do next. I don’t expect to go to any one thing and expect to come out of there knowing the right, the wrong or the indifferent way to proceed. I want it to help me think about what I can do differently.

- And I think that I definitely learned some tools and some information to share with other people but it’s not-that’s not to me in my mind at least going to make a difference.

**Critiques of the Facilitation**

- And we talked to three of them for a long time about it and my impression of it and a lot of it was focused on the process too.

- I just didn’t feel like the way the facilitation worked was pulling out enough information that could help with some of that divide of feeling attacked or feeling like you know when they said on day one feeling about being all white or racist and you’re like, “whoa.”

- And I said, for me, I liked it. Because this person had heard that some of the people didn’t. And I said, I could- I’m not surprised because white people might have felt attacked. And people of color probably didn’t feel attacked.

- There were some parts I thought were really well done and some that I thought maybe weren’t facilitated that great.

- But I actually told co-workers that other than being offended what did I walk away from? I had a basic history lesson.

- But I, I did talk about it with one person and it really- it was more about – a little bit about the facilitation, a little bit about, you know, more about the content then more about wishing more strategies had been given as we talked about how are we going to implement this.

- Cause if there were a different presenter, I think, I mean the subject and some of the stuff they said was great but then there was that in your face stuff that just how could you concentrate on the other?

- I think that [the classroom style of facilitation] was a big difference and for me I think that [including more discussion] kind of thing would be really useful.

- That we’re really talking too long, preaching to the choir.

- Which is what I think a lot of people had a problem with is that something happened in their session with the facilitator that either caused them to shut down or someone got confronted and made people anxious and felt like they couldn’t share.

- They didn’t really give us anything to use.

- And when we would ask for it, they would get really worked up about it.
Suggestions for Improving the Workshops

- You left with having an understanding that racism may not be as blatant as it was historically, you know, in our history. But that it is very institutionalized but it came from more of a collective roundtable type of discussion over three days with involving external community stakeholders so anyway, just a thought to have a book to read that- to prepare, and to at least reference and you leave with that. And you know, just kind of the structure of learning.

- I would have liked to have seen was the trainers that were more knowledgeable about what we actually do.

- Because if they really knew what public health did or what our goal is in our programs I think they could have given us some more tools.

- How do I as an individual contribute to that dialog and you know some strategies for dealing with it. … I thought it was a good two days. But if there was some more talk about strategies and approaches and that kind of stuff it would have been nice as well.

- Not feeling like there were a lot of strategies that were being used other than this knowledge base but taking that—using those strategies to look specifically at how are we going to do this, this and this. … That was a piece that was missing.

- But similar to what [Name] was saying, I came away from it. You know, really feeling like, you know, now what?

- It really opened my mind to some of the issues, but I think that – I was hoping to take something back to work and be like ‘this is what I’m going to do now’.

- how can we show the data differently or how can we organize people to show fact sheets or whatever it is, but how do you really make an impact?

- And that you weren’t really effective and they didn’t really give us anything. Tell us any ways to be more effective.

- Because we asked for that some tools to take back to our programming. And it was obvious that was-

- Not part of the program.

- It would have been nice to have a couple strategies. Just because it’s like ‘you sold us’ that there’s institutionalized racism and we’re part of institutions and we feel like it’s important so then what are just one or two things we can start the ball rolling?

- But it almost seems like it’s good to kind of seize the moment [right after the workshop] and start talking about it while it’s fresh in everyone’s mind and where the experience had a big impact.

White Privilege

- I felt like it was focusing on institutions to break down as well as being aware that, you know, for white people that they have privilege and that the privilege came out of institutions setting up privileges.

Institutional Dynamics

- Well we talk about all these policies and these institutions but we make up the institutions. And so to get us in that mindset that, you know what, even though you’re an individual, you can
make some difference in your institution because you’re a part of it. Even if it’s a small difference. Now, what exactly that difference is I’m not sure yet. But it has planted that seed that you are a part of what does contribute to the problem.

- I mean there was that discussion about programs and the sort of comparison between the women’s movement and the civil rights movement. … And so that to me I think was part of the message, is that if you’re part of an institution then you look at how the institution brings its power to- even as a African American who’s trying to help other African Americans that sometimes you unknowingly are perpetuating – but you’re intending to do a good job but you may be perpetuating the cycle without even knowing it.
3. The Undoing Racism Workshop facilitators encouraged each of you to learn about different ways to think about racism including cultural racism and institutional racism. What do those words mean to you now? And after going to the workshop?

SUMMARY:
The workshop participants had a wide variety of responses to this question. Some responses attempted to provide definitions for both cultural and institutional racism, but it is clear that the respondents had differing background knowledge of the differences between the terminology of institutional and cultural racism. The wide number of personal definitions suggests that participants have not developed a cohesive definition shared by the collective group.

Some participants focused on **government policies and segregation practices** that were highlighted during the Undoing Racism workshops. Other participants spoke of their understandings of **preferential treatment and privilege** that is prevalent in our culture and institutions.

Others spoke of cultural and institutional racism in less defined ways. Some, for instance, emphasized how cultural and institutional factors influence each other and change over time, but did not specify what those factors were. Still others focused on how racism can be unintentional or personal or involve thinking in new ways. While many participants stated that cultural and institutional racism was hard to identify or to define, others said these concepts were already familiar, but neither group provided definitions.

Other group participants spoke of personal responsibility to address racism or new ways they were thinking about addressing racism. Finally, there was a group of participants expressing a variety of ideas that were not related to the other themes.

This variety of responses suggests that the Undoing Racism participants held a variety of understandings of cultural and institutional racism even after they participated in the workshops.

COLLATED RESPONSES:

**Government Policies and Segregation Practices**

- Institutional racism to me is how we as a government entity treats people that come to us for services. That’s institutional racism to me.

- And they were just segregated into this building, that building based on their dialect, the color of their skin. And a lot of them were stamped a liability to the public institution. That’s what was marked on their paperwork if the inspector didn’t like the way that they looked, or didn’t feel that they would have enough money or just something about their being—the, the inspector just took that upon themselves to just stamp that on
their paperwork and a lot of people were just sent back based on the way that they acted or that they looked. And I think a lot of the things we deal with, even today, are- they just go back, that far back. … It just really brought back a lot of the things that we talked about in the training.

**Preferential Treatment & Privilege**

- It’s the education system, and you know, for me it was eye opening of the whole it’s catered toward female, whites and I’m like, “oh.” But I’m a female that’s white so it probably didn’t bother me. You know?

- I think of institutional racism as the, like the powers that structure society to give different races and ethnicities, different access and choices in the world, things like that.

- To me, I view it as a system that’s fixed for a target group to always come out on top. And to the extent of what goes on to accomplish that and maintain that status quo is- I came away with a deeper understanding of that but, you know, a fixed system where one group is going to come out on top.

- So when I think of institutional racism I’ve always kind of thought of things in kind of a historical context but it’s more so for me now. You know I try, I think about, I just think about opportunities and how opportunities lead to different things and it’s amazing to me how it can lead to you know, affecting your health. I think of it more as a historical context.

**Interconnections and Mutual Influence**

- And I thought they did a good job of showing that chronologically and just seeing how it [institutional racism] builds on each other to you know, where we’re at right now.

- And whereas with an institutions I look at the policies, the norms, the services, the mission. And I see it more as circular. And how it keeps on reproducing itself. And so that’s how I distinguish it.

- But when I think about cultural racism in my own mind I think of it as ideas, morals, values that go upward. It may start at a very base level but then a group and somehow it just continues to rise.

**Unintentional Racism**

- I think one of the aspects of institutional racism that I think was kind of new to me was the idea that we in effect can be a part of that institutional racism because I often would think of like, that’s them, you know, who promotes institutional racism but we have all these great programs. And there was a lot of talk at the sessions I went to about how programs can actually be promoting it and made me think about what can we begin to do as people with a particular program to address institutional racism rather than inadvertently promoting it in some way. And that was a really good aspect of it- learning.

**Reframing Messages**
• Cultural, I think I started going outside the box and thinking about messages, like stereotyping, like maybe what {name} was saying, I think about that a little bit more.

**Personal Perceptions**

• Cultural racism is to me, how, it's on a more personal level. It's how, when I'm in public how I perceive things and how people perceive me. To me that's cultural. [1c]

**Difficult to Identify and Define**

• I kind of just think of it as it's so engrained you don't even think about it.

• It's kind of invisible.

• Where I think cultural racism, and again I'm not so sure that we spend as much time, kind of dissecting it but it's not always as easy to define.

• Growing up in Northern Michigan, it's just the way it was. There were I think there were three African American kids. They were on the baseball team with us. And I saw them get picked on and teased but I never was in a moment where I got treatment over them so I'm sitting there thinking, "Wow, I-" and it just is what it is. It wasn't there in my face to say the education system blatantly favored it so I'm feeling bad, like, "Wow." There's got to be stuff, I know it's out there but I just couldn't-and so right now I can't think of an exact example of being left out of social security or the black and white drinking fountain. So I think it's there, but I also think it's more invisible.

• Cultural is still harder for me, institutional I think I have a more of a sense but not necessarily a specific to what they said.

• I felt like we focused so much on the institutions and the systems, the governments, and the medicals and the education and all these different pieces that I honestly couldn't tell you cultural racism.

• I guess I don't. That's the problem.

• But still they had so many issues in that area and to hear that they were able to get community people involved in that area just spoke volumes. So I was very interested to hear, I just couldn't, I could never figure out from the training what our community was, you know?

• And I don't know if it's necessarily-I'm not sure that I'm on board with it being racism as much as it is targeting areas that could be impoverished and might have populations that are not having those services in the same ways. But it was something that was questioned, brought up. And something I've been thinking about so.

**Familiar Concepts**

• I just, I don't think that those were-that was terminology that I was either experiencing or reading about so those [definition of cultural racism] weren't new realities for me.

• Yeah, I just felt that maybe I came away with a deeper understanding of what institutional racism means and you know, just how far it could go,
you know, kind of thing. But I don’t, I don’t think it was anything too different.

- For me, that one [cultural racism] was more familiar. [inaudible] it was easier for me to grasp, to apply that specifically to my life, my work. It wasn’t so much an eye opener, like a ‘whoa’, that the other institution- the institution, I was definitely more affected by that.

**Personal Responsibility to Address Institutional Racism**

- Institutional racism I’m at a loss because at what point do you get to where, you know, your hands are tied? And that part I struggled with.

- How the system is just set up to maybe where we feel that we don’t have input, because this policy is here, that policy is there. I just see it more so being so much more complicated in terms of making an impact.

- I understood what they meant about institutional racism, I get that, but I didn’t understand within my job and what I do already how I could go that step farther, to some, you know what I mean? To make something else, different.

- I didn’t really view my role in trying to help people as one that would also be contributing to the institutional racism.

- And I thought, “man, do we ever go into our clinics and I review all of these records and these audits that we do, and do we ever go into the clinic and say ‘what will be helpful?’”

**Need New Ways to Address Racism**

- A lot of the data we report is black, white and other. …And you know it’s really easy to say, “oh, it’s just because the population size is so small so we can’t have reliable rates.” But we don’t, I don’t think put in enough effort to either you know, combine multiple years of data.

- Sometimes we get these poorly written RFPs and some community agencies don’t stand a chance because they’re just not savvy enough to write RFPs in a way that would make them acceptable to us.

- We just did that [provided technical assistance] and it made a huge difference. With a group that we knew was doing wonderful stuff. And they needed just that little bit of help to communicate it.

- That’s what I came away with from too was how the grassroots could be involved in taking a policy and examining it or re-evaluating it and making it useful to, you know, situation where they lived or a culture.

- And they talked about bringing people from that community that you’re going to serve into your meetings and your planning issues…. So I took that out of it, that’s for sure.

- We have a lot of opportunities to start passing off some of the tools as we use and deal with the institution as we’re trying to help people.
But that would make a much better change if we were more proactive and we don’t like to look at who we fund a little bit differently.

Other Statements

We have a similar thing with an advisory committee with families involved with FASD (?) and one of the questions that some of the co-chairs and elders, if you will, in that group said, was that “has anybody taken a policy and looked at how it effects us?” And so one of the things in our training that was said was that many times to quote ‘fix a problem’, while it’s like ok we’ll do this from the top down as opposed to involving the group that would be effected. And how, just like {name} explained that policy could be re-examined or re-evaluated and then incorporate some of the cultural needs of that particular group whatever it might be. And so, I thought that was cool.

I think of an example that someone gave before, you know, working at a clinic and how they expected that everyone come in person to make an appointment. I think about how the institution thought that that was ok. And how they don’t realize that, maybe realize that in trying to service some of their customers that’s not ok. But we go through life everyday, go to work and it’s ok because that’s what we said.

the discussion of the communities that we work at or work with and looking at needs assessments and identifying by certain demographics the areas that we do our work in and it was kind of framed in a way it that was like, well, that’s institutionalized racism.

Yeah, some things are so minor. I mean just find a male nurse. It wouldn’t take much but you have to take the time to look.
4. What are some examples of policies and practices at your work setting that you think might be related to this idea of cultural or institutional racism?

SUMMARY:

The focus group participants spoke of various examples of policies and practices, but they also spoke of other factors that seemed important for understanding the roots of cultural and institutional racism. For instance, many spoke about broader political barriers such as having access to political influence and power. Others talked about capacity barriers that many minority-serving organizations have in their efforts to secure funding and implement programs. One person also spoke about how surveys (typically conducted in English) may represent a language barrier for effective surveillance of health disparities. This quote illustrates one participant’s frustrations:

“I worked in adolescent health and the goal was to reduce infant mortality. And the top ten is still the top ten and you can’t- and if I get a little emotional it’s because I just don’t get it. We know, and yet somehow we haven’t- I mean it goes down but the it will go back up. We haven’t consistently impacted it.”

The most prevalent practice cited was the ineffective support and technical assistance provided to community-based organizations (CBOs) serving minority groups. These statements concur that many community-based organizations need more support and technical assistance in order to write good grant proposals and to implement state-funded programs effectively. This quote is an example:

“There are small organizations that are, we talk about this in terms of teen pregnancy, it’s like there are small organizations out there that really have an in with the highest risk referrals, you know, are they even going to have a fair chance to compete for this RFP that we’re going to reissue? When you’re competing against people that have, you know, a grant writer who know how to do logic models, who know how to speak the language of grants. And so that’s definitely an issue with the RFP that’s kind of an inherent inequity.”

Another set of practices that was cited as related to cultural and institutional racism were the methods used for surveillance of health inequities and racial disparities. Finally, several respondents talked about the need for more effective programs and policies that directly addressed race disparities. This participant suggests the current programs may hold minority groups back:

“You wonder, are we continually perpetuating people to stay in need so they can get our programs?”

Some respondents (perhaps in response to other comments) suggested that there have been broad cultural changes that have improved opportunities for African Americans. As one participant noted, this cultural change could be symbolized by the recent election of President Obama.
COLLATED RESPONSE:

Political Barriers

- And you know what I’m just going to put it out there I think it’s political. I think it has a lot to do with the politics around health. Because they have a lobby that impacted change, but when you look at poor people, when you look at people who are – have other kinds of issues and they don’t have the lobby. They don’t have the voice.

- We know and we talk among ourselves about huge awful disparity in infant mortality, we see it in infant mortality, we see it all the chronic diseases. But yet we say that, but when you look at our plans to address the issue it never-- never is a strong word-- rarely show that that is a major problem in any of the distribution of funds or effort or focus. The focus is always political one. Evenly across the state knowing that you’ve got these canyons of problems.

- And we know where a lot of the canyons [of problems] are but- and what an impact it could make if we could go to the canyon [of problems]. But there’s usually different reasons why we can’t. … I don’t think people [in policy] know about [the problems]. But maybe I’m wrong. But I mean, it is so shocking, it’s shocking.

Language & Cultural Barriers

- I think that some of the questions that are used on the surveys like the BRFSS don’t really adequately speak to other cultures and races.

Capacity Barriers for Community-based Organizations

- Well, I mean those of us who have worked here for a long time, we have a hard time interpreting some of these requirements in public health and we’re supposedly the educated and we don’t have that ability to understand this, and so the other organizations don’t even have the educational level to be able to begin to compete.

- There are small organizations that are, we talk about this in terms of teen pregnancy, it’s like there are small organizations out there that really have an in with the highest risk referrals, you know, are they even going to have a fair chance to compete for this RFP that we’re going to reissue? When you’re competing against people that have, you know, a grant writer who know how to do logic models, who know how to speak the language of grants. And so that’s definitely an issue with the RFP that’s kind of an inherent inequity.

- We also have an administrative cap, so it’s the larger organizations that can absorb that – absorb some of the cost of administering the program and I think right now a lot of our community based organizations are really struggling.

Need for More Effective Support and Technical Assistance

- I mean, I’m not sure exactly how it will work but I think if we plan far enough in advance. To set aside some money for TA, or to say this is going to be a lot of work but we’re committed to doing this next year. I think we could do it.
But I think if you have that support and focus that time and energy with them it makes a really big difference, and building trust, like you said. Not being the State person coming out and saying you need to do this, this and this but they can come to you and you can have that dialog and be flexible. I think that makes a huge difference.

So we as a State have money to fund communities. And we tell the communities what to do and how to do it. As opposed to working with very involved community members, community organizers I think they call them? Is that the term? And really working through them more closely. ...And how do we as State workers that have to blanket the state with different initiatives make sure that we are really engaging the community and involve community members.

... like they were saying that really empowering communities and getting that community leadership from the ground up takes time and that we maybe have, you know, like generally we get pots of money for three years, for five years or some finite period of time.

You know, it’s like grants to, to run programs, to see this many kids, to do this work. It’s not to build leadership and empower - help the community, you know, and work on empowerment and things like that.

It’s just giving them [clients] what they need- so they can’t understand the process, why A gets them to B and B gets them to C. We just go A, and yeah, we’ll take this.

I think it built that relationship of ‘I value what you are saying.’ I’m not going to be this state person saying it must be this survey that we’re a team and so it opens up, it kind of opens up the door to being able to do new and creative things because you’ve built in that relationship. So we did that at this time and we’re trying the instrument with revised questions and if we have to revise it again next year then to me it’s like we’ll just have to keep on revising it until it’s doable.

**Need for More Effective Surveillance**

- And we have to look at the ways of collecting this data too. You know? Because not everybody has a computer, right?

- When I hear several people mention, “no we don’t always collect that data.” I’m like, “Really? We don’t collect- Really? Are you kidding me?” We’re the State Health Department, what do you mean we don’t collect it and we don’t have a plan to do something about it. ...I’m surprised, I’m surprised that a State department hasn’t done this.

- And so that’s what I mean. I’m happy I think we need to get on the message, everybody – we have something to say, okay we got this, now let’s keep building on to it. But then as I look at it and hear about it I’m like, “Really? We had to put that on paper?” In one sentence to say look at the disparity. Actually track it, report it, we’re not doing that?

**Need for More Effective Programs & Policies**

- And we were, we were struggling with how to take, you know, the requirements of the feds agency that we have to do and yet we know X,Y,Z works but that’s
not what the money’s for and so how to mesh those two worlds.

- Yeah, we provide them care and are successful in doing but we’re not- unless we’re going outside, above what we’re being asked to do we’re not doing anything to help them stand on their own.

- You wonder are we continually perpetuating people to stay in need so they can get our programs?

- And just the mindset in even coming for the help is, and the handout is- we’re done. Until the next problem arises. We have all of these policies set up, and you know you have to look at all of your programs and make sure that you’re getting all these different communities and your given all of these public awareness responsibilities and different guidelines and you know you’re, you don’t have any different income guidelines and you know don’t have anybody [inaudible], you’re still missing all these families that could be potentially eligible. I don’t know, just, you know, where- where’s that- what would it take to get us where we need to be? It’s not just policy it’s kind of a, I kind of want to say lack of a policy but also lack of awareness [inaudible].

**Cultural Changes**

- I think that blacks have more opportunities than they used to have. I think our work with disparities has, you know, institutionalized, has improved some of the white people’s acceptance of different cultures.

- Well, look at our president. I mean it never was even discussed we have a president that is black.

- Now, that [having a black president] was addressed in ours though and I think it was suggested as an example of how there have been some progress, but when you look at the disparities, and the disparities are so great there’s still a lot more to do.
5. What are some ways that policies and practices in your work setting could be changed to reduce cultural and institutional racism. So what is it you imagine could feasibly happen here in your work setting?

SUMMARY:

The participants were most likely to imagine engaging community members and community-based organizations in discussions about effective policies and practices as a way to reduce cultural and institutional racism. The methods of engaging the community in these discussions varied from greater communications (e.g., distributing newsletters) to supporting more involved partnership efforts. Many suggested that communications and partnerships with local community agencies and citizens would increase the possibility that state-run programs and policies would more effectively improve the health in local communities with improve health outcomes for minority race groups.

Other participants suggested that MDCH staff conduct studies to learn more about the root causes of health disparities and strategies to reduce disparities. As one participant noted:

“To me that will be one of our first steps is to at least look at the problem and know what the problem is, isn’t that the way to solve a problem? Is to first recognize it? And make sure you understand what it is. And to be able- and to continuously measure if you’re making a change.”

Several people stated that MDCH needed to establish continuous and sustainable efforts to address racial health disparities. They suggested commitments to “keep checking ourselves...keep checking each other” and “keep looking at how we do things.” One participant suggested that MDCH “address all the cultural differences” in their programs.

The last strategy participants imagined was to be more creative in the use of State funding. Establishing policies and programs that used flexible funding strategies would allow MDCH staff to more effectively support local communities address their local health needs.

COLLATED RESPONSES:

Engage Community Members and Agencies

- Honestly I don’t know what’s happened with that because you don’t see the newsletters like we used to. I’m not seeing the communication that there once was.

- I agree with that [creative use of funds] and I think we need to spend more time in communities. We never ask communities or we rarely do, what they really need.

- Which says to me we’re trying to get their input on our terms.
• Because one of the things that struck me also from the workshop was that community organizing piece. That was a piece to really think about, try to figure out how to incorporate.

• I don’t know that we know how to get their input on their terms.

• I don’t think we’ve ever done this but I wonder if somehow we could form some kind of partnership with some organizations in the community that we could nurture. … One thing we never tried is maybe trying to form a partnership with them to advocate for them to get other funding from their local community. For example, getting together with the United Way office or a local foundation in their community and supporting them by even helping them to write a grant or meeting with those other funders and be an advocate for them.

• And from my point of view, honestly I still struggle with that because I don’t- I guess I my vision of policy comes from here down. It doesn’t come from down here and go over. … And how do we incorporate all of that together so that we’re all working together? And we’re all getting on the same page?

• Well they are trying to do more coalitions, get into the communities but your average Joe doesn’t want to.

• It [policy/programs] needs to come from the ground and go up.

• So one of the things that we’re looking at is going into the communities and saying can we fund people [inaudible] in order to get more involved and there’s more awareness in general than you have with a specific population.

• And have a pulse on the community, I don’t know how but someone, maybe not each individual but that someone has a pulse on the community that we can have some communication.

**Study the Problems and Strategies**

• We need to look at other states who are doing – I mean, we just can’t operate in a silo because it’s not just Michigan. We’re talking about a country, we’re talking about group of people being so sick and having a whole set of health issues when – little things can happen just to turn, start turning the tables.

• To me that will be one of our first steps is to at least look at the problem and know what the problem is, isn’t that the way to solve a problem? Is to first recognize it? And make sure you understand what it is. And to be able- and to continuously measure if you’re making a change.

• It doesn’t matter what the policy is but they’re looking at the impact on health and I kind of like that concept that- we need to look at everything in terms of how it [policy] impacts health and I wish we could figure out how we could foster that more

• And we have to address all of the cultural differences with those programs as well.

**Continuous Effort to Address Disparities**

• We got to keep checking ourselves and we’ve got to keep checking each other. And just trying to see what we can do, how we can do it differently.
Now we have money to try and address it. It’s got to become a way of life for us. It’s got to be interwoven in everything that we do and we can’t just talk about it today or through June and that be it. We have to talking about it, we have to keep looking at how we do things and we have got to keep checking on ourselves.

I think that it’s important that we continue to talk about this and we don’t let it die once the money dries up.

**Flexible Funding Strategies**

I think we could try to be more creative about our use of the State funding that we have because we have more restriction on federal dollars and how they must be spent, they’re so precise, but-and our program does have some state resources that maybe we could try to leverage more to use in capacity building in a way that we can’t always use our federal dollars. So creative use of funds.

I think if we had creative pots of money, if we really truly had pots of money for communities that could be pulled and we could go in there and really talk and figure out what it is that you need that this community [inaudible] may not have.

I really feel that we do our best with the strengths that we have. But it’s like if we had more fluid pots of money and we really could have that flexibility to tailor that money to what the needs of that community might be than I think that would go a lot farther than how we do things.
Appendix D: Health Equity Social Justice Workshop Evaluation Report
Analysis of Health Equity Social Justice Workshop Evaluation Surveys

Allison Krusky, MPH
Thomas M. Reischl, PhD
November 18 2011

Workshop Date

<table>
<thead>
<tr>
<th>Date of the workshop (MDCH Staff Only)</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid 8/15/11</td>
<td>17</td>
<td>23.0</td>
<td>23.0</td>
<td>23.0</td>
</tr>
<tr>
<td>8/29/11</td>
<td>15</td>
<td>20.3</td>
<td>20.3</td>
<td>43.2</td>
</tr>
<tr>
<td>9/19/11</td>
<td>24</td>
<td>32.4</td>
<td>32.4</td>
<td>75.7</td>
</tr>
<tr>
<td>9/29/11</td>
<td>18</td>
<td>24.3</td>
<td>24.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>74</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

The Health Equity Social Justice workshop was attended by 74 MDCH participants. There were an additional 13 participants from partnered community organizations. There were 4 Health Equity Social Justice workshops; each consisting of 2 and a half workshop days. There was a 2-4 week break between the first two days, ending with a half day follow-up session.

1. What is your job title? (Check one answer.)

<table>
<thead>
<tr>
<th>Job Title (MDCH Staff Only)</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Administrative/Management</td>
<td>12</td>
<td>16.2</td>
<td>17.9</td>
<td>17.9</td>
</tr>
<tr>
<td>Program</td>
<td>10</td>
<td>13.5</td>
<td>14.9</td>
<td>32.8</td>
</tr>
<tr>
<td>Coordinator/Specialist</td>
<td>25</td>
<td>33.8</td>
<td>37.3</td>
<td>70.1</td>
</tr>
<tr>
<td>Program Consultant</td>
<td>7</td>
<td>9.5</td>
<td>10.4</td>
<td>80.6</td>
</tr>
<tr>
<td>Administrative Support</td>
<td>13</td>
<td>17.6</td>
<td>19.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
<td>90.5</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing System</td>
<td>7</td>
<td>9.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>74</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The largest proportion of program attendees identified themselves as a Program Consultant. There were roughly similar amounts of Program Coordinator/Specialists, Administrative/Management, and Other. Slightly fewer identified themselves as Administrative Support.

29. What Division/Section do you work in? (Check one answer.)

<table>
<thead>
<tr>
<th>Main Division (MDCH Staff Only)</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Division of Family &amp; Community Health</td>
<td>55</td>
<td>74.3</td>
<td>80.9</td>
<td>80.9</td>
</tr>
<tr>
<td>Division of Health Wellness and Disease Control</td>
<td>6</td>
<td>8.1</td>
<td>8.8</td>
<td>89.7</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>9.5</td>
<td>10.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>91.9</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing System</td>
<td>6</td>
<td>8.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>74</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Missing did not have pre-tests.

Most of the Health Equity Social Justice MDCH participants were from the Division of Family and Community Health. The remaining participants were split evenly between the Division of Health Wellness and Disease Control or Other.

<table>
<thead>
<tr>
<th>Section (MDCH Staff Only)</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Health Disparities Reduction and Minority Health</td>
<td>3</td>
<td>4.1</td>
<td>4.9</td>
<td>4.9</td>
</tr>
<tr>
<td>HIV/AIDS Prevention and Intervention</td>
<td>4</td>
<td>5.4</td>
<td>6.6</td>
<td>11.5</td>
</tr>
<tr>
<td>Women, Infant and Family Section</td>
<td>28</td>
<td>37.8</td>
<td>45.9</td>
<td>57.4</td>
</tr>
<tr>
<td>Child and Adolescent Section</td>
<td>18</td>
<td>24.3</td>
<td>29.5</td>
<td>86.9</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>10.8</td>
<td>13.1</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>61</td>
<td>82.4</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing None</td>
<td>3</td>
<td>4.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>System</td>
<td>10</td>
<td>13.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>17.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>74</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Missing- None are those who selected a MDCH Division but selected None for Section.
The largest proportion of MDCH participants were from the Women, Infant and Family Section, or the Child and Adolescent Section. There were several participants from the Health Disparities Reduction and Minority Health or HIV/AIDS Prevention and Intervention sections.

30. Are you a person of Hispanic, Latino, or Spanish origin? (Check one answer.)

<table>
<thead>
<tr>
<th>Hispanic (MDCH Staff Only)</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid No</td>
<td>66</td>
<td>89.2</td>
<td>97.1</td>
<td>97.1</td>
</tr>
<tr>
<td>Yes</td>
<td>2</td>
<td>2.7</td>
<td>2.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>91.9</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing System</td>
<td>6</td>
<td>8.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>74</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: Missing did not have pre-tests.*

Almost all MDCH participants were non-Hispanic.

31. What is your race? (Check all that apply)

<table>
<thead>
<tr>
<th>Race (MDCH Staff Only)</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>51</td>
<td>68.9</td>
<td>75.0</td>
<td>75.0</td>
</tr>
<tr>
<td>Black or African</td>
<td>12</td>
<td>16.2</td>
<td>17.6</td>
<td>92.6</td>
</tr>
<tr>
<td>Asian</td>
<td>2</td>
<td>2.7</td>
<td>2.9</td>
<td>95.6</td>
</tr>
<tr>
<td>Asian and White</td>
<td>1</td>
<td>1.4</td>
<td>1.5</td>
<td>97.1</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2.7</td>
<td>2.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>91.9</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing System</td>
<td>6</td>
<td>8.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>74</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: Missing did not have pre-tests.*

The majority of MDCH participants were White (75%), with Black/African American (18%) as the next largest group. A select few identified themselves as Asian, multi-racial or other.
Pretest and Posttest Self-Rated Competencies

How much do you agree or disagree with the following statements about your level of confidence in successfully conducting these specific tasks?

<table>
<thead>
<tr>
<th>I am confident I can…</th>
<th>Mean</th>
<th>SD</th>
<th>Mean</th>
<th>SD</th>
<th>Paired t-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=82)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Articulate an understanding of target identities and non-target identities.</td>
<td>3.25</td>
<td>1.10</td>
<td>4.64</td>
<td>.51</td>
<td>-9.91*</td>
</tr>
<tr>
<td>33. Articulate an understanding of the four levels of oppression and change.</td>
<td>2.62</td>
<td>.92</td>
<td>4.44</td>
<td>.74</td>
<td>-14.72*</td>
</tr>
<tr>
<td>34. Articulate the difference between health disparity and health inequity.</td>
<td>3.43</td>
<td>1.05</td>
<td>4.38</td>
<td>.88</td>
<td>-6.97*</td>
</tr>
<tr>
<td>35. Articulate an understanding of social determinants of health.</td>
<td>3.72</td>
<td>.87</td>
<td>4.41</td>
<td>.73</td>
<td>-5.54*</td>
</tr>
<tr>
<td>36. Articulate an understanding of cultural identity across target and non-target groups.</td>
<td>3.03</td>
<td>.92</td>
<td>4.32</td>
<td>.72</td>
<td>-9.87*</td>
</tr>
<tr>
<td>37. Articulate an understanding of public health’s historical role in promoting social justice.</td>
<td>3.28</td>
<td>.94</td>
<td>4.33</td>
<td>.78</td>
<td>-8.44*</td>
</tr>
<tr>
<td>38. Articulate an understanding of the root causes of health inequity.</td>
<td>3.54</td>
<td>.92</td>
<td>4.38</td>
<td>.69</td>
<td>-7.02*</td>
</tr>
<tr>
<td>39. Analyze case studies in a social justice/health equity framework.</td>
<td>3.12</td>
<td>.99</td>
<td>4.40</td>
<td>.60</td>
<td>11.00*</td>
</tr>
<tr>
<td>40. Identify opportunities for advancing health equity at my workplace.</td>
<td>3.29</td>
<td>.85</td>
<td>4.29</td>
<td>.60</td>
<td>-9.36*</td>
</tr>
</tbody>
</table>

* p < .001

Participants showed statistically significant (p < 0.001) increases in all reported self-confidence ratings in understanding social justice and health equity/disparities terminology, and in their ability to identify opportunities for addressing health equity.
## Pretest and Posttest Content Knowledge Items

*Please circle True or False or Not Sure for the following statements.*

<table>
<thead>
<tr>
<th>Knowledge Question</th>
<th>Correct Answer</th>
<th>n</th>
<th>Pretest</th>
<th>Posttest</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>41. Men are the “non-target” group for identifying gender oppression and privilege.</td>
<td>True</td>
<td>80</td>
<td>28.8%</td>
<td>83.3%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>42. The experience of oppression and privilege can change frequently based on our target and non-target group identities.</td>
<td>True</td>
<td>81</td>
<td>64.7%</td>
<td>92.6%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>43. Nearly everyone experiences some form of unearned privilege, regardless of how hard they work to achieve success.</td>
<td>True</td>
<td>81</td>
<td>60.3%</td>
<td>69.1%</td>
<td>.327</td>
</tr>
<tr>
<td>44. One way health departments can address the social determinants of health is by promoting healthier eating habits.</td>
<td>False</td>
<td>81</td>
<td>38.8%</td>
<td>64.2%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>45. The field of public health developed in response to social injustice brought about by the industrial revolution.</td>
<td>True</td>
<td>82</td>
<td>33.8%</td>
<td>82.4%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>46. The social justice framework for public health practice suggests that health problems are primarily caused by lower-income individuals making bad health choices.</td>
<td>False</td>
<td>81</td>
<td>76.5%</td>
<td>88.2%</td>
<td>.077</td>
</tr>
<tr>
<td>47. The social justice movement in public health is an attempt to shift focus from health inequities to health disparities.</td>
<td>False</td>
<td>81</td>
<td>43.3%</td>
<td>76.1%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>48. The term “health disparities” refers to the underlying causes of “health inequity.”</td>
<td>False</td>
<td>82</td>
<td>27.5%</td>
<td>44.9%</td>
<td>.017</td>
</tr>
<tr>
<td>49. Thoughts, beliefs, and values held by an individual are examples of the cultural level of oppression and change.</td>
<td>False</td>
<td>81</td>
<td>21.2%</td>
<td>69.7%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>50. The institutional level of oppression involves rules, policies, and practices that advantage one cultural group over another.</td>
<td>True</td>
<td>82</td>
<td>81.2%</td>
<td>97.1%</td>
<td>.007</td>
</tr>
<tr>
<td>51. The personal level of oppression involves actions, behaviors, and language.</td>
<td>False</td>
<td>82</td>
<td>7.2%</td>
<td>49.3%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>52. Eliminating interpersonal level oppression involves change in community norms and media messages that reinforce stigma and negative stereotypes.</td>
<td>False</td>
<td>81</td>
<td>10.3%</td>
<td>64.7%</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

Participants showed statistically significant (p < 0.001) increases in knowledge for 8 of 12 content knowledge questions. Significant increases in knowledge were not seen on questions regarding unearned privilege, the social justice framework, differentiating health equity and health disparities, and defining racism at the institutional level. Pre-test scores ranged from 7.2% to 81.2%, with post-test scores ranging 44.9% to 97.1%.
Workshop Evaluation Questions

53. In what ways will this workshop help you better address racial health disparities at your job? Please list your ideas of what you could do or would like to do in your job that is different from what you are currently doing.

Summary: A majority of participants were able to provide ideas for ways that they could address racial health disparities, ranging from generic to detailed plans. Some ideas suggested included becoming advocates for social justice, increasing awareness by including trainings or presentations on social justice and changing how data is managed. The specific ideas suggest that participants were able to make connections between workshop lessons and apply them to their work setting. Participants also looked at ways to foster what they had learned by interacting and communicating with others about health equity.

(61 responses)

- **Share Knowledge of Health Equities**
  
  Educate/share info with my staff, colleagues and the communities I serve
  
  Continue to try and educate myself and others about health inequalities and SDOH
  
  Share these experiences with others

- **Increase dialogue/communication**
  
  More dialogue with appropriate management.
  
  It gave me better ideas about how to start the dialogue and ensure that everyone has a voice.
  
  Integrate health inequity, privilege and oppression conversations with colleagues and dialogue into training
  
  Encourage people to "ask me about health inequities" (button) and be prepared to do quick (and in-depth) conversation about it
  
  Communication with providers
  
  Create dialogue around racism
  
  Will utilize rules of dialogue to address racism.
  
  Utilize strategies in dialogue to promote "consciousness"

- **Increased awareness**
  
  Pay attention to institutional and cultural racism that may be interfering with our ability to adequately address health disparities
  
  By bringing awareness within my work.
  
  Make me more aware of racial disparities
  
  Heightened awareness of root causes of health disparities. How racism may impact access to services.
Be aware and recognize possible perceptions of actions

use an equity lens at all times
Keep the health inequity lens

Keep the issue on my mind

I will be able to understand injustice in the context of the four levels, making it easier to identify potentially successful intervention points
It will make me look first at how I deal with all people no matter what their issues or disparities are.

Reassess how I think, talk and treat others.

- **Address Policies/Procedures**

  look at workplans, policies and procedures, RFPs to make sure we are considering the impact of racism.

  Address in all our assessments
  Identify if 1 of 4 levels of oppression are present.

  making sure we are addressing root causes

  Recommend changes in policies.

  Policy development

  Policy changes

  Assessment of policies, programs/initiatives as they impact target groups

  Support policies and resources that include this content.

infuse concepts learned into policies, procedures, programs, impr. plan, strategic plan and personal actions/though/beliefs

- **Community Engagement**

  Build capacity among groups that do not traditionally get invited to the table or receive grant funding.

  lots of ideas of tangible changes I can do/make associated with community action, capacity building and creation of ambassadors to address racism and social determinants of health

  Raising awareness and input into development of work plans for programs I work with- -In consultation with community partner and program partner

  Engaging community partners to start a dialogue on root causes

- **Change to health equity framework**

  Utilize a different lens for confronting racial health disparities from a social justice framework incorporating strategies into program that speak to health equity and social determinants of health.

- **Tools/Skills received from workshop**

  this workshop provides the materials and skills to bring up the dialogue and thought process of racial health disparities

  Toolkit of strategies to move forward
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- **Collaboration**
Taking a team approach to addressing racial health disparities

engage others to develop allies.

Continue and expand efforts to bring representatives from “target” groups to the table to help.

**Trainings/Workshops**

training, dialogue

Include racism as training topic- ongoing

Discuss the root causes of health disparities when given an opportunity to do so through meetings, trainings, work plans, etc.

include this discussion as a topic in every training and workshop

Staff training and supervision

Promote awareness to others.

Will be part of program trainings for providers

Include content in disseminated info, curricula, training sessions, etc.

Incorporate health disparity information in presentations (ie. as a presenter add as session when planning a conference)

Integrate SJ Framework to teaching.

- **Fund Health Equity Projects**

concentrate funds for projects that address disparities

address health disparities in workplans w/grantees.

- **Take Action**

More work toward direct action; activism

I will actively try to address inequities both in the work place and the community.

find a daily challenge

Address the issues of maternal mortality such as more black women dying within one year of giving birth.

will add requirement to contractual work plans

Gave ideas to help keep it present in my daily work

post visual images

Take a look at my presentations to make sure there are no language or other words/phrases/ideas that could be perceived as oppressive.

re-examine policies, trainings and interactions w/ external partners to ensure that health equity is increased.

Speak up more with my new language when I see contributions to health inequity

Applying an equity lens to all decisions/situations or "4 levels" analysis
Assure that I am incorporating the principles of equity and social justice into the technical assistance I provide to local communities.

always be mindful of what I've learned about here and practice it. Silence is agreement; continue to be the voice of change.

Partake in activities that help law makers and the general public realize that health disparities is something that can be changed starting at the personal interpersonal and institutional level, and educating them on how to recognize it and putting together action plans to reduce health disparities.

• **Improve Data Management**

Look at data in terms of race/ethnicity in different ways. Make an effort to gather high quality data on race/ethnicity

consistently analyze data and policies to discover health disparities and develop actions to address them.

Collect more complete race/ethnicity data and make it available.

Better data and analysis of data as it applies to target groups.

Make work of our epidemiologist/scientist more useful, accessible to the general public as (a) public health information resource for public health undertaking(s)

• **Other Comments**

Review objectives for Rhd [racial health disparities?].

it was insightful to the issues, whereas previous to the workshop they were not even thought about.

Captured in group list [?] at the end

It’s difficult to say because I am in a position that does not make decisions but follows directions given.

Identify potential for decisions made in deciding resource environments to [?] health inequity! Social disparity

Work to improve infant mortality in Michigan

Continue to always provide the best services available
54. Describe the most useful or valuable outcomes of this workshop.

Summary: Most participants listed either knowledge of racism and concepts surrounding health equity or high quality discussions (dialogue) as the most useful/valuable outcome of this workshop. While practicing the principles of dialogue, participants were able to work as a team to problem solve and further develop strategies to use in the workplace. Participants appreciated the opportunity to practice the workshops lessons through role play.

(65 responses)

- **Communication (Dialogue)**

  Conversation (storytelling, sharing opinions, etc.)

  Attempting to begin to have dialogue on tough issues.

  When communicating my ideas and concerns, use information on how to approach individuals and groups.

  The conversations and enactments were really interesting

- **Health Equity**

  Terminology/Concepts

  Terminology

  White privilege

  useful conceptual frameworks to integrate into overall thinking- and thereby to more consistent and effective, appreciate

  Understanding the 4 levels and how you can make change learning about the 4 levels of oppression (defining them)

  Refocusing of Health Disparities concept, 4 levels at SDOH

  Framework (4 types of oppression) to actually use
Intent/Impact

providing these definitions related to health equity and social justice to provide a foundation for future departmental work.

understanding of the 4 levels of oppression and change.

Understanding of target and non-target groups.

The most valuable was a deeper level of understanding of the 4 levels of oppression and the increased ability to analyze situations using the concepts to achieve a more favorable outcome.

The convening of the group- the people the tools you shared, time to dedicate to thinking about this issue case studies/practice

The specific ways to respond to inequities...exploring these through scenarios and role play.

The role playing and strategies for influence

the role-playing case studies

Practice and assess strategies for engaging others at interpersonal level.

Role playing

Role playing on Day 3! Relevant to our work- not just "random " scenario!

Learning about four levels of oppression and change and addressing them in the workplace and activities

- Increased awareness/knowledge Learning about the impact of lifelong racism on infant mortality rates

Unnatural causes video- increased my awareness of racism on African American births- poor outcomes the degree of the chronic stress

a raised awareness of health affects of racism on the population I am try[ing] to help

A greater understanding of social justice in public health

the experience of people of different cultures and how they are treated.

Raising awareness of health inequities and ways to work to eliminate.

Awareness of the root causes of health inequities

Awareness of the problems and how we can make an impact

More awareness of the nuances of racism Insight on minorities and what they face daily, which contributes to the health inequities we face.

different viewpoint and concrete ways to utilize new knowledge/awareness

The awareness

Somewhat better understanding

Understanding 6 core feelings and differences between target and non-target groups.

Most valuable outcome was the information.
Gain an understanding of health disparities and what are the root causes.

Racism is the cause for health inequity

Look at all my actions and behaviors.

- **Opportunity to Problem Solve**

  mindful thinking and program planning

  To begin to identify areas that I can address in my work to achieve an increase in knowledge of health inequities.

  Ideas for how to engage individuals/groups in the consideration of root causes.

  How we can improve things with our work

  Opportunity to learn and explore the root causes of racism beyond just looking at the data, and how we personally can make changes.

  Also what each person can do on an individual and institutional level to help change health disparities.

- **Workshop Aids**

  Some great slides and presentations of how to think about emotions levels of oppression; diagram of root-social determinants- health.

  Very accessible.

  Slides and content

- **Workshop Tools/Strategies**

  Tools and examples shared. Resources provided

  Knowing that I can "try on" different strategies. Remembering the importance of both/and

  Sharing of strategies to address inequities/disparities

  tools/language for meaningful dialogue

  Leaving with a plan/action steps to make changes and create an empowered/proactive approach

- **Facilitators**

  Listening to Doak was very valuable. I feel like his presentation skills were powerful and engaging.

  Having informed/well-versed facilitators to expand participant knowledge & stretch minds to look at things different.

  and the workshop leaders.

- **See outside personal lens**

  Helping me to think about health disparities through a health inequity/social justice lens

  Learning from the perspective of others.

- **Energized/Empowered**

  making me realize that I can use my privilege to confront many types of "isms"

  Empowering the privileged to use their power to impact health inequity or mitigate potential negative impact in health inequity.

  I also feel more empowered to advocate for change.
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I now know what health disparities and inequities are and how I can implement change.

The workshop was very thought-provoking and re-instilled my desire to devote my career to promoting health equity and social justice.

Renewed enthusiasm for taking action

- **No Judgment**
  Ability to talk freely

Created a comfortable environment with an uncomfortable topic

Did not leave the individuals feeling vulnerable.

- **Other**
  worked w/structure! 2 1/2 days!

Everything

No more "but" to be used

still processing but...vast.

Started having participants think about how to incorporate the info learned.

Embracing or making room for discomfort
55. How did this workshop improve your specific knowledge or skills you use for your job? Please list the specific areas of knowledge or skill development that improved.

Summary: Participants listed improved knowledge in social justice and health equity, and in particular the ‘4 levels of oppression’, terminology (eg. white privilege, non/target groups) and concepts. Participants reported that this increase in the foundational knowledge of health equity and social justice, along with conversational skills will help them when interacting with others and in making changes in their jobs.

(62 responses)

- Knowledge: Social justice, disparities, inequity, oppression

  Enhance knowledge regarding disparities/inequities.

  Detail social determinants of health (had general knowledge/reading in resource [?] background)

  My knowledge of SDOH and presentation of true root causes.

  racism as a root cause of health disparity- this was news to me.

  Increased knowledge and awareness.

  Information target groups.

  I did not previously have the historical background/knowledge about disparities in our culture.

  helped w/Health dis v. Health equity

  More thorough understanding of the social determinants of health

  Understanding levels of oppression

  This workshop better defined the 4 levels of oppression and how they impact health outcomes such as infant mortality.

  New knowledge of levels of oppression.

  Increased level of understanding of 4 levels of oppression

  Levels of oppression.

  Four levels of change

  4 levels, layers of social structure

  Awareness of the four levels of oppression.

  Information [on] oppression

  4 levels of oppression. (3)

  understanding of the 4 levels of oppression and change.

  Provided clear historical data related to actual system/government policies that have created great inequities.

  Oppression

- Ideas for Change
Gave some possible action steps to continue promoting this.

I felt it provided more actions on how to make change.
Advocating for change when a program or policy is not very effective.

Will work to improve objectives and needs for program change.

I improved in many ways; especially gained better understanding of how public health information is/should be conveyed for gaining greater public support.

Better data and analysis of data as it applies to target groups. Assessment of policies, programs/initiatives as they impact target groups.

- **Tools/Skills to take action**

  language use to bring up policy change

  Looking at 4 levels to determine where/how change occurs

  I have specific tools to use such as the 4 levels

  The 4 levels of oppression will cause me to reflect on how I think & interact with others, and how I can help improve program delivery.

  Identifying the difference between disparity and inequity - now I can integrate the idea of inequities into how I frame data results.

  Strategies.

  Realization that this skill is continuously evolving and we do have some tools now

- **Conversation skills**

  Talking across differences and speaking up even when it's uncomfortable

  Skills in communicating health inequity concerns in the workplace

  Skills and knowledge: Communicate cause/purpose of H. Equity work to leadership and how to be explicit with this work in addressing R/E health disparities.

  non-confrontational ways to bring up conversations in meetings. big picture view of the purpose [of] uncomfortable conversations

  use of dialogue

  To gather tools necessary to start a conversation about inequities.

  provide the languages for future + far reaching discussions

  Role playing increased the skill/understanding of the value of collective dialogue.

  Provide language to talk about the issues at work.

  Additionally the ability to dialogue/open the dialogue regarding the SDOH and the root causes

  Creating a dialogue

  Discussing ways to talk with colleagues about these issues.

  Attempting to begin to have dialogue on tough issues.
listening with open mind, for intent and impact

- **Terminology/Concepts**
  New terminology, definitions, concepts
  Privilege. Target and non target
  
  gave me new terminology for the same problems
  
  greater understanding of terms and differences between terms and ideas
  
  Understanding of target and non-target groups.
  
  Terms and understanding
  
  Target "Non-Target" < defining and acknowledging
  
  Unearned privilege and intent/outcome
  
  A skill that I am taking away is the Both/And concept and an [up arrow (increased?)] ability to articulate that in dialog.
  
  useful conceptual frameworks to integrate into overall thinking- and thereby to more consistent and effective, appreciate)
  
  Framework (4 types of oppression) to actually use. Renewed enthusiasm for taking action
  Specific concepts were taught which helped to frame the context
  
  It taught me a few new concepts/constructs that will help me both understand and articulate my beliefs to what is going on around me, others (e.g. four levels of oppression, intent vs. impact)
  
  solidifying concepts of health equity to redirect and fine tune existing work.
  
- **Workshop provided practice**
  
  The role playing was very valuable
  
  The last group exercise helped in solidify what can be done
  
  It was interesting in coming up with creative thinking on how to solve the scenarios we were presented within helping to come to a conclusion.
  
  case studies were valuable tools in taking the leap from theory to practice
  
- **Self reflection on work role**
  
  Made me think about what tasks I do in my job [and] where my power lies - even though I am not high-ranking
  
  Look at me and what I bring to work. Be an example.
  
- **New perspective/awareness**
  learned of the inequities that exist for all the programs in my unit
  
  It helped me to see areas that I had not considered before.
  
  Insightfulness across the board.
  
  Looking at the specific actions of providers, people through the lens of health inequity.
  
  Awareness of privilege.
  
  I think I improved by becoming more aware of the health disparities the children of Michigan face
recognizing disparities for target group vs non-target group understanding how discrimination and racism adds to health disparities and infant mortality rates for African Americans who do all the right things before having a child (eat right, exercise, don't smoke) but still have low weight babies and other problems that can be contributed to discrimination and racism that causes stress to the body (even before childbearing age) that have an effect on infant mortality for African Americans. hearing other voices that gave new perspectives on prospective and existing issues

- **Other**

  Hope to have better support at work.

  Still having difficulty translating all this into my job

  Makes me understand why infant mortality rates are so low - this helped put a lot into perspective for me.

  use of "and"
In what ways did this workshop disappoint you or fail to meet your expectations?

Summary: Although quite a few participants reported not being disappointed in the workshop, there were a variety of suggestions to improve the session. The most frequent suggestions revolved around desiring more individualized ideas for change, and more open conversations. Other improvements included updating examples to have more recent events, adding more time, and addressing some privacy concerns (e.g., Evaluation and target group exercise).

(45 responses)

- **Still have questions**

  Third day seemed to have left things unanswered for me.

  Did not address comments made in writing (except 1) at end of day 2.

  Wondering what the next step will be

  no solutions for existing problems that we've been struggling with for a long time.

- **Scheduling of the Workshop**

  The timing, which is no one's fault- it came at a very stressful work time.

  Really good not to afford to take this much time from job duties. Would have preferred a better time but understand....

- **Lower ranking position did not feel empowered**

  Still feel powerless to make changes since not a manager. Will try to get economic support.

- **Workshop content/exercises**

  Some beginning parts were redundant

  I've studied this a lot over the years so already had a lot of the info presented.

  I would not have made participants circle their target/non-target group among co-workers for LGBT vs. Not groups

  I believe the workshop could be "updated" with more recent history of social injustice,

- **Wanted more open discussions**

  Did not fail expectations, but sometimes I don't feel the conversation was as genuine and open as it could've been.

  It seemed rather "nice". I'm still not clear if the apparent lack of discomfort addressing touchy subjects was due to the nature of this particular group, the skilled facilitation, or the lack of really pushing the issues that tend to make people uncomfortable.

- **Was not disappointed**

  None (9)

  N/A (8)

  It didn't. (2)

  It did not disappoint me at all.
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In no ways.

was not disappointed

did not disappoint.

0 Disappointment

0

- **Met/Exceeded Expectations**

  It met my expectations.

  was much better than expectations

  Exceeded my expectations

- **Difficulty Sharing Terminology**

  The only issue I have is when I discuss these concepts with others, who haven't had the benefit of these workshops, the term unearned privilege is very challenging. It has been suggested to me that "inherent privilege" is a more appropriate term, but I wonder if individuals are simply scared of losing privilege? They do not feel that they have not worked very hard for where they are in life.

- **Workshop length**

  I'd love more- but realize the difficulty w/current time commitments

  Wish it were longer.

  Would have liked to do the 4 day training I heard about!

  - **Not Attended by Everyone**

    I am disappointed that my entire workplace is not able to attend this workshop. I hope you guys can get funding to offer this outside of Lansing.

  - **Evaluation**

    In order to solicit more honest opinions-evaluations should be confidential instead of attached to poster. This could affect reliability of the evaluation.

  - **Other**

    ? (2)

    (dash/negative sign with circle around it)

    I feel as though I had a wall put up before I came in due to Undo Racism. The verbal abuse I experienced at Undo Racism made me distrust these trainings. This training slowly regained my trust- thanks!

    ensuring a follow-up to the concrete ways recommended for institutional change
57. What would have made this workshop more successful?

Summary: There was a variety of suggestions to make the workshop more successful, although there was a portion who felt that the workshop was successful as it was. Some of the suggestions with the most respondents included adding more time to the workshop (although there were a few comments to shorten) and keeping the groups approximately the same size or smaller. Most responses were compliments of the workshop or facilitators.

(47 responses)

- **Group Composition**

  Less people

  Keeping the group small made this successful. About 20 people seemed just right. The previous "Undoing Racism" workshop with people Institute was too big...60 participants.

  A proportion of target groups rather than primarily white women. Not sure how this could have been avoided.

  Involve more from my agency and use examples applicable to the agency.

- **Workshop logistics**

  more comfortable atmosphere- tables to put drinks on, take notes... I understand the circle concept, but hate it because it is physically uncomfortable maybe held away from work location

  Better facilities, more comfortable chairs/seating

  Schedule was really rough considering participants' real life circumstances and lives (childcare, commuting, other work responsibilities.

- **Nothing**

  Nothing (3)

  Nothing. More than I expected.

  No suggestions

  N/A (5)

  It was successful

  I think it was fine the way it was

- **More time**

  Simply need more time.

  more time (2)

  In a perfect world we would have had more time - 4 days.

  Day 3- Dialogue should go until 3pm to allow more time to delve into solutions and next steps.

  The 4 day workshop would have gone into more depth on some topics

  More practice time with communicating. Pair up 1:1 and have everyone practice each roles.

- **Less time**

  I would have preferred it to be shorter

  I think the workshop was too long. I often start drifting off into my own world and not listening to the information.
• **Workshop Compliments**

Content was excellent.

was excellent overall it was excellent, I can see why the additional days are important

It was outstanding and the facilitators did an

amazing job

'As is' -> excellent!

The workshop was excellent.

It created a safe environment to hold dialogue.

• **Compliments for the Facilitators**

Kudos to the interaction and dialogue demonstrated by the facilitators.

Great job! Excellent facilitators.

Facilitators were great.

Renee and Doak did a fantastic job presenting some very difficult info

• **Workshop Itinerary/content**

3rd day whole day to do more role playing activities

more movies

More tool focused/ideas for strategies in everyday conversations in addition to the workplace/institution

would have liked to see more info on other minorities (Hispanic, Arabic, Asian, etc.)

Richer conversation, dialogue

let's have a 6 month "check-up"

More work with professional change- but only if the workshop is longer

• **Other**

Not sure (2)

? (2)

A little more tolerance for the value of scientific input.
On a five-point scale, how useful was this workshop for your work?

*Circle one answer:*

1. Not at all Useful
2. A little Useful
3. Somewhat Useful
4. Very Useful
5. Extremely Useful

Mean Rating for the HESJ Workshop: 4.14
Mean Rating for the UR Workshop: 3.96
Standard Deviation: .85 (UR: .93)

Participants of the Health Equity Social Justice Workshop rated the usefulness of the workshop as 4.14 on a 5 point scale, with 1 being ‘Not at all useful’ and 5 being ‘Extremely Useful’. This rating is higher than the average usefulness rating of 72 other professional training events.

Comparison of this Mean Usefulness Rating with Mean Usefulness Ratings of 72 other professional training events:
58. If we offered this workshop again in the future, would you recommend it to a colleague?  

Check one answer:

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>0%</td>
</tr>
<tr>
<td>Recommend with reservations</td>
<td>17.4%</td>
</tr>
<tr>
<td>Recommend with NO reservations</td>
<td>82.6%</td>
</tr>
</tbody>
</table>

82.6% of the participants would recommend this workshop without reservations, versus 73.8% of Undoing Racism Workshop Participants.
Appendix E: Training Evaluation Summary
PRIME Trainings Evaluation Summary

Undoing Racism Workshops:
Participants:
- 152 Michigan Department of Community Health (MDCH) employees;
- 11 other participants;
- Attendees were primarily Non-Hispanic, Caucasian (60.8%) or Non-Hispanic African Americans (30.1%);
- A majority (68.7%) reported attending previous workshops or trainings on health disparities, undoing racism, or health equity.

Pretest – Posttest Evaluation Results:
- Participant’s showed statistically significant (p < 0.001) increases in all reported self confidences to define and identify various racial disparity/health equity components, with the exception of the ability to ‘identify policies and practices in the Michigan Department of Community Health that address racial health disparities.’

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Pretest</th>
<th>Posttest</th>
<th>Paired t-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am confident I can… (1= Strongly Disagree to 5=Strongly Agree)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59. Articulate an understanding of <em>racial prejudice.</em></td>
<td>3.97 .65</td>
<td>4.42 .54</td>
<td>7.57*</td>
</tr>
<tr>
<td>60. Articulate an understanding of <em>racism.</em></td>
<td>3.98 .64</td>
<td>4.46 .60</td>
<td>7.82*</td>
</tr>
<tr>
<td>61. Explain racial privilege and power in the United States.</td>
<td>3.76 .79</td>
<td>4.51 .57</td>
<td>11.20*</td>
</tr>
<tr>
<td>62. Define <em>institutional racism.</em></td>
<td>3.63 .85</td>
<td>4.46 .58</td>
<td>11.76*</td>
</tr>
<tr>
<td>63. Define <em>cultural racism.</em></td>
<td>3.60 .78</td>
<td>4.29 .60</td>
<td>9.65*</td>
</tr>
<tr>
<td>64. Identify institutional norms and accepted practices that adversely affect minority race groups.</td>
<td>3.51 .76</td>
<td>4.33 .62</td>
<td>11.41*</td>
</tr>
<tr>
<td>65. Define <em>internalized racism.</em></td>
<td>3.55 .84</td>
<td>4.41 .57</td>
<td>12.23*</td>
</tr>
<tr>
<td>66. Define racial <em>health disparity.</em></td>
<td>3.88 .76</td>
<td>4.40 .59</td>
<td>8.09*</td>
</tr>
<tr>
<td>67. Identify and explain <em>social determinants</em> of racial health disparities.</td>
<td>3.56 .90</td>
<td>4.35 .70</td>
<td>9.62*</td>
</tr>
<tr>
<td>68. Identify policies and practices in the Michigan Department of Community Health that address racial health disparities.</td>
<td>3.15 .83</td>
<td>3.38 .82</td>
<td>2.52 (ns)</td>
</tr>
<tr>
<td>69. Identify policies and practices that provide guidance in my job duties and that may influence racial health disparities.</td>
<td>3.19 .85</td>
<td>3.55 .85</td>
<td>3.99*</td>
</tr>
</tbody>
</table>

* p < .001
Participants’ Comments:
- Most respondents reported that the workshop helped them to better address racial health disparities at their job by increasing their awareness and understanding.
- This increased knowledge (of history and definitions) and understanding were also rated as the most useful/valuable outcome from this workshop.
- Many reported a desire to address racial health disparities by making changes in their workplace, with the most commonly reported changes being increased community collaboration and inclusion in decision making.
- Some reported confusion over how to apply what they learned in the workshop to their job.
- Participants also reported an increase in self-awareness and ability to identify personal biases.
- Most participants did not report disappointments in the workshop, although some wanted more time, and others expressed concern of the facilitation style. Participants wanted more time to get into small groups for discussions and yearned for more ideas to make changes after the workshop.

Participants’ Satisfaction Ratings:
- On a 5 point scale (1= Not at all useful, 5= Extremely Useful), on average, participants rated the UR workshop 3.96 (SD=.93).
- 75% would recommend this workshop without reservations

Undoing Racism Focus Groups:
Overview:
- Three focus groups were held with participants of the Undoing Racism Workshops.
- Some themes in the focus group were similar to those from the post-test of the workshop, including a reported growth in knowledge, and a desire to increase collaboration with community members. Critiques and discussion of the facilitations style were interwoven throughout the focus group discussions.

After the Workshop:
- UR participants who reported speaking with colleagues did so to help clarify and process ideas.
- Although participants reported being more aware of policies/practices and racism, they still found it difficult to identify racism in practice.
- Participants were concerned that certain work practices may be contributing to racial disparities.

Suggestions:
- To address racial disparities at work, UR participants suggested improving communication, both within MDCH and partners, making changes to proposal criteria, increasing technical assistance, creating more flexible funding and adjusting data collection methods.
- Participants wanted to see an increased commitment and effort from MDCH on creating and enforcing policies and practices to end racial disparities.
Health Equity Social Justice Workshops:
Participants:
- 74 MDCH employees;
- 14 other participants;
- Most participants (80.9%) were from the Division of Family and Community Health, with the highest proportion from the Women, Infant and Family Section (45.9%).
- Attendees were primarily Non-Hispanic, Caucasian (75%) or Non-Hispanic African Americans (17.6%).

Pre-/Post-Test Results:
- Participants showed statistically significant (p < 0.001) increases in all reported self confidence ratings in understanding social justice and health equity/disparities terminology, and in their ability to identify opportunities for addressing health equity.

How much do you agree or disagree with the following statements about your level of confidence in successfully conducting these specific tasks?

<table>
<thead>
<tr>
<th>(n=82)</th>
<th>Pretest</th>
<th></th>
<th>Posttest</th>
<th></th>
<th>Paired t-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
<td></td>
</tr>
<tr>
<td>70. Articulate an understanding of target identities and non-target identities.</td>
<td>3.25</td>
<td>1.10</td>
<td>4.64</td>
<td>.61</td>
<td>-9.91*</td>
</tr>
<tr>
<td>71. Articulate an understanding of the four levels of oppression and change.</td>
<td>2.62</td>
<td>.92</td>
<td>4.44</td>
<td>.74</td>
<td>-14.72*</td>
</tr>
<tr>
<td>72. Articulate of the difference between health disparity and health inequity.</td>
<td>3.43</td>
<td>1.05</td>
<td>4.38</td>
<td>.88</td>
<td>-6.97*</td>
</tr>
<tr>
<td>73. Articulate an understanding of social determinants of health.</td>
<td>3.72</td>
<td>.87</td>
<td>4.41</td>
<td>.73</td>
<td>-5.54*</td>
</tr>
<tr>
<td>74. Articulate an understanding of cultural identity across target and non-target groups.</td>
<td>3.03</td>
<td>.92</td>
<td>4.32</td>
<td>.72</td>
<td>-9.87*</td>
</tr>
<tr>
<td>75. Articulate an understanding of public health’s historical role in promoting social justice.</td>
<td>3.28</td>
<td>.94</td>
<td>4.33</td>
<td>.78</td>
<td>-8.44*</td>
</tr>
<tr>
<td>76. Articulate an understanding of the root causes of health inequity.</td>
<td>3.54</td>
<td>.92</td>
<td>4.38</td>
<td>.69</td>
<td>-7.02*</td>
</tr>
<tr>
<td>77. Analyze case studies in a social justice/health equity framework.</td>
<td>3.12</td>
<td>.99</td>
<td>4.40</td>
<td>.60</td>
<td>-11.00*</td>
</tr>
<tr>
<td>78. Identify opportunities for advancing health equity at my workplace.</td>
<td>3.29</td>
<td>.85</td>
<td>4.29</td>
<td>.60</td>
<td>-9.36*</td>
</tr>
</tbody>
</table>
Participants showed statistically significant (p < 0.001) increases in knowledge for 8 of 12 content knowledge questions. Significant increases in knowledge were not seen on questions regarding unearned privilege, the social justice framework, differentiating health equity and health disparities, and defining racism at the institutional level. Pre-test scores ranged from 7.2% to 81.2%, with post-test scores ranging 44.9% to 97.1%.

<table>
<thead>
<tr>
<th>Content Knowledge Question</th>
<th>Correct Answer</th>
<th>n</th>
<th>Pretest</th>
<th>Posttest</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>79. Men are the “non-target” group for identifying gender oppression and privilege.</td>
<td>True</td>
<td>80</td>
<td>28.8%</td>
<td>83.3%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>80. The experience of oppression and privilege can change frequently based on our target and non-target group identities.</td>
<td>True</td>
<td>81</td>
<td>64.7%</td>
<td>92.6%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>81. Nearly everyone experiences some form of unearned privilege, regardless of how hard they work to achieve success.</td>
<td>True</td>
<td>81</td>
<td>60.3%</td>
<td>69.1%</td>
<td>.327</td>
</tr>
<tr>
<td>82. One way health departments can address the social determinants of health is by promoting healthier eating habits.</td>
<td>False</td>
<td>81</td>
<td>38.8%</td>
<td>64.2%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>83. The field of public health developed in response to social injustice brought about by the industrial revolution.</td>
<td>True</td>
<td>82</td>
<td>33.8%</td>
<td>82.4%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>84. The social justice framework for public health practice suggests that health problems are primarily caused by lower-income individuals making bad health choices.</td>
<td>False</td>
<td>81</td>
<td>76.5%</td>
<td>88.2%</td>
<td>.077</td>
</tr>
<tr>
<td>85. The social justice movement in public health is an attempt to shift focus from health inequities to health disparities.</td>
<td>False</td>
<td>81</td>
<td>43.3%</td>
<td>76.1%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>86. The term “health disparities” refers to the underlying causes of “health inequity.”</td>
<td>False</td>
<td>82</td>
<td>27.5%</td>
<td>44.9%</td>
<td>.017</td>
</tr>
<tr>
<td>87. Thoughts, beliefs, and values held by an individual are examples of the cultural level of oppression and change.</td>
<td>False</td>
<td>81</td>
<td>21.2%</td>
<td>69.7%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>88. The institutional level of oppression involves rules, policies, and practices that advantage one cultural group over another.</td>
<td>True</td>
<td>82</td>
<td>81.2%</td>
<td>97.1%</td>
<td>.007</td>
</tr>
</tbody>
</table>
**Content Knowledge Question**

Please circle True or False or Not Sure for the following statements.

<table>
<thead>
<tr>
<th>Correct Answer</th>
<th>n</th>
<th>Pretest</th>
<th>Posttest</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>False</td>
<td>82</td>
<td>7.2%</td>
<td>49.3%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>False</td>
<td>81</td>
<td>10.3%</td>
<td>64.7%</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

89. The *personal* level of oppression involves actions, behaviors, and language.

90. Eliminating *interpersonal level* oppression involves change in community norms and media messages that reinforce stigma and negative stereotypes.

**Participants’ Comments:**

- A key outcome mentioned by HESJ workshop attendees included an increase in knowledge, especially in health equity terminology (e.g. four levels of oppression, target/non-target), and concepts.
- Participants suggested using their new knowledge and skills to take action by assessing work policies/procedures, advocating for health equity, and adjusting data management.
- Ideas for making changes in the workplace were usually non-specific. However there were suggestions to increase community engagement and include health equity in future presentations and trainings.
- Multiple participants also mentioned developing skills in using ‘dialogue’ and enjoying the opportunity to have open respectful conversations.
- Participants enjoyed the opportunity to practice their new skills through case studies and role play.

**Participants’ Satisfaction Ratings:**

- In a 5 point scale (1= Not at all useful, 5= Extremely Useful), participants rated the HESJ workshop 4.14 (SD= .85).
- 82.6% would recommend this workshop without reservations.