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

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This report provides a summary of evaluation efforts, including descriptions of project activities. The report is organized to first address three evaluation questions from the Kellogg Foundation guidance document. After addressing these evaluation questions, we include summaries of evaluation efforts and project activities as they related to the list of 10 program evaluation activities that we proposed to conduct for this project.

1. Evaluation Questions From Kellogg Guidance

1. In what communities did you implement the curriculum and toolkit around the development and implementation of Maternal and Child Health policies, practices and programs? How were these communities chosen? To what extent did the project activities change the practices and policies of Maternal and Child Health providers in these communities toward more effectively addressing and reducing racial disparities? What evidence is there that these efforts are impacting racial disparities in infant mortality rates, breastfeeding rates, and access to screening and care?

The curriculum and toolkit that will be developed in the project will be for state BFMCH staff. Components of the curriculum and toolkit may be adaptable for other state departments and local providers.

The project, however, continues to engage local public health professionals in the training opportunities offered to MCH staff. There were five local community members who attended the Health Equity Social Justice Workshop held for the Women, Infants, and Children (WIC) division. Also, there were four participants at the first Learning Lab session from local WIC agencies and two participants from community partner organizations.

One example of Bureau of Family, Maternal and Child Health staff sharing health equity messages with local public health professionals is the Teen Pregnancy Prevention Staff integrating a health equity speaker into every Personal Responsibility and Education Program (PREP) Institute and at their annual coordinator meeting they offered a pre-conference session.

2. What evidence was gathered through the monitoring of statewide reports that this project may have increased the usage of the social determinants of health in health disparities reporting in Michigan?

PRIME project staff and steering team members continued discussions about available data and new data collection opportunities that would allow increased monitoring of social determinants of health and of health disparities.

PRAMS

The Pregnancy Risk Assessment Monitoring System (PRAMS) questionnaire continues to offer the richest source of Michigan data related to social determinants of health and their associations with pregnancy and birth outcomes. PRAMS is a surveillance project of the Centers for Disease Control
and Prevention (CDC) and state health departments. PRAMS collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. The PRAMS questionnaire has potential for assessing social determinants of health because of its potential for accounting for differences in access to health care, barriers to receiving care, hardships and stressors during pregnancy, and financial resources (e.g., household income, Medicaid status). Additionally, PRAMS respondents can be linked with state birth records to determine how responses to different questions may be associated with a variety of perinatal health outcomes.

PRIME is using PRAMS in two ways to better understand determinants of the disparity in infant mortality rates among African Americans and American Indians in Michigan:

1) The CDC-funded Michigan PRAMS oversamples African Americans each year. However, the Michigan PRAMS does not oversample American Indians and as such results in sample sizes far too small to allow analyses specific to American Indians. As a result, the PRIME project initiated a special PRAMS project for all women who gave birth to a Native American infant in Michigan in 2012. This special Native American PRAMS (NA PRAMS) is being implemented by a partnership between the Michigan Department of Community Health, Inter-Tribal Council of Michigan, Great Lakes Inter-Tribal Epidemiology Center, and the Michigan State University Office of Survey Research. The NA PRAMS aims to understand risk factors for infant mortality among American Indians, with a focus on maternal care, infant care, and infant health. The NA PRAMS uses the Michigan PRAMS as a model and mirrors questionnaire design and survey methodology as closely as possible to ensure comparability between the two surveys. However, the NA PRAMS is highlighted by several unique elements:

a. Attempts to be inclusive and relevant for Tribal communities:
   - The Inter-Tribal Council of Michigan presented the project at a Tribal Health Directors meeting before data collection began, and continues to provide updates to the Tribal Health Directors.
   - The Inter-Tribal Council of Michigan and MDCH created Memorandums of Understanding between MDCH and each tribe to allow tribes to access tribe-specific data and offer options for analysis of tribe-specific results (tribe-specific analyses will only be done by the request of the tribe and by the entity each tribe identifies to do the analysis).

b. Revisions to PRAMS Questionnaire and methodology:
   - Added questions about barriers to receiving care, experiences with racism, additional social determinants of health, home visiting, and tribal affiliation of mother and father.
   - Modified relevant response options to include tribal clinics as a place of receiving care and to differentiate tribal home visiting programs.
   - Used an expanded definition of “Native American infant” to sample any infant born to a Native American mother or father, as indicated by any mention of American Indian on the birth certificate. (This is different from standard practice to use only the primary race of the mother.)

c. Attempts to increase response rate
• The Inter-Tribal Council of Michigan designed and vetted a new cover to appeal to Native American audiences.
• A list of “Frequently Asked Questions” about the NA PRAMS was circulated among nurses and staff at tribal clinics to provide information about the project. The Inter-Tribal Council of Michigan created several communications materials to increase awareness of the project, including an article featuring the NA PRAMS in their newsletter and distributing flyers to tribal communities.
• MDCH sent an email to increase awareness of NA PRAMS to locations serving pregnant women/new mothers:
  - Local health departments, WIC, MIHP, Family Planning, Early Hearing Detection providers

As of 12/6/2012, the total response rate for the first batch of questionnaires was 49%. Subsequent batches are still in progress.

Data will be available for analysis in 2013. It is expected that the NA PRAMS will provide a rich source of data related to American Indian maternal and child health in Michigan, and will allow a much deeper analysis of risk factors for infant mortality in this community.

2) The second way the PRIME project is using PRAMS data is to monitor social determinants of health among pregnant women and new mothers in Michigan. Recognizing that PRAMS is the best source of data regarding social determinants of health and pregnancy and birth, the PRIME project is creating a tool to use to monitor relevant determinants in Michigan. This tool is not meant to monitor the impact of the PRIME project, rather it is meant to describe the social experience of pregnant women/new mothers in Michigan, and monitor how that experience and adverse health outcomes changes over time. This tool will be available in 2013.

Michigan Health Equity Data Project

The Michigan Health Equity Data Project (HEDP) is a project run by the Health Disparities Reduction and Minority Health Section (HDRMHS). Three staff members from HDRMHS sit on the PRIME Steering Team. The HEDP measures and monitors health disparities among Michigan’s racial and ethnic minority populations. Among the 18 indicators monitored, 5 are social determinants of health (median household income, children at or below poverty, unemployment, high school dropout rate, and persons not registered to vote). This reflects the view that inequities in SDOH must be monitored as carefully as inequities in other risk factors and health outcomes if we are to achieve health equity in Michigan. In 2012, the methodology established by the HEDP was used by Michigan Medicaid to analyze racial and ethnic disparities in eight access to care measures among the Michigan Medicaid Managed Care population. The finding that large racial/ethnic disparities exist in this population is significant as it demonstrates that these disparities exist in a population with similar healthcare coverage and income levels. The Medicaid project is currently being expanded to include six additional measures, including a postpartum care measure. Additionally, the HDRMHS was recently contacted by the Kalamazoo County Health Department about assisting them with modifying the HEDP for Kalamazoo County. This would allow the Kalamazoo County
Health Department to identify inequities in their community, including inequities in social determinants of health.

**Continuous Quality Improvement Survey**

In the summer of 2012, MDCH conducted a “data inventory” and quality improvement project to standardize the collection and use of race, ethnicity, sex, language, and disability status (RESLD) data. The data inventory revealed ways in which MDCH could improve data collection and use to better capture consistent RESLD data. Additionally, the data inventory identified which MDCH data systems include social determinants of health data. The quality improvement project showed a need to increase awareness in the department around RESLD data. A workgroup is being formed to address these issues at a more systemic level throughout MDCH. It is hoped that more consistent RESLD data collection and use will better allow MDCH to understand how these factors affect health status and access to care, and how to better target interventions to specific populations.

The HDRMHS manager leads the workgroup and PRIME’s Principal Investigator was a key member of the CQI team.

**Life Course Workgroup**

The Life Course workgroup leadership team has developed a template grid for indicators that emphasizes the connection between Healthy People, Prepared Communities and Effective Systems. Social determinants, community, cultural and spiritual resources and addressing institutional racism are key domains. In addition, Michigan is one of seven states participating in the AMCHP-Kellogg Life Course Indicators project. Each indicator must have implications for health equity and many measure determinants of health that while not traditional public health domains are correlated with health and also have intergenerational influence. Proposed indicators move beyond traditional social determinants, educational attainment and poverty, to look at community capacity, neighborhoods, safety, the environment, societal issues and others. The project is scheduled to be complete later in 2013.

3. **How has the Michigan Dept. of Community Health/Bureau of Family, Maternal and Child Health as an agency changed its policies and practices to strengthen racial equity and inclusivity?**

**Nurse Family Partnership & Use of the Kitagawa Method**

The Nurse Family Partnership and the use of the Kitagawa method to calculate the excess percent risk of infant mortality rate by race/ethnicity for each of the high risk counties participating in the home visiting program was discussed in the last report to Kellogg.

It has not been uncommon for the Division of Family & Community Health (DFCH) staff to receive “push back” from local communities when promoting policies to focus increased efforts to decrease infant mortality among racial and ethnic populations. In some instances the community argues that “all” woman should be targeted to reduce poor birth outcomes.
Some local agencies are reluctant to accept the use of the Kitagawa method to identify populations at high risk of infant mortality. To respond to these questions, the MCH epidemiologist, along with the health disparities epidemiologist and DFCH staff prepared summaries of the technical methods, in depth analysis of selected counties and conducted a literature review. Local agencies were also informed that the approach was not a quota, but means to identify the most at risk populations within their counties, with the goal to improve outreach into these communities. In October, under the guidance of the MCH director, the Women, Infant and Family Health section manager and the MCH epidemiologist presented a Webinar “Michigan’s Experience to Achieve Health Equity” as part of the Association of Maternal and Child Health Program’s (AMCHP)-Kellogg action learning collaborative “Utilizing Health Reform to Move toward Health Equity”.

Although some resistance to change has been encountered, DFCH continues to rely on this analysis of infant mortality risk to guide caseload targets. The PRIME Evaluation Workgroup is working with staff to document this policy change with the intent of publishing the findings.

**Strategies to address racial and ethnic disparities:**

- **Health Disparities Reduction and Minority Health (HDRMHS) Section** – Developed a Health Equity Toolkit (with video vignettes) to increase community and professional awareness around health and racial equity. Activities are planned to disseminate the toolkit in January, 2013; The MDCH intradepartmental Health Equity Steering Committee (HESC) is co-chaired by the HDRMHS Manager. The HESC began to survey staff in 2012 to collect information on health equity best practices throughout the MDCH.

- **Fetal Infant Mortality Review (FIMR)** - FIMR Network meetings continue to have an “Undoing Racism” exercise at the beginning of each meeting. To better understand the impact of inequities on poor pregnancy outcome and infant mortality, FIMR will utilize the Life Course Theory (LCT). In August 2012, the Michigan FIMR program received a one-time grant from National FIMR and American Congress of Obstetricians and Gynecologists to integrate LCT into the work of the 14 existing local projects.

- **Maternal Infant Health Program (MIHP)** - Orientation training for all new MIHP employees hired after September 1, 2012, and for all nurses conducting home visits for NICU Follow-up. Training includes a fish bone diagram describing social determinants and contributing factors to infant mortality and a list of definitions (racism, health equity, social determinants).

- **Women, Infants and Children (WIC)** – Reviewing racial/ethnic reports to assess Native American enrollment; 2013 plan includes a review of WIC policies in the context of social justice/health equity and will make recommendations for policy change to improve services to Native American and Black populations.

- **Perinatal Regionalization** - A health equity lens is used in the implementation plan for perinatal regionalization; inquire about health disparities on the Local Maternal & Child Health Block grant.

- **Adolescent and School Health** - Teen Pregnancy Prevention staff have integrated a health equity speaker into every Personal Responsibility and Education Program (PREP) Institute; Child & Adolescent Health Center staff added a health equity speaker to their annual coordinator meeting; Offered a pre-conference session, “Health Equity and Social Justice as the Core of Primary Prevention” at the 5th Annual Moving Toward Solutions: Addressing...
Teen Pregnancy Prevention in Michigan conference; PREP funding to reduce teen pregnancy among high risk adolescents, specifically African American youth.

Collaborative efforts with other agencies and organizations to reduce racial disparities:

- **HDRMHS** – Manager continue to chair a CQI project at MDCH to standardize collection and use of Race, Ethnicity, Sex, Language, and Disability data in compliance with new Health Care Reform (ACA) requirements; collaborating with Michigan Medicaid to identify racial/ethnic disparities in eight measures related to accessing care. The project is being expanded to include six additional measures, including a postpartum care measure; plan to assist the Kalamazoo County Health Department with modifying the Michigan Health Equity Data Project for Kalamazoo County to identify inequities in their community.

- **MDCH Health Equity Steering Committee** – The Health Equity Ambassador pilot project assessed health equity practices is a few programs; identified program managers willing to participate a survey and in-person interview; identified health equity best practices, shared ideas for implementation and provided health equity resources; next steps include expanding the number of MDCH programs to be included in the project; a report of the pilot project has been completed.

- **MIHP** - Collaboration with Chronic Disease and WIC to facilitate culturally competent training on breastfeeding to MIHP providers through CDC breastfeeding enhancement grant; arranging breast feeding peer support sites at MIHP sites in SE Michigan in collaboration with the Black Mothers Breastfeeding Coalition and the Chronic Disease section.

- **WIC** – Collaboration with MDCH Obesity prevention section to apply for a grant to increase the support of breastfeeding mothers in low-income populations of colors to continue breastfeeding; provided 5 regional trainings for all breastfeeding peer counselor and peer managers on the what, where, why’s and how’s of multicultural breastfeeding issues; CDC grant to conduct breastfeeding training for approximately 100 MIHP health care providers.

- **Adolescent and School Health** – Helped to convene an interdepartmental workgroup with the Michigan Department of Education to look at racial disparities.
Summary of Evaluation Activities and Results

1. Evidence of program implementation in the area of human resource & capacity development will be project outputs such as the hiring of a project coordinator, counts of leadership team meetings, leadership team attendance records & meeting minutes.

Steering Team and Workgroups Activities

The Steering Team met on five occasions between June 2012 and November 2012. The work during this period focused on the development of a PRIME curriculum for MDCH, dissemination of PRIME activities at national and state level conferences, development of a PRIME webpage, and review of materials and products to create a PRIME toolkit.

The PRIME project has five work groups to plan and implement the primary project activities. A subcommittee was created within the Intervention workgroup to collaborate with partners from University of North Carolina, Chapel Hill, and Native American consultants in the development of a PRIME curriculum (Health Equity Learning Labs). The five work groups are:

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

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.
### STEERING TEAM (22 members)

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<th>Meeting Dates</th>
<th>Number of Participants</th>
<th>Meeting Objectives</th>
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| June 4, 2012  | 13                     | • Project Status Update  
|               |                        |   o Recent Media  
|               |                        |   o Kellogg Reporting  
|               |                        |   o Budget Update  
|               |                        | • Old Business  
|               |                        | • New Business  
|               |                        |   o Hogan/Rowley Site Visit  
|               |                        |   o Learning Activity & Discussion  
|               |                        | • HDRMH & Division Updates  
|               |                        | • Workgroup Updates  
|               |                        |   o Evaluation  
|               |                        |   o Intervention  
|               |                        |   o Local Learning Collaborative  
|               |                        |   o NA PRAMS Survey  
|               |                        | • Next Steps  
| July 9, 2012  | 11                     | • Project Status Update  
|               |                        |   a. Recent Media  
|               |                        | • Old Business  
|               |                        | • New Business  
|               |                        |   a. Kellogg Reports  
|               |                        |   b. PRIME Goals & Timeline  
|               |                        |   c. Perinatal Regionalization System  
|               |                        |   d. HESJ Workshop Dates  
|               |                        |   e. Learning Activity: Race – The Power of An Illusion, Sorting People  
|               |                        | • BFMCH Division & HDRMH Updates  
|               |                        | • Workgroup Updates  
|               |                        |   a. Evaluation  
|               |                        |   b. Intervention  
|               |                        |   c. Local Learning Collaborative  
|               |                        |   d. NA PRAMS Survey  
|               |                        |   e. Website Development  
| August 6, 2012| 14                     | • Project Status  
|               |                        | • Old Business – Website News  
|               |                        | • New Business – HESJ Workshop #1; Learning Activity  
|               |                        | • BFMCH Division and HDRMH Updates  
|               |                        | • Workgroup Updates  
|               |                        |   • Evaluation Workgroup  
|               |                        |   • Intervention Workgroup  
|               |                        |   • Local Learning Collaborative  
|               |                        |   • NA PRAMS Survey  
|               |                        | • Next Steps  


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<td>September 10, 2012</td>
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<td>• Project Status Update</td>
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<td>a. HESJ Workshops Update</td>
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<td>b. SDOH Learning Labs Update</td>
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<td>c. Meeting with Native American Consultants</td>
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<td>d. WIC Organizational Assessment Results</td>
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<td>e. Website Development Update</td>
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<td>• BFMCH Division &amp; HDRMH Updates</td>
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<td>h. Local Learning Collaborative</td>
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<td>i. NA PRAMS Survey</td>
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<td>October 22, 2012</td>
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<td>• Project Status Update</td>
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<td>a. Recent Media</td>
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<td>b. Timeline/Budget</td>
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<td>• New Business</td>
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<td>a. AMCHP Webinar</td>
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<td>b. Health Equity Learning Labs Update</td>
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<td>c. Michigan Premier Public Health Conference Update</td>
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<td>d. Website Development Update</td>
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<td>a. PRIME Meetings in 2013</td>
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<td>Meeting Dates</td>
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<tr>
<td>June 4, 2012</td>
<td>8</td>
<td>• Meeting Minutes 5/14/12&lt;br&gt;• Organizational Assessment Update&lt;br&gt;• Hogan/Rowley Visit&lt;br&gt;• PRIME Timeline &amp; Tasks&lt;br&gt;• NAACHO’s Roots of Health Inequity Curriculum&lt;br&gt;• Next Steps</td>
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<td>July 2, 2012</td>
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<td>• Review Meeting Minutes from 6/4/12&lt;br&gt;• PRIME Kellogg Report&lt;br&gt;• PRIME Dissemination Efforts&lt;br&gt;• HESJ Workshops&lt;br&gt;• Organizational Assessment Update&lt;br&gt;• NAACHO’s Roots of Health Inequity Course&lt;br&gt;• PRIME Timeline &amp; Tasks&lt;br&gt;• Next Steps</td>
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<td>August 6, 2012</td>
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<td>• Review Meeting Minutes from 7/2/12&lt;br&gt;• PRIME Dissemination Efforts&lt;br&gt;• HESJ Workshops&lt;br&gt;• NAACHO’s Roots of Health Inequity Course&lt;br&gt;• Organizational Assessment-Draft Report&lt;br&gt;• Social Determinants of Health Training for WIC staff&lt;br&gt;• Future Funding/Grant Writing&lt;br&gt;• Next Steps</td>
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<td>September 10, 2012</td>
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<td>• Meeting minutes 8/6/12&lt;br&gt;• HESJ Workshop Update&lt;br&gt;• Organizational Assessment Update&lt;br&gt;• SDOH Learning Labs/NA Consultants Mtg&lt;br&gt;• PRIME Dissemination Efforts&lt;br&gt;• NAACHO’s Roots of Health Inequity Course&lt;br&gt;• Next Steps</td>
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<td>October 8, 2012</td>
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<td>• Meeting minutes 9/10/12&lt;br&gt;• MI Premier Public Health Conference&lt;br&gt;• Health Equity Learning Labs/NA Consultants Mtg&lt;br&gt;• APHA&lt;br&gt;• Sustainability Plan&lt;br&gt;• Steering Team Retreat&lt;br&gt;• NAACHO’s Roots of Health Inequity Course&lt;br&gt;• Next Steps</td>
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## INTERVENTION WORKGROUP (9 members)

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<tr>
<th>Meeting Dates</th>
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<td>November 5, 2012</td>
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<td>• Meeting minutes 10/8/12</td>
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<td>• APHA Update</td>
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<td>• Health Equity Learning Labs</td>
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<td>• Sustainability Plan</td>
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<td>• Kellogg Report</td>
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<td>• Tool-kit Development</td>
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<td>• NAACHO’s Roots of Health Inequity Course</td>
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## INTERVENTION SUBCOMMITTEE WORKGROUP

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<th>Meeting Dates</th>
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<tr>
<td>August 24, 2012</td>
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<td></td>
<td></td>
<td>• Discuss Native American Initiatives and areas of collaboration</td>
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<td>• Discuss and outline consultation needs for PRIME initiatives</td>
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<td>October 1, 2012</td>
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<td>• Overview of the mission, goals and work of the Intertribal Council</td>
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<td>• Review Learning Lab lecture modules and add content, examples, citations</td>
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<td>• Review Learning Lab modules and add content, examples, citations</td>
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<td>• Review LL tools and choose items for an abbreviated instrument</td>
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<td>• Present overview and get feedback</td>
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<td>October 31, 2012</td>
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<td>• Review meeting minutes</td>
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<td>• Review follow-up items</td>
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<td>• Specific areas for inclusion of NA culture</td>
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<td>• Videotaping</td>
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<td>• Discuss logistics</td>
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<td>November 30, 2012</td>
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<td>• Review the goals and purpose of Learning Labs 1 and 2</td>
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<td>• Observations of Lab 1</td>
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<td>• Discussion/case studies</td>
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<td>• Next Steps</td>
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## EVALUATION WORKGROUP (6 members)

<table>
<thead>
<tr>
<th>Meeting Dates</th>
<th>Number of Participants</th>
<th>Meeting Objectives</th>
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| August 13, 2012   | 5                      | • Review meeting minutes from 5/14/12  
• Kellogg Evaluation Report  
• WIC Organizational Assessment Report  
• PRIME Baseline Metrics  
• HESJ Workshop Pre/Post Tests  
• MI Premier PH & APHA Conferences  
• Evaluation of LLC Activities |
| September 17, 2012| 6                      | • Review meeting minutes from 8/13/12  
• HESJ Workshop Update  
• HE Learning Labs Update  
• WIC Organizational Assessment  
• DFCH Nurse Family Partnership  
• PRIME Baseline Metrics  
• MI Premier PH & APHA Conferences  
• Evaluation of LLC Activities  
• PRIME Retreat |
| October 15, 2012  | 4                      | • Review meeting minutes from 9/17/12  
• HESJ Workshop Update  
• MDCH Organizational Assessment  
• PRIME Baseline Metrics  
• DFCH Nurse Family Partnership  
• MI Premier PH & APHA Conferences  
• NA Consultant Mtg/HE Learning Labs Update  
• PRIME Retreat  
• Evaluation of LLC Activities |
| November 15, 2012 | 4                      | • Health Equity Learning Labs  
• MDCH Organizational Assessment  
• DFCH Nurse Family Partnership  
• APHA Conference  
• Kellogg Report  
• PRIME Retreat  
• PRIME Baseline Metrics  
• Evaluation of LLC Activities  
• 2013 Meeting Dates |
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<th>Meeting Dates</th>
<th>Number of Participants</th>
<th>Meeting Objectives</th>
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</table>
| July 27, 2012     | 8                      | • Update on MDCH & on PRIME work  
• PRIME Website Status  
• PRIME LLC Contracts/Updates |
| September 28, 2012| 7                      | • Preparation for MI Premier Public Health Conference, Pre-Conference Session       |
| November 16th, 2012| 13                     | • Review Meeting Minutes  
• Update on MDCH & PRIME Activities  
• PRIME Website Status  
• MI & Local Historical Overviews/Racial Scans  
• Teen Peer Education Project & Region V’s Health Equity Council  
• LLC Members Questions: What would you like to see as next steps for the LLC?  
• PEDIM Update/LLC Member Sharing  
• 2013 Meeting Dates  
• Next Steps |
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<tr>
<td>June 21st, 2012</td>
<td>5</td>
<td>• Website requirements and MDCH approval process</td>
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<td>July 5th, 2012</td>
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<td>• Website review &amp; editing</td>
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<td>July 31st, 2012</td>
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<td>• Discuss State of Michigan’s policies for website development</td>
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<td>• Discuss security standards and access to link</td>
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<td>• Discuss the comps on PRIME site</td>
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<td>September 4th, 2012</td>
<td>2</td>
<td>• Website review &amp; editing</td>
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<td>October 19th, 2012</td>
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<td>• PRIME website status</td>
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<td></td>
<td>• Results from DTMB review</td>
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<td></td>
<td>• Discussed website content</td>
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<td>• Next Steps</td>
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**Intervention Development**

The PRIME Intervention Workgroup has developed and administered the first session of the PRIME Health Equity Learning Labs (the embodiment of the PRIME curriculum). The Intervention Workgroup is currently making adjustments to the second and third Learning Lab sessions based on evaluation results of the first Learning Lab session. The Intervention Workgroup has also been conducting additional health equity trainings, investigating resources for the PRIME toolkit, planning a PRIME project retreat, and discussing sustainability of the PRIME project. The Intervention Workgroup selected the Women, Infants, and Children (WIC) division as the first Division of Bureau of Family, Maternal & Child Health to attend the PRIME Learning Labs. To facilitate the implementation of the workforce trainings, two WIC managerial staff joined the Intervention Workgroup for additional insight.

**Curriculum Development (Health Equity Learning Labs)**

The Intervention Workgroup spent a large portion of this reporting period working on the development of the PRIME curriculum. To advance the curriculum development process, the Intervention Workgroup formed an Intervention Subcommittee. The Intervention Subcommittee consisted of 4 Intervention Workgroup Team members, and consultants from the University of North Carolina, Chapel Hill. The Intervention Subcommittee gathered input from PRIME Native American consultants and the University of Michigan (UM) Office of Public Health Practice during the development phase. The Intervention Subcommittee updated PRIME members during Intervention Workgroup meetings and Steering Team meetings.

The Intervention Subcommittee decided to create an interactive curriculum, and therefore decided to call the sessions, “Health Equity Learning Labs.” The Health Equity Learning Labs were developed to be delivered over 3 Labs. Each Learning Lab session consists of 3 consecutive half-day sessions (i.e., 12 hours of training per Lab). The consultants from North Carolina, Chapel Hill, and two of their research assistants were the presenters of the first Learning Lab session for the WIC Division. A consultant with the Inter-Tribal Council of MI also presented during the session. They will also present at the remaining Learning Lab sessions.

The Intervention Subcommittee created an outline and objectives of the Health Equity Learning Lab Sessions. The Subcommittee decided to discuss historical trauma, equity frameworks, training on practical skills for handling political criticism of health equity work, and how to apply those concepts to a topic familiar to the WIC Division (e.g., Breastfeeding).

There were 3 goals of the Learning Labs:
1. Develop a culture within WIC that promotes and never inhibits equity
2. Staff will become sensitive and more aware of their role in equity
3. Develop proficiency- staff will not wait for health equity opportunities, but will develop opportunities

To achieve these goals, the Learning Labs will scaffold knowledge and skills to provide staff with resources to further develop other topic areas in the future (e.g., infant mortality). Although, MDCH staff were the main focus of the Learning Lab sessions, all sessions were open to community partnered organizations and local community members.
A main feature of the Learning Labs was the concept of a personal ‘portfolio’. Participants were asked to gather notes, articles, photos, or other items for the personal portfolio that answered two questions: (1) what have you learned (and in what ways) from the first Learning Lab session? and (2) how have/much have you changed in skills, practice, knowledge, attitudes around the promotion of health equity? The items selected should be examples of where the participant saw potential opportunities to apply equity thinking and approaches or where the participants actually acted to promote equity (i.e. confronted and addressed equity issues).

The portfolios can contain:

- solicitations for community input
- instances where changes were made to accommodate special vulnerabilities (race, class, gender, history)
- journal entries from the participants reflection on the first Learning Lab session
- a note about a negative interaction where inequities were maintained or strengthened
- examples of where punishments or challenges were disproportionately imposed for certain groups, or misrepresentations of another group’s culture
- any item that the participants personally feel is relevant to health equity

Participants were asked to note the significance of the event. North Carolina consultants will randomly select participants from the first Learning Lab session to check on their progress with their portfolio. In addition, a reminder e-mail was sent to participants of the first Learning Lab session. Participants who are willing to share contents of their portfolio will be encouraged to share the items at the second Learning Lab session for group discussion.

The Intervention Subcommittee met with Native American community members and consultants in October 2012 to discuss the formation of the Learning Labs curriculum. The purpose of the meeting was to incorporate examples and perspectives relevant to Native American populations. One of the Native American Consultants was a co-presenter at the first Learning Lab session.

The Intervention Workgroup collaborated with the University of Michigan (UM) Office of Public Health Practice to video tape the Health Equity Learning Lab Sessions. The intervention Workgroup, North Carolina collaborators and staff from the UM Office of Public Health Practice discussed methods for presenting Learning Lab materials in an online format. As a group, it was decided that UM Office of Public Health Practice staff would video tape the Learning Lab sessions, and the Intervention Subcommittee would identify which material they would use for online components. Staff from the UM Office of Public Health Practice filmed the first Learning Lab session, and also filmed interviews with Learning Lab participants about their experiences during the first Learning Lab session.

The first Learning Lab session was held in November 2012 with WIC Division staff members. The second and third Learning Lab sessions have been scheduled for February and April, 2013. More information on the evaluation of the first Learning Lab can be found in Appendix.
The Intervention Workgroup, Learning Lab presenters (North Carolina Consultants and Native American Consultant) and Evaluation Director conducted debriefing meetings at the conclusion of the first Learning Lab session. The content of the second and third Learning Lab sessions will be slightly modified based on the feedback received from the evaluation report of the first Learning Lab session. Attendees at the debriefing suggested identifying case studies, incorporating information on African Americans, and developing small group work with facilitators for the second learning lab.

The second and third Learning Lab sessions will be focused on assisting participants in identifying both short-term and long-term goals, connecting equity actions with day-to-day work, identifying points of intervention, and developing a work plan that reflects the concepts addressed in the first Learning Lab session. In-between Learning Lab sessions, North Carolina consultants will be available to support Learning Lab participants as needed.

After WIC has completed the third Learning Lab session, the WIC Division will provide a “progress report” to the North Carolina consultants that will detail successes and challenges that could help to inform a more universal curriculum to be used in the future.

**Trainings**
During previous reporting periods, 4 groups of MDCH staff have attended the Health Equity Social Justice Workshops. These workshops are facilitated by PRIME partners at the Ingham County Health Department. During this reporting period, three additional groups of MDCH staff members from the WIC Division attended HESJ workshops. The next HESJ workshops are scheduled to begin in February 2013 for staff members in the Children’s Special Health Care Services Division. Evaluation results of the HESJ workshop held for the WIC Division are provided in Appendix.

**Organizational Assessment**
The Intervention Workgroup partnered with University of Michigan Health System Program for Multicultural Health to develop and administer an Organizational Assessment in April 2012. The Organizational Assessment was distributed to members of the WIC Division before they attended PRIME trainings. The University of Michigan Health System Program for Multicultural Health developed and managed the online survey. The Intervention Workgroup created a report on the results of the Organization Assessment which is provided in the Appendix.

MDCH staff was asked to share their perspective on multiple aspects of health equity at the Bureau, Division, and individual level. The cultural competency questions within the Organizational Assessment were asked for both African Americans/Blacks and Native Americans. The results of the Organizational Assessment were available as a resource to inform the development of the Learning Labs curriculum.

The Intervention Workgroup also presented the results of the Organizational Assessment to the WIC Division staff in September 2012. During this presentation, WIC staff were able to ask questions about the results of the Organizational Assessment, and PRIME. Additionally, WIC staff also discussed barriers, and made suggestions to improve their division. The formal written report of the Organizational Assessment results was provided to WIC Division staff shortly after the presentation.
The Intervention Workgroup decided that the Evaluation Workgroup should take responsibility for disseminating the Organizational Assessment to other Divisions. The Intervention Workgroup discussed shortening the Organizational Assessment with the Evaluation Workgroup. Based on WIC responses, the Evaluation Workgroup has developed a shortened version of the Organizational Assessment.

The Evaluation Workgroup plans to distribute the shortened version of the Organizational Assessment to the staff of Children’s Special Health Care Services Division before they attend the PRIME trainings. These results will assist the Evaluation Team in being able to measure “cultural shift” as a result of the PRIME project’s efforts.

**Sustainability**

The Intervention Workgroup has stressed the importance of sustainability during the development of the Learning Labs. Group members have discussed whether PRIME project activities will continue through “champions” identified within MDCH, or through staff from the Health Disparities Reduction Minority Health Section. The Intervention Workgroup identified 2 MDCH staff members who may be good candidates to be involved in the development of a sustainable plan for PRIME. The Intervention Workgroup plans to discuss sustainability with the PRIME Steering Team at the PRIME project retreat (see below for more information on the PRIME project retreat).

As mentioned previously, the Intervention Workgroup has partnered with the UM Office of Public Health Practice to develop a technology component of the Learning Labs to increase the sustainability of the workshops.

Additionally, the Intervention Workgroup has agreed to begin to look for future funding opportunities.

**NAACHO’s Roots of Health Inequity Curriculum**

During the June 2012 meeting, members of the Intervention Workgroup decided to investigate NAACHO’s Roots of Health Inequity Course. Members felt that the NAACHO curriculum would be a worthwhile resource for MDCH staff members. The NAACHO curriculum is comprised of 5 units with several activities and a discussion forum within each unit.

The PRIME coordinator set-up a PRIME group to complete selected NAACHO courses. The PRIME coordinator would periodically send out a schedule of activities to complete within each course, along with discussion questions. Ten PRIME members volunteered to complete the NAACHO courses.

Intervention Workgroup team members began reviewing NAACHO’s Roots of Health Inequity courses in July 2012. During Intervention Workgroup meetings, members report comments, suggestions, and concerns about the NAACHO courses. Intervention Workgroup members participated and reviewed the NAACHO course topics listed below. A more detailed schedule is listed in Appendix.
1. Unit 1: Where do we start?
   a. Workforce Capacity
   b. Community Engagement
   c. Leadership
2. Unit 4: Root Causes
   a. Gender and Relations of Power
   b. Hurricane Katrina: The Unnatural Disaster?
   c. Class Oppression
3. Unit 5: Social Justice: Elements and Characteristics of this Approach
   a. Developing Strategies

Tool-kit Development

Intervention Workgroup members have begun to identify resources to be shared with staff that will be included in the PRIME toolkit. The Intervention Workgroup plans to gather information from past meetings and other resources to begin in forming the PRIME toolkit. Intervention Workgroup members are discussing a centralized location where tool-kit resources can be stored. Eventually, PRIME will post all toolkit resources on the PRIME webpage.

Steering Team Retreat

Intervention Workgroup decided that the PRIME project should hold a half-day retreat in March 2013. The Intervention Workgroup is developing ideas for an agenda of the workshop. Proposed agenda items include recapping the results from PRIME project over the past year, sharing the budget, and developing a plan for sustaining PRIME.

Capacity Building

Consultants

As mentioned previously, PRIME has collaborated with Native American consultants and consultants from University of North Carolina, Chapel Hill. PRIME Intervention Subcommittee members, and all consultants met in August 2012 to discuss Native American initiatives and areas of collaboration. The team also discussed and outlined the consultation needs for PRIME initiatives. PRIME Intervention Subcommittee members presented the results from the WIC Organizational Assessments. The Organizational Assessment results informed the development of the Health Equity Learning Labs.

In October 2012, UNC consultants traveled to Michigan to meet with the PRIME project coordinator and Inter-Tribal Council of MI consultants to discuss the agenda for the Health Equity Learning Labs. Members discussed the need to include Native American examples and perspectives relevant to Native American populations in Michigan into the Health Equity Learning Labs. The goal of the meeting was to develop Learning Lab components which improve the understanding of Learning Lab participants understanding of the role of racism, class, gender and history in shaping institutional inequities as experience by US populations, and to guide approaches toward eliminating these inequities. The Native American consultants provided an overview of the mission,
goals and works of the Intertribal Council. Consultants from North Carolina shared proposed Learning Lab modules, content, and examples. Native American consultants provided their feedback on proposed Learning Lab materials.

Internships

The PRIME project continued to receive valuable involvement of interns in the project. A UM School of Public Health student worked on the project from May-August of 2012. She worked on the development of the website and helped to take minutes at the Steering Team and Workgroup meetings. The project has allotted funds for a student assistant from October, 2012 to September, 2013. The department conducted interviews for the position in November.

Dissemination of Results and Presentations

The Intervention Workgroup submitted several abstracts to disseminate results of the PRIME project activities. In October 2012, PRIME presented an oral presentation and 2 poster presentations at the American Public Health Association. The presentation titled, “Evaluating Undoing Racism and Health Equity Training with a State Health Department,” focused on the pre/post test and focus group results from last year’s Undoing Racism and Health Equity Social Justice trainings. PRIME Evaluation Workgroup members have discussed the possibility of developing a manuscript based on the oral presentation. The two PRIME poster presentations included, “PRIME: A state health department effort to build organizational capacity to reduce health disparities,” and “Historical and spatial relations as fundamental determinants of American Indian infant mortality in Michigan”

Michigan Premier Public Health Conference

In October 2012, a PRIME member presented a poster titled, “The Effect of Previous Health Disparities/Equity Training on Undoing Racism Pre- and Post-Tests with a State Health Department,” at the Michigan Premier Public Health Conference.

The LLC conducted a second pre-conference session at the 2012 Michigan Premier Public Health Conference. Panelists representing MDCH, Kent County Health Department, Strong Beginnings, Inter-Tribal Council of Michigan, and Berrien County Health Department address the following 5 questions:

1) Describe the work that has been done in your organization around undoing racism/health equity and the connection to infant mortality reduction
2) What “action” has been taken to achieve health equity in your organization?
   a. Describe policy/practice changes,
3) What would you describe as your “best practices” in achieving health equity in your organization?
4) What have been major challenges in doing this work?
5) What are 1 or 2 recommendations to organizations that are beginning to engage in health equity work?
The PRIME Website was reviewed during the session and participants watched a video prepared by the Executive Director of Ingham County Health Department who is a PRIME Steering Team member. The video described the impact of racism on infant mortality. Participants were also informed about the other videos on the site that describe social determinants, historical trauma in the Native American community, MDCH’s health equity work and best practices from LLC members. A variety of health equity resources that included websites and videos where shared with participants at the end of the session.

Twelve evaluations were submitted on the PRIME Pre-conference session. There were five questions and each was rated on average between 4.33 to 4.92 out of a 5.0 rating. The participants agreed that the PRIME session was helpful in understanding more about health equity and the activities at state and local departments related to the improvement of infant health and promotion of health equity. Details of the survey results are included in separate evaluation report in the Appendix.

An additional 50 copies of the booklet highlighting the health equity work in each of the LLC communities was printed and distributed at the conference.

**PRIME Website**

During this reporting period, the design and development of the PRIME website was completed. In October 2012, a year after the Website Development Workgroup convened, a prototype of the website was presented at the Michigan Premier Public Health Conference. The site is planned to “go live” in January 2013. The website will be utilized as a mechanism to disseminate information about the PRIME Project and local work of the Local Learning Collaborative. An additional role is to provide a broad audience access to information about health equity, health disparities, racism, and social justice. Members of this group include: the PRIME Project Coordinator and intern; MDCH staff from the Health Disparities Reduction and Minority Health Section (HDRMHS); LLC members from Kent County Health Department, Grand Rapids African American Health Initiative, Strong Beginnings Healthy Start, and Wayne County Health Department; and the Michigan Public Health Institute (MPHI).

The site includes a list of resources about health equity, infant mortality, and institutional racism. Videos of PRIME Steering Team members describing the importance of the project and its relation to health equity issues and LLC members sharing their best practices are included on the site. There is a forum page where LLC members will share articles and discuss new solutions to health disparities. The interactive map, titled “What’s Happening in Your County,” will allow community members to learn about organizations in their area and information on health equity activities.

During the first quarter of 2013, the website workgroup will develop a dissemination plan to inform a variety of stakeholders about the website.
Webinar

In October, a PRIME member from the Women, Infant and Family Health section manager and the MCH epidemiologist presented a Webinar “Michigan’s Experience to Achieve Health Equity.” This presentation was a part of the Association of Maternal and Child Health Program’s (AMCHP)-Kellogg action learning collaborative “Utilizing Health Reform to Move toward Health Equity”. This webinar presentation provided background information on Michigan’s infant mortality rates, the Maternal, Infant and Early Childhood Home Visiting grant, development of the selection process for the Nurse Family Partnership and information on the PRIME project.

2. The project coordinator and the leadership team will read state policy documents and review administrative practices to understand the association between state policies and maternal/child health care outcomes. Evidence of program implementation for these activities will be counts of MDCH employees involved in policy reviews, the number of policy documents reviewed and discussed, and a final report on the reviews.

The Local Learning Collaborative (LLC), a subgroup of the PRIME project, became aware of projects in Tennessee which looked at different policies and connect them to health outcomes. The Tennessee programs also did a Perinatal Periods of Risk (PPOR) data analysis, along with a historical policy review and local historical reviews. A Local Learning Collaborative member, Hannalori Bates Frick (JD, MPH) will conduct a historical analysis of State policies and National Policies and their impact on racial inequities to demonstrate the influence of history on current disparities in infant mortality and birth outcomes. Ms. Bates Frick (JD, MPH) works for Dispute Resolution Center and is contracted by PRIME to complete the historical analysis. Ms. Bates Frick began the review in October and will complete the first portion in January 2013.

A historical overview will support the objectives of PRIME by identifying federal and state policies that have impacted the infant mortality rate for the American Indian and African-American populations in Michigan. An overview will aid in explaining the contextual conditions in PRIME’s logic model. It also can potentially improve effective engagement of all stakeholders by documenting their role in making key decisions. The three specific objectives of this project are: a) to demonstrate how policies and practices have affected the Native American and African American populations in Michigan, thereby linking the social determinants of health specifically to infant mortality outcomes, b) to supplement instructional resources used to increase awareness of health disparities and provide a template for further research, and c) to prepare materials that can be presented to a broad audience, including all Michigan stakeholders responsible for creating and implementing policy that impacts the infant mortality rate.

The first deliverable is a timeline, which includes the following: 1) major events in Michigan’s history from 1837 to present, 2) key national events and federal legislation in history from 1837 to present, and 3) Michigan legislation and regulations. All policies and events relate to six social determinants of health: 1) economic stability, 2) safety, 3) housing, 4) education, 5) health services, and 6) social cohesion. The timeline will also specify how listed events and policies have impacted infant mortality in the state. Events and policies are listed in a chart format and can be sorted by date, social determinant of health, population most affected, whether the event or policy directly impacts infant mortality, and whether the event or policy occurred at the state or federal level.
The Steering Team has had discussions about the ability to review MDCH policies and reports to provide recommendations on how to reduce the racial disparities in infant mortality. The project will not be able to conduct a comprehensive review of MDCH policies and reports within the time that remains in the project. The project will outline policy changes that resulted from staff’s engagement in the project. Some of the policies involve the use of data to inform policy and decision making and particularly for the Native American population. Additional policy involves the Bureau’s approach to focus community efforts to identify disparities among infant mortality rates and tailor outreach and activities for the identified populations as described later in the report by using the Kitagawa method. An additional approach discussed is to create a template that staff can use to guide them to think about the policy decisions they make for various programs.

3. **Collaboration with MDCH epidemiologists & local health department leaders will be documented by counting the number of meetings & the number of participants from different sectors/constituencies.**

**Collaboration with MDCH Epidemiologists, Local Health Departments & Community-Based Organizations**

The Local Learning Collaborative (LLC) established in March 2011 continues to meet every six weeks. The LLC is made up of representatives from Local Health Departments, all six Michigan Healthy Start Projects and other community organizations that have worked in their local community to address racism, health equity and disparities.

The BFMCH Director continues to serve as the co-chair of Michigan’s Partnership to Eliminate Disparities in Infant Mortality (PEDIM) Action Learning Collaborative (ALC). The Project Coordinator and several PRIME Steering Team and LLC members also participate on the ALC. The collaborative will end in February 2013. The three strategies of the collaborative are to:

1) Promote participation in workshops and trainings that address racism, health equity, and social justice
2) Compile toolkits to provide tools and resources to un-do racism
3) Improve both the quality and the quantity of data collection related to race and ethnicity within the health care system

The PRIME Project Coordinator continues to participate on 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.

Last year, a partnership with MDCH, the Inter-Tribal Council of Michigan, Great Lakes Inter-Tribal Epidemiology Center, and Michigan State University formed to design a Michigan Pregnancy Risk Assessment Monitoring System (PRAMS) survey to include all mothers of Native American infants. The group continued to monitor the implementation process for the survey.
Finally, as mentioned earlier in the report, the project has collaborated with the University of Michigan Public Health Practice Office to fund the Health Equity & Social Justice workshops that WIC staff participated in in the summer of 2013. The UM Practice Office also videotaped the first Health Equity Learning Lab and will partner with the project to develop online curriculum.

4. Other evidence will be documents describing strategies for addressing racial disparities in infant mortality & other health problems.

The PRIME project plans to develop a final report with policy recommendations.

5. A major activity will be staff training of MDCH professional staff on racial disparities, racism & other social determinants, and systems change models. Evidence of training activities will include counts of training sessions, number trained & curriculum documents.

The PRIME project conducted two separate trainings during this reporting period. The first of these trainings was the Health Equity Social Justice (HESJ) Workshop held for MDCH staff members of the Women, Infants, and Children (WIC) Division. There were three HESJ workshops held during July and August. Each HESJ workshop consisted of two and half days of activities and discussion. There was a 2-4 week break in-between the first two days of the workshop and the last half-day follow-up session. There were 56 MDCH staff who attended the HESJ workshops, with an additional four participants from partnered community organizations.

The PRIME project intervention group worked extensively with consultants from the University of North Carolina, Chapel Hill, to develop and present the Health Equity Learning Labs. The Learning Labs have been developed as a sequence of three Labs. Each Lab will build upon the previous Lab. The Learning Labs are designed to be half-day sessions, lasting for three consecutive days.

The first Learning Lab session was held November 27th-29th, 2012, for staff members in the WIC Division. There were 39 MDCH participants which attended the first Learning Lab session. An additional four participants were from local WIC agencies. There were two groups (morning and afternoon), with slightly more participants in the morning session.

6. A survey of key stakeholders will be conducted to assess their perceptions of the success & effectiveness of the program work. The feedback will be used to shape the project.

The next annual survey of key stakeholders of PRIME will occur in March 2013.
7. The outcome evaluation methods will include the widespread use of the tool kit & curriculum within MDCH & local health departments. Counting of units that request use will be the indicator.

We plan to assess the use of all PRIME project products by other state and local health departments. The PRIME Tool kit is currently being developed by the Intervention Workgroup. As mentioned above, the PRIME curriculum has been implemented through the Health Equity Learning Labs. Currently, one MDCH division, Women’s, Infant, and Children’s, has completed the first learning lab session. The PRIME team will revise the Health Equity Learning Labs based on feedback from the WIC division. We anticipate that the tool kit and curriculum (Health Equity Learning Labs) will be ready for distribution by the end of the third project year.

8. We will also assess increase in staff knowledge by using a method for assessing change in knowledge used in other studies of training programs for state & local public health staff (Reischl & Buss, 2005). This method uses a pretest-posttest design to assess knowledge before & after training.

During the reporting period, there were three Health Equity Social Justice workshops held in the WIC Division. The Evaluation Workgroup created pretests and posttests which assessed self-rated competencies and knowledge change among workshop participants. We noted statistically significant improvements in all reported self confidence ratings in understanding social justice and health equity/disparities terminology and in participant’s ability to identify opportunities for addressing health equity. We also noted statistically significant improvements in almost all content knowledge questions. Additional information of the workshop is provided in Appendix in the Analysis of Health Equity Social Justice Workshop Evaluation Surveys Report.

After discussions with the consultants from the University of North Carolina, Chapel Hill, the Evaluation Workgroup decided that the Learning Lab sessions were not conducive to content knowledge assessments. However, the Evaluation Workgroup did as Learning Lab participants to complete self-rated competencies before and after attending the first Learning Lab session. We noted statistically significant improvements in most self reported competencies. Additional information of the workshop is provided in the Appendix under Analysis of Health Equity Learning Labs Evaluation Surveys Report.

9. Another outcome is that MDCH will improve & expand its monitoring of social determinants of health in statewide reports of health disparities. Evidence will be based on content analysis of statewide reports before, during & after the pilot

We will continue to discuss issues associated with using PRAMS for monitoring social determinants as well as other methods in the project’s second year. MDCH is currently conducting a supplemental PRAMS survey with women who gave birth to Native American babies. Questions on racism and social determinants of health have been 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 was derived from the summit included an emphasis on social determinants across all activities in the work plan. This action plan, released by the State of Michigan in August 2012, was titled “Michigan Infant Mortality Reduction Plan.” This work plan outlines 8 strategies and goal to address infant mortality. The full report can be found on the State of Michigan’s website:

Updates to systematic efforts within MDCH to include social determinants in statewide reports of health disparities are summarized on pages 2-5

Finally, as mentioned previously, a Life course Workgroup (within the Division of Family and Community Health) has developed a template grid for indicators that emphasizes the connection between Healthy People, Prepared Communities and Effective Systems. Social determinants, community, cultural and spiritual resources and addressing institutional racism are key domains.

10. Annual assessments of efforts made by MDCH staff to support efforts to reduce racial disparities. Web based surveys will be used for all MDCH employees each year. The survey will also be used to assess collaborative efforts with other state agencies & organizations to reduce racial disparities.

The annual assessment of MDCH staff effort was initiated with the survey of Women, Infants & Children (WIC) Organizational Assessment – see report on pp. 18-19. A copy of the Organizational Assessment Tool is included in the Appendix.

The PRIME Evaluation Workgroup has revised the Organizational Assessment survey, which will be used for annual assessments of the Bureau of Family, Maternal, and Child Health staff’s perceptions of organizational capacity to address health disparities. We will collect another round of organizational assessment surveys from the Division of Children’s Special Health Care Services in January 2013.
APPENDICES

Analysis of Health Equity Learning Labs Evaluation Survey

Analysis of Health Equity Social Justice Workshop Evaluation Survey

Organizational Assessment

NACCHO Course Schedule

PRIME Pre-Conference Evaluation (Michigan Premier Public Health Conference)
The first Health Equity Learning Lab was attended by 48 participants from various workplaces. Of these 48 participants, 39 worked at MDCH. The remaining participants were from local WIC agencies or Other. There were 2 groups (AM/PM) which participated in 3 half-day sessions.

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

<table>
<thead>
<tr>
<th>Job Title</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>9</td>
<td>18.8</td>
<td>19.6</td>
<td>19.6</td>
</tr>
<tr>
<td>Program Coordinator/Specialist</td>
<td>13</td>
<td>27.1</td>
<td>28.3</td>
<td>47.8</td>
</tr>
<tr>
<td>Program Consultant</td>
<td>8</td>
<td>16.7</td>
<td>17.4</td>
<td>65.2</td>
</tr>
<tr>
<td>Administrative Support</td>
<td>5</td>
<td>10.4</td>
<td>10.9</td>
<td>76.1</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>22.9</td>
<td>23.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
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<td>95.8</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing System</td>
<td>2</td>
<td>4.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Most program attendees identified themselves as a Program Coordinator/Specialist. The second largest group selected “Other”. There were roughly equal numbers of Administrative/Management, Administrative Support and Program Consultants.
2. What is your primary workplace?  (Check one answer.)

Main Division (MDCH Staff Only)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDCH WIC</td>
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<td>70.2</td>
<td>70.2</td>
</tr>
<tr>
<td>MDCH Other</td>
<td>6</td>
<td>12.5</td>
<td>12.8</td>
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<tr>
<td>Local WIC Agency</td>
<td>4</td>
<td>8.3</td>
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<td>91.5</td>
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<tr>
<td>Other</td>
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<td>8.5</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>47</strong></td>
<td><strong>97.9</strong></td>
<td><strong>100.0</strong></td>
<td></td>
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<tr>
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<td><strong>Total</strong></td>
<td><strong>48</strong></td>
<td><strong>100.0</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Missing did not have pre-tests.

Most of the Health Equity Learning Lab Session 1 Participants were from the MDCH. The remaining participants were either from a Local WIC Agency or Other.

3. Which WIC Section do you work in?  (Check one answer.)

WIC Section

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Vendor Management</td>
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<td>21.2</td>
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<tr>
<td>Data and Systems Management</td>
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<td>16.7</td>
<td>24.2</td>
<td>84.8</td>
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<tr>
<td>WIC Administration</td>
<td>5</td>
<td>10.4</td>
<td>15.2</td>
<td>100.0</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
<td><strong>68.8</strong></td>
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<td></td>
</tr>
<tr>
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<td></td>
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<tr>
<td>-------------</td>
<td>---</td>
<td>------</td>
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<td></td>
</tr>
<tr>
<td>System</td>
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<td></td>
</tr>
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<tr>
<td>Total</td>
<td>48</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Missing - None are those who worked in another MDCH Division or worked outside MDCH.

The largest proportion of Health Equity Learning Lab participants were from the Nutrition Program and Evaluation Section within the WIC Department. The next two highest sections were Data and Systems Management and the Vendor Management Section. The remaining participants were from the WIC Administration or worked outside of WIC.
4. 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 No</td>
<td>46</td>
<td>95.8</td>
<td>97.9</td>
<td>97.9</td>
</tr>
<tr>
<td>Yes</td>
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<td>2.1</td>
<td>2.1</td>
<td>100.0</td>
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<tr>
<td>Total</td>
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<td>97.9</td>
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</tr>
<tr>
<td>Missing System</td>
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<td>2.1</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Most Health Equity Learning Lab participants were non-Hispanic.

Are you a person of Arab, or Chaldean origin? *(Check one answer)*

<table>
<thead>
<tr>
<th>Arab or Chaldean</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid No</td>
<td>46</td>
<td>95.8</td>
<td>97.9</td>
<td>97.9</td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
<td>2.1</td>
<td>2.1</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>97.9</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing System</td>
<td>1</td>
<td>2.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Most Health Equity Learning Lab participants were not of Arab, or Chaldean origin.
5. 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 White</td>
<td>28</td>
<td>58.3</td>
<td>59.6</td>
<td>59.6</td>
</tr>
<tr>
<td>Black or African American</td>
<td>12</td>
<td>25.0</td>
<td>25.5</td>
<td>85.1</td>
</tr>
<tr>
<td>Asian</td>
<td>2</td>
<td>4.2</td>
<td>4.3</td>
<td>89.4</td>
</tr>
<tr>
<td>American Indian/Alaskan Native (AIAN) and White</td>
<td>1</td>
<td>2.1</td>
<td>2.1</td>
<td>91.5</td>
</tr>
<tr>
<td>Black or African American and White</td>
<td>1</td>
<td>2.1</td>
<td>2.1</td>
<td>93.6</td>
</tr>
<tr>
<td>Other and White</td>
<td>1</td>
<td>2.1</td>
<td>2.1</td>
<td>95.7</td>
</tr>
<tr>
<td>Asian and White</td>
<td>2</td>
<td>4.2</td>
<td>4.3</td>
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</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>97.9</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Note: Missing did not have a pre-test.

The majority of Health Equity Learning Lab participants were White (58%), with Black/African American (25%) as the next largest group. A select few identified themselves as Asian or biracial.
### 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</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am confident I can…</td>
<td>(n=41)</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>7. Identify my unique skills to contribute to the equity building process at MDCH.</td>
<td>3.80</td>
<td>.72</td>
<td>4.12</td>
</tr>
<tr>
<td>8. Identify individual strengths and weaknesses with respect to teamwork, out-of-box thinking, and change at MDCH.</td>
<td>3.85</td>
<td>.62</td>
<td>4.05</td>
</tr>
<tr>
<td>9. Identify collective strengths and weaknesses with respect to teamwork, out-of-box thinking, and change at MDCH.</td>
<td>3.55</td>
<td>.82</td>
<td>3.98</td>
</tr>
<tr>
<td>10. Articulate what I can do at my job to change social determinants of health (SDOH) that affect women and children.</td>
<td>3.78</td>
<td>.65</td>
<td>4.00</td>
</tr>
<tr>
<td>11. Identify opportunities at my job to address health inequities.</td>
<td>3.83</td>
<td>.77</td>
<td>4.15</td>
</tr>
<tr>
<td>12. Describe models and frameworks of social determinants of health equity (SDOHE).</td>
<td>3.49</td>
<td>.79</td>
<td>3.92</td>
</tr>
<tr>
<td>13. Articulate an understanding of how social determinants of health equity (SDOHE) can affect women’s lives and health.</td>
<td>4.01</td>
<td>.69</td>
<td>4.24</td>
</tr>
<tr>
<td>14. Articulate an understanding of social determinants of health equity (SDOHE) within MDCH and the WIC program that can effect women’s lives and health.</td>
<td>3.73</td>
<td>.74</td>
<td>4.15</td>
</tr>
<tr>
<td>15. Make changes(s) in my own work to address social determinants of health (SDOH).</td>
<td>3.80</td>
<td>.78</td>
<td>4.12</td>
</tr>
</tbody>
</table>

* p < .05  ** p < .01  *** p < .001

Participants showed statistically significant increases in most of the reported self confidence ratings. There was not a significant increase in one self confidence rating, “Identifying individual
strengths and weaknesses with respect to teamwork, out-of-box thinking, and change at MDCH."
Workshop Evaluation Questions

10. 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: Participants most frequently listed ideas for action to better address disparities at their work. Several participants mentioned engaging native and minority populations in decisions and program development. Other staff mentioned reviewing policies and procedures, while keeping health equity as a work priority. A few participants were unsure of how the workshop will help them to address racial health disparities.

(37 responses)

- **Action**
  - Provide additional awareness to co-workers when seeing racial health disparities
  - Make more suggestions that are thinking out of the box in terms of serving underserved clients
  - Advocate for getting the right staff involved with the right activities within their division
  - We are working on "client-centered" approaches that involve continually, consistently inviting and encouraging the client identify their relevant issues and interest
  - Identify opportunities/segments to improve or impact any determinants I may be able to or have control over-IE-ensure the quantity and type of food available to WIC participants
  - Identify opportunities to learn how to structure program initiatives to address needs of specific populations
  - Begin by talking with the rest of local agency staff-what they see. Assess what we are doing and what could be done differently
  - My first step is to become more educated on the true history of why races were classified and also Native American history in America
  - Pull in others to our work group (FAC-food authority committee) to get their input for food choices
  - Reach out and engage minority groups
    - Follow-up on Native-American contacts
    - Go out and "seek" input from different races, nationalities, ethnicities, etc on how they like or dislike our services and for what
changes we can make to better our services to them

Get input from targeted groups

Commit MDCH Diversity Council to add native people to representation

invite representatives of groups most affected by health inequity to participate in decision making discussions

Find opportunities to look for input from wide variety of voices

Do more outreach with the tribal community

- **Review and/or change policies/procedures**
  - ID what federal solicitation/comment period addresses equity
  - Do a review of all of our policies that affect clients, beginning with getting clients enrolled in the program and promoting client-centered services
  - Interaction/Training for local WIC Coordinators
  - Look at policies that could be more human. Include "seeking" as a part of ME's-program evaluation.
  - Optional training specific as to how WIC can better address racial disparities
  - Include concepts in training
  - Start utilizing focus groups

Consider that we are asking those to drive to certain meetings/trainings. What impact might this have on them

- **Uncertain of Learning Labs impact**
  - I am not sure what the labs will help me do differently
  - Don't know, may have a better understanding when all 3 labs are done
  - This was not an actual focus of this lab. It may have been the intentions but was mostly generic lecturing on theory
  - Not sure-new tools and ideas didn't get around, but we have been working on

- **Increased Awareness**
  - Greater Awareness
  - Become more sensitive to diversity and cultures
  - Increased my consciousness of impact of decision-making.
  - Understanding different cultures and background and how it affects their health, historical trauma
  - Greater Education

- **Prioritize Health Equity at work**
  - Bring these things to forefront when considering my work
  - I make a personal commitment to improving health equity and social justice too
• **Utilizing data**  
  1. Identify opportunities to improve health disparities by looking at WIC data among different WIC populations  
  2. Develop tools where data can be shared more freely at a level for coordinates to review  

    I can look at ways data can contribute to changes on a state agency level  

    this for several years  

• **Other**  
In my current job I don’t think we have racial health disparities  

    Lynda  

    N/A  

    Interested in practical, successful applications/strategies for applying health in my work  

• **Unsure**  
I am too new to answer this  

    Have to see based as we haven’t had a chance to go back to assess what has been learned  

    Not sure yet
11. Describe the most useful or valuable outcomes of the Health Equity Learning Labs.

Summary: Participants listed knowledge of history, and awareness as the most valuable outcomes of the Learning Labs. Participants appreciated the Native American speaker, and learning about Native American history. Several participants enjoyed being able to discuss Health Equity with their colleagues.

(37 responses)

- **General Knowledge**
  Increased knowledge base

  Understanding the racial disparities all over the world. Other countries seem to have this

  History

  Understanding social determinants of health epigenetics

  Eye-opening info and data given from the leaders of labs

  History of "ism"

  I felt the presentations on the history of the inequities for the various groups.

  The lab sessions provided an arena for me to learn more about disparities and how I am able to contribute to change

  Awareness of the SDOH

  Gave me more insight into the communities we serve, to keep in mind their needs while serving them

  Awareness

- **Knowledge of Native Americans**
  Info on the background/history of Native American experience

  The information on the Native American Culture

  Awareness of Native Americans

- **Discussions**
  Exchange of ideas among participants

  Wrap-up discussion was most valuable

  Being able to hear the stories of others

  More awareness of health equity is needed in today's society

  Raising my awareness

  I feel the most valuable outcome of these learning labs are the change in perspectives of others and the lives they've lived

  Becoming more aware of health inequities among races

  More time "absorbing" the cultural differences and how significant they are therefore the complexity of supporting and absorbing into policy, program design, etc
Sharing
The networking/sharing opportunity

Became aware of thoughts, ideas, and perspectives and others that I might be able to use. Many good ideas were shared.

Discussion for potential health equity leverage points

- **Native American Speaker**
  Increased understanding of historical trauma and of Native American culture/considerations (much needed)

  Personal experiences detailed by Linda and video clips

  Linda’s story

  Listening to Linda and the NA/AN experiences

- **Workshop Content**
  I appreciated the lectures, exercises

  The typology exercises was great for beginning the application process of these ideas

  I felt that the most impactful was the Brooks survey as it really helped hit home the reality of what I do or how I feel

  The panel was very knowledgeable and willing to engage any questions in a positive manner

- **Waiting to see outcomes**
  TBD-I'm excited to see where things stand with next session
  TBD

  N/A We haven't been through all the labs so I unsure of what the most valuable outcome will be

- **Other**
  Same as 10 (My first step is to become more educated on the true history of why races were classified and also Native American history in America)

  Break down of lives, work, etc and what really affects decisions and outcomes (positive and negative)

  Resources in MI

  Offer options on how to evaluate program efforts

  I look forward to working more closely with staff from MDCH
  I find it hopeful that MDCH has such committed staff willing to make change

  Everything

  All of it
12. How did these learning labs 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 of Native American history and culture, along with the history of the Michigan Department of Community Health. Some participants reported an increase in awareness of health equity issues, and a sense of empowerment. However, there were a few participants who did not feel that the Learning Labs improved their knowledge or skill base.

(33 responses)

- **Knowledge: Native American History**
  Gave me a historical perspective of MCH and of the Native American Indian

  Specific history that impacts our diverse populations health (i.e. Native Americans)

  See 11 (Increased understanding of historical trauma and of Native American culture/considerations (much needed))

  I specifically increased my knowledge of the Native American culture. I really appreciated Linda sharing

- **Ideas for Change**
  Makes me rethink how I gather information, who and what is considered
  Gave me strategies for affecting change

  I believe so. I need to include this way of thinking as I do my work.

  Policy/training development strategies. Puts this in the forefront again; I hope it helps us all in WIC to prioritize this area.

  Policy development training

- **General Knowledge**
  The learning labs increased my awareness
  More insight into barriers within WIC

  SDOH-I so buy into the addition of the green boxes especially the seek help

- **Empowerment**
  Helped me realize the power I do have even though I feel discouraged in many ways.

  Getting me to really start thinking about what we can do in small steps

  Gave ideas that can be used to improve and reduce disparities

- **New perspectives**
  I’m able to approach my work differently after the discussion about walking in other people’s shoes and understanding the
background and being conscious about a client's history

There is always more than meets the eye. Brought up knowing this...better am now more aware of the background or meaning behind that phrase.

- **Focus on Client-Centered Services**
  Develop and make effort to understand the clients' needs instead of just providing what we think is right.

  Involve communities to help make policy decisions

  Contacts to do outreach within the state

- **Knowledge: History of MDCH**
  Understanding the hx of MCH

  Able to describe privilege, social determinants of health, interdisciplinary stresses, opportunity for change to normalize services

- **No Improvement**
  Already well versed

  They haven't yet

  Unfortunately not much

- **No Disparities**
  I feel my job doesn't have a lot of disparities

- **Other**

Same as 10 (My first step is to become more educated on the true history of why races were classified and also Native American history in America)

N/A

Not sure yet

Infant mortality difference awareness drive the question "WHY"

Typology tool-while needs further development (reliability, validity) good multi-level beginning overview. Like idea of global do you do or see this personally/work/institution. Would prefer to do rank for each domain separately

Reinforced my beliefs on how to treat people and how you see others

Understanding different variables

The labs have improved my ability and awareness to see opportunities. I work with data so on an interpersonal level I'm limited with what I can do. However, I am open for opportunity
13. In what ways did these learning labs disappoint you or fail to meet your expectations?

Summary: The most commonly reported disappointment was the lack of concrete examples and ideas for how to enact effective change. Other participants provided suggestions for improving the workshop itinerary and facilitation. Several participants desired more participant interaction and discussion.

(35 responses)

- **Implementation Ideas**
  Concrete ideas in each of our roles/opportunities to decrease health disparities. I suspect more of this to come with future trainings

  I would like to see more application activities—perhaps that is coming in future sessions

  I would like to move more toward application in the work world

  Looking for ways to move forward with implementing ways to institutionalize incorporation of SDOH in allocating resources, determining policy

  Not sure may be needing more emphasis on what staff can use/do to address equity.

  I would like to work more in coming up with ideas or next steps in helping to make the changes needed...particularly between the state wic office and local wic offices

  Wanted more examples of what others (states, cities, organizations) are actually doing are health equity application

  Expressed the desire for discussion/brainstorming around focuses, strategies

- **Facilitation Processes**
  Build in a break

  Day 1 seemed to be lacking in things I could ID as accomplishments; which is a major focus within MDCH culture

  The BET modified exercise may need some tweaking

  Not real focused on tools for addressing state functions and responsibilities

  The facilitation was lacking. Participants were just allowed to talk with no real guidance or redirection took away from learning about real issues.

  Please do not force people to comment if they are not ready or don’t have anything different to add to the conversation. Just because people don't speak every time does not mean they are not participating mentally

  Many definitions were given that I didn't necessarily agree with that were over generalizations. This led to my mindset
being in debate over the subsequent subject matter-IE. institutions, gatekeepers, etc. Need to allow more time

Did not like the scheduling of the workshops

- **Want more interaction**
  Speak at you rather than get interactive

  Seemed more lecture based. Limited sharing of experiences.

  A little too much lecture

  Not enough group activities

  Have more interaction between people

- **No Disappointments**
  I was not disappointed at all.

  Found it useful-beyond what I expected

  No disappointment

- **More background information**

I was expecting more "lecture" type of learning. I am not very familiar with social justice and hope to learn more.

- **Whole picture**
  Need a "road map" where prime training is now, and where we "plan" to go.

- **Other**
  Didn't know what to expect

  N/A (6)

  Didn't know what to expect...seems more accepting from previous training

  Can't answer this until I have done all the labs. I would feel better to answer then

  It was great in terms of the knowledge shared/presented
14. What would have made these learning labs more successful?

Summary: Most participant responses focused on the format and content of the workshop. Participants suggested better organization of materials, and more awareness among the facilitators about WIC staff’s previous training. Additionally, participants suggested more data as concrete examples.

(25 responses)

- **Workshop Agenda & Content**
  
  Incorporate 2-5 minute breaks...I know we are pushed for time, but it’s nice to leave without feeling like I missed something during the presentations

  Clearer introductions, explorations of activities and break outs

  Maybe it would have been more helpful if facilitators would have been able to be more knowledgeable about what types of trainings and concepts participants already have gone through. This would help cut down on redundancy.

  Would like the slides to be in the same order they were presented. Sometimes it was a lot of information to present in a short time

  Better use/tabs to have slides looked at by us as presenter was talking (helps to take notes). Staff had to hunt what pages in the binder presenter was on

  1st day seemed like a refresher of social justice workshop-almost somewhat wasted time. Good material and discussion and exercises on 2nd and 3rd day could be expanded upon.

  Keep working on developing tools

  Some feelings that NA viewpoint was dominant when AA Arabic, immigrant populations were not as representative

  Same as 13 (Not sure may be needing more emphasis on what staff can use/do to address equity).

  I really appreciated the different perspectives everyone brought from different workplaces, though.

- **More data/information**

  More information regarding the "isms-Racism, sexism, gender inequality etc. Everyone in the room didn't have an understanding of the history

  Perhaps pointing out successful programs/initiations that we can use for inspiration.

  I like the combination of learning/reviewing history and concepts I feel that it better focuses the discussion

  For the clinicians in the room, it would have been helpful to have more scientific data background specific to infant mortality, racial disparities in Michigan-maybe this will come later
More about epigenetics

I think more scientific information about genetics would be helpful, one question I have is how long would it take to turn off their genetic switch...

- **More interaction**
  More interaction, brainstorming what we can do at work

  More group exercises, change format

  Small groups sessions

  Right now we need more interaction with the people in the room

- **More time to process**
  Having more time to read and answer questions

  Sometimes it felt rushed and I didn't have a lot of time to process the material. I wish there would have been more time for personal thought and reflection

- **Other**
  Don't know

  This was a great lab-I appreciate your efforts. Thank you so much!!

  They were very good

  N/A

  Not sure

  Will have a better idea after the sessions have been completed.
On a five-point scale, how useful was this workshop for your work?  

*Circle one answer:*

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

Useful  
Useful  
Useful  
Useful  
Useful  

Mean Rating for the Health Equity Learning Labs: 3.68  
Mean Rating for the WIC Health Equity Social Justice (HESJ) Workshop: 4.23  
Mean Rating for the HESJ Workshop: 4.14  
Mean Rating for the Undoing Racism (UR) Workshop: 3.96  

Standard Deviation: .94 (UR: .93; HESJ: .85; WIC HESJ: .91))

Participants of the Health Equity Learning Labs rated the usefulness of the workshop on average as 3.68 on a 5 point scale, with 1 being 'Not at all useful' and 5 being 'Extremely Useful'. Participants in the AM session rated the workshop higher on average (4.00) than the PM session (3.25).

**Comparison of this Mean Usefulness Rating of the 2 Learning Lab (LL) groups (AM/PM) with Mean Usefulness Ratings among 13 other PRIME training events:**
Mean Usefulness Rating

UR1 (n=14)  UR2 (n=17)  UR3 (n=23)  UR4 (n=22)  UR5 (n=27)  HES1 (n=17)  HES2 (n=16)  HES3 (n=19)  HES3WIC1 (n=17)  HES3WIC2 (n=16)  HES3WIC3 (n=13)  LLAM (n=21)  LLPN (n=16)

Mean Usefulness Rating:
- UR1: 4.00
- UR2: 3.41
- UR3: 3.70
- UR4: 4.14
- UR5: 4.11
- HES1: 4.26
- HES2: 3.94
- HES3: 4.53
- HES3WIC1: 4.35
- HES3WIC2: 4.39
- HES3WIC3: 4.19
- LLAM: 4.08
- LLPN: 4.00
- Mean: 3.25
15. 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>No</th>
<th>Recommend with reservations</th>
<th>Recommend with NO reservations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
<td>0.0%</td>
<td>41.7%</td>
<td>58.3%</td>
</tr>
</tbody>
</table>

58.3% of the participants would recommend this workshop without reservations.  
Comparison of the percent of participants who would recommend this workshop without reservations of the 2 Learning Lab groups (AM/PM) with percent recommendations without reservations among 13 other PRIME training events:
Analysis of Health Equity Social Justice Workshop Evaluation Surveys

Allison Krusky, MPH

Thomas M. Reischl, PhD

December 14, 2012

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</td>
<td>7/23/12</td>
<td>18</td>
<td>32.1</td>
<td>32.1</td>
</tr>
<tr>
<td></td>
<td>8/27/12</td>
<td>18</td>
<td>32.1</td>
<td>64.3</td>
</tr>
<tr>
<td></td>
<td>10/25/12</td>
<td>20</td>
<td>35.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Health Equity Social Justice workshop was attended by 56 MDCH participants. There were an additional 4 participants from partnered community organizations. There were 3 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>7</td>
<td>13.7</td>
<td>13.7</td>
<td>13.7</td>
</tr>
<tr>
<td>Program Coordinator/Specialist</td>
<td>13</td>
<td>25.5</td>
<td>25.5</td>
<td>39.2</td>
</tr>
<tr>
<td>Program Consultant</td>
<td>17</td>
<td>33.3</td>
<td>33.3</td>
<td>72.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>Administrative Support</td>
<td>7</td>
<td>13.7</td>
<td>13.7</td>
<td>86.3</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>13.7</td>
<td>13.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>91.1</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing System</td>
<td>5</td>
<td>8.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Most program attendees identified themselves as either a Program Consultant or Program Coordinator/Specialist. There were equal numbers of Administrative/Management, Administrative Support and Other.
**What Division/Section do you work in?**

*(Check one answer.)*

<table>
<thead>
<tr>
<th>Division/Section</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division of Family &amp; Community Health</td>
<td>7</td>
<td>12.5</td>
<td>13.7</td>
<td>13.7</td>
</tr>
<tr>
<td>WIC Division</td>
<td>38</td>
<td>67.9</td>
<td>74.5</td>
<td>88.2</td>
</tr>
<tr>
<td>Division of Health Wellness and Disease Control</td>
<td>3</td>
<td>5.4</td>
<td>5.9</td>
<td>94.1</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>5.4</td>
<td>5.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>91.1</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

**Missing**

<table>
<thead>
<tr>
<th>Missing System</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>System</td>
<td>5</td>
<td>8.9</td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
<td>100.0</td>
</tr>
</tbody>
</table>

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

Most of the Health Equity Social Justice MDCH participants were from the WIC Division. The remaining participants were either in the Division of Family & Community Health, Division of Health Wellness and Disease Control, or Other.
<table>
<thead>
<tr>
<th>WIC 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 Nutrition Program and Evaluation</td>
<td>17</td>
<td>30.4</td>
<td>42.5</td>
<td>42.5</td>
</tr>
<tr>
<td>Vendor Management</td>
<td>7</td>
<td>12.5</td>
<td>17.5</td>
<td>60.0</td>
</tr>
<tr>
<td>Data and Systems Management</td>
<td>6</td>
<td>10.7</td>
<td>15.0</td>
<td>75.0</td>
</tr>
<tr>
<td>WIC Operations Unit</td>
<td>3</td>
<td>5.4</td>
<td>7.5</td>
<td>82.5</td>
</tr>
<tr>
<td>WIC Administration</td>
<td>4</td>
<td>7.1</td>
<td>10.0</td>
<td>92.5</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>5.4</td>
<td>7.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>71.4</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing None</td>
<td>10</td>
<td>17.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>System</td>
<td>6</td>
<td>10.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>28.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>56</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 WIC MDCH participants were from the Nutrition Program and Evaluation Section within the WIC Department. The next two highest sections were Vendor Management and the Data and Systems Management Section. The remaining participants were from the WIC Operations Unit, WIC Administration or Other. There were 10 MDCH participants who worked in other sections.

2. Are you a person of Hispanic, Latino, or Spanish origin? *(Check one answer.)*
### Hispanic (MDCH Staff Only)

<table>
<thead>
<tr>
<th></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>49</td>
<td>87.5</td>
<td>96.1</td>
<td>96.1</td>
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<tr>
<td>Yes</td>
<td>2</td>
<td>3.6</td>
<td>3.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>91.1</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>System</td>
<td>5</td>
<td>8.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Most MDCH participants were non-Hispanic.
3. 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 White</td>
<td>33</td>
<td>58.9</td>
<td>66.0</td>
<td>66.0</td>
</tr>
<tr>
<td>Black or African</td>
<td>9</td>
<td>16.1</td>
<td>18.0</td>
<td>84.0</td>
</tr>
<tr>
<td>American</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>2</td>
<td>3.6</td>
<td>4.0</td>
<td>88.0</td>
</tr>
<tr>
<td>Asian and White</td>
<td>1</td>
<td>1.8</td>
<td>2.0</td>
<td>90.0</td>
</tr>
<tr>
<td>AIAN and White</td>
<td>1</td>
<td>1.8</td>
<td>2.0</td>
<td>92.0</td>
</tr>
<tr>
<td>Black or African</td>
<td>1</td>
<td>1.8</td>
<td>2.0</td>
<td>94.0</td>
</tr>
<tr>
<td>American and White</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1.8</td>
<td>2.0</td>
<td>96.0</td>
</tr>
<tr>
<td>White and Other</td>
<td>2</td>
<td>3.6</td>
<td>4.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>89.3</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing System</td>
<td>6</td>
<td>10.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>56</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 (66%), 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>Pretest</th>
<th>Posttest</th>
<th>Paired t-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1= Strongly Disagree to 5=Strongly Agree)</td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>(n=39)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Articulate an understanding of target identities and non-target identities.</td>
<td>3.08</td>
<td>.93</td>
<td>4.69</td>
</tr>
<tr>
<td>7. Articulate an understanding of the four levels of oppression and change.</td>
<td>2.62</td>
<td>.88</td>
<td>4.67</td>
</tr>
<tr>
<td>8. Articulate of the difference between health disparity and health inequity.</td>
<td>2.97</td>
<td>1.01</td>
<td>4.31</td>
</tr>
<tr>
<td>9. Articulate an understanding of social determinants of health.</td>
<td>3.41</td>
<td>.97</td>
<td>4.36</td>
</tr>
<tr>
<td>10. Articulate an understanding of cultural identity across target and non-target groups.</td>
<td>2.95</td>
<td>.83</td>
<td>4.41</td>
</tr>
<tr>
<td>11. Articulate an understanding of public health’s historical role in promoting social justice.</td>
<td>3.03</td>
<td>1.04</td>
<td>4.08</td>
</tr>
<tr>
<td>12. Articulate an understanding of the root causes of health inequity.</td>
<td>3.18</td>
<td>.91</td>
<td>4.31</td>
</tr>
<tr>
<td>13. Analyze case studies in a social justice/health equity framework.</td>
<td>3.00</td>
<td>.99</td>
<td>4.13</td>
</tr>
<tr>
<td>14. Identify opportunities for advancing health equity at my workplace.</td>
<td>3.05</td>
<td>.82</td>
<td>4.15</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>15. Men are the “non-target” group for identifying gender oppression and privilege.</td>
<td>True</td>
<td>42</td>
<td>23.8%</td>
<td>92.9%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>16. The experience of oppression and privilege can change frequently based on our target and non-target group identities.</td>
<td>True</td>
<td>42</td>
<td>54.8%</td>
<td>90.5%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>17. Nearly everyone experiences some form of unearned privilege, regardless of how hard they work to achieve success.</td>
<td>True</td>
<td>42</td>
<td>45.2%</td>
<td>85.7%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>18. One way health departments can address the social determinants of health is by promoting healthier eating habits.</td>
<td>False</td>
<td>41</td>
<td>22.0%</td>
<td>51.2%</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>19. The field of public health developed in response to social injustice brought about by the industrial revolution.</td>
<td>True</td>
<td>38</td>
<td>39.5%</td>
<td>65.8%</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>20. 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>39</td>
<td>76.9%</td>
<td>89.7%</td>
<td>.227</td>
</tr>
<tr>
<td>21. The social justice movement in public health is an attempt to shift focus from health inequities to health disparities.</td>
<td>False</td>
<td>40</td>
<td>37.5%</td>
<td>67.5%</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>22. The term “health disparities” refers to the underlying causes of “health inequity.”</td>
<td>False</td>
<td>41</td>
<td>17.1%</td>
<td>39.0%</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>23. Thoughts, beliefs, and values held by an individual are examples of the cultural level of oppression and change.</td>
<td>False</td>
<td>41</td>
<td>9.8%</td>
<td>73.2%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>24. The institutional level of oppression involves rules, policies, and practices that advantage one cultural group over another.</td>
<td>True</td>
<td>42</td>
<td>68.4%</td>
<td>90.5%</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>25. The personal level of oppression involves actions, behaviors, and language.</td>
<td>False</td>
<td>42</td>
<td>6.7%</td>
<td>71.4%</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>
26. Eliminating *interpersonal level* oppression involves change in community norms and media messages that reinforce stigma and negative stereotypes.

<table>
<thead>
<tr>
<th></th>
<th>False</th>
<th>42</th>
<th>4.0%</th>
<th>59.5%</th>
<th>&lt;.001</th>
</tr>
</thead>
</table>

Participants showed significant increases in their content knowledge for a majority of content knowledge questions from the pretest to the posttest. Only one content knowledge question did not show a significant increase: “The social justice framework for public health practice suggests that health problems are primarily caused by lower-income individuals making bad health choices.” The pretest score for the social justice framework question was the highest of all pretest questions (77%), and although it did have an increase from pretest to posttest, the change between tests was not significant.
Workshop Evaluation Questions

27. 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: Participants reported that the workshop increased their awareness of disparities and health equity. It also provided them with confidence to address health equity issues. Several participants listed ideas for policy or procedural changes that would help to promote health equity. Other ideas that participants developed after attending the workshop to address racial health disparities included making changes to the data analysis process and staff training.

(38 responses)

- **Increased awareness of health equity**
  - Be conscientious of others circumstance
  - Increase level of awareness when interacting with local health department, WIC clients and WIC vendors
  - First off in actually recognizing disparities
  - It’s definitely helped me to be able to recognize and bring awareness to racial health disparities
  - To recognize potential levels of oppression in operation

  Awareness (2)

  I will be better equipped to identify the disparities

  My organization does this already, but continuing to be conscientious of the events (speakers & audiences) we hold can contribute to addressing racial health disparities in MI.

  Increase personal awareness and attention to issues

  More awareness, sensitivity
It has increased my awareness which will make me more effective at finding which things need to change

Help me to communicate with my boss and the higher-ups better

Tailor my thinking towards racial topics more and prepare my ways to communicate these more

Always be willing to speak up and support for getting resources to areas of health inequities

The workshop has really shifted the lens by which I view the work I do

This workshop has helped give ideas & confidence to confront & address things at an interpersonal level- how to engage in dialogue with people if I observe something that's promoting inequities and how to articulate my ideas

The workshop has given me a different perspective and my awareness of my role and how I can effect others has changed

I can be an advocate of others

• **Empower/Confidence**

  I can speak out when things are not right

  I will be more mindful of how I can advocate for others by using my power for the good of others

  I will participate with more security (more empowered) evaluating my options

  I could be more outspoken when recognizing inequality at the office

• **Empowerment**

  Learning to speak out & not be afraid to address issues at hand

  By hopefully insuring that all people regardless of race are equally promoted within the department

  Speaking to health disparities evident in the work I do

  There are certainly multiple opportunities to apply this information to my work, but the

• **Policy/Procedure Changes**

  Encourage and promote the next year 2013 pilot is expanded to areas where it will have a greater impact on feeding hungry kids during summer (SEBTC prgm)
most evident one right now is through our RFP process

Make sure the role of health inequities is considered in our strategic planning

Gives me ideas regarding policy and procedural changes that can be looked at that were not previously considered as important or significant

Within WIC- talk with co-workers as policies are being developed that impact the delivery of services to our clients.

Create policy changes that will have an impact on services offered to clients

Influence on statewide policy- institutional impact. Influence on food authorization decisions.

Create collaborations with other programs to streamline or enhance services

Continue working together as a team to make the necessary changes to the allowable food in Michigan to better serve the diverse population

We have experiences with people of many different backgrounds but only really offer literature/assistance from our own world-view (in our department). Expanding the way we communicate with and attempt to understand vendors and clients of different backgrounds will make WIC more effective.

Identify high need, underserved pockets of potential WIC clients and link infant mortality with (health services & WIC to decrease social determinants of health resources)

- **Developing Ideas**
  Currently looking for ways to integrate health equity as a fundamental part of our daily work.

  Use what I learned here about the 4 levels of oppression to help me know where to start making a change when I recognize inequities

  Will explore strategies, research or other organizations experiences to implement health equity practices

- **Staff Training**
  Talk to my staff about answering phones in a manner that does not make people feel they can't or don't want to call due to the staff's rudeness to outside callers

  Training, hiring

  Encourage opportunities for staff to experience/be exposed to client experience (Fd Avail, visiting clinics)
Data Analysis
As a data coordinator, I can help to analyze and distribute data and articles that can highlight the racial disparities we see for our population, and provide tangible solutions to reduce the disparities we see.

Look across the WIC population based on income, environment and race statistically to promote change.

Use/analyze the data we collect to look at racial health disparities.

Other Comments
None

I would like to see better foods & larger grocery store in the urban area & not have food deserts.

action and making room for discomfort

Currently, I am adapting a violence prevention program for a target group & this work is important to show that small changes in evidence-based programs for a particular group can improve health outcomes.

Provided a language for me to address others on issues related to racial or other causes of health disparities.

Broaden the discussion of health disparities from the obvious to more of the underlying causes.
28. Describe the most useful or valuable outcomes of this workshop.

Summary: A large portion of participants reported being more aware of health equity and knowledge of oppression as the most useful or valuable outcome of this workshop. Others also mentioned developing a language and skills to discuss health equity, along with feeling empowered by this workshop to take action. Participants reported that the workshop offered a time for self-reflection, along with developing a team cohesion with colleagues.

(42 responses)

- **Increased awareness/knowledge**
  Understanding the virtually all of us experience some form of unearned privilege. This is a helpful example to help people understand inequity. I will keep that as a "back pocket" example.

- Understanding that we move in and out of target groups

- Increased awareness/knowledge of oppression

- The ability to "see"

- Becoming more aware of oppression in everyday life

- Opening my eyes to others positions

- Awareness of different people's perspective

- **Communication (Dialogue) Skills**
  Conversation skills and ideas

- Created an awareness

- Awareness

- Creating more awareness about these issues

- Understanding that people don't all think alike

- Made aware of disparities of the disadvantaged

- Awareness & knowledge

- Having a language to communicate these ideas to a framework to understand common situations
and that using the guidelines for dialogue can greatly help me to express my ideas.

The opportunity to engage in these conversations, process information and practice applying it.

how to thoughtfully dialogue about some of these topics.

Dialogue techniques

Communication (dialogue) techniques

Learning how to have discussions/initiate discussions on difficult topics.

Being able to articulate these issues. I knew they existed but making the argument they exist and therefore being able to effect change has been missing.

guidelines for discussion

- **Empowered**
  Good reminder of all us being part of the solution, change sense of being hopeless.

Knowing that I have power and privilege that I can leverage and use to my advantage.

Inner power

Reminder that oppression continues to occur and individuals have power to overcome.

Identifying my power.

handling challenging topics

Recognizing the power I have to effect change

realizing that I can make things change

Making me aware that I do have power to address/discuss this with individuals

- **Health Equity Terminology/Concepts**
  Language to describe & articulate health inequity

Understanding target/non-target groups

Understanding of oppression and privilege, especially unearned privilege.

Appreciate target vs. non-target groups, earned vs. unearned privileges, levels of oppression.
Framework for understanding & identifying how to approach/address people, situations, institutions related to health inequity

The most useful outcome for me is learning about the levels of oppression

Gained an understanding of target and non-target groups as well as privilege and unearned privilege

Concept of "target/non-target"

• **Reflection**
  as well as an increased personal reflection on my own role in perpetuating inequity and how I can start to change that

The personal reflective activities on Day 1

Raised personal awareness

Digging deep into my values and feelings of the issues of health disparity and social injustice

Realizing that a power change can happen internally

Increased personal awareness. I feel I have come further in my personal journey to own and move beyond my own prejudices.

Relearning after some time apart

  • **Developing team cohesion**
    Team work with WIC together

  shared rhetoric developed

learning & working together at multiple levels of management

Going through process with coworkers—better understanding of their background/perspective

Interacting with co-workers more and talking about these important issues with them

Understanding racism and how different team members understand and are impacted by it

• **Action**
  To change the way of thinking & working with other people

the tangible things to do in my job I found on Day 3
possibilities for action

Techniques/strategies to use in influencing others

Learning the levels of change and where to start

ideas for starting a topic

• **Embracing Discomfort**
  that discomfort is necessary before change can occur

The ability to make room for discomfort

• **Other Comments**
  The most useful outcome when the workshop consist of a varieties of individuals not just one culture/race

Realization

Role play was a good way to see what pointers could be used to help get a change made
29. 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 terminology, increased communication skills and heightened awareness of health equity issues. Participants reported vocabulary for better expressing health equity, along with understanding the importance of how to engage in conversations and actively listen. Several participants reported being better able to identify steps they could take, along with feeling more empowered to take action.

(39 responses)

- **Knowledge: Social justice, disparities, inequity, oppression**
  
  Knowledge=levels of social justice

  Concept of "target/non-target"

  Learning about the 4 levels of oppression

  Levels of oppression

  Understanding the difference between disparities and inequities.

  Framework for understanding

  New concepts.

  Identifying 4 levels of oppression and change

  Intent vs. Impact. Trying vs. [left blank].

  Unearned privilege

  Introduced me to the different levels of how racism can be addressed: personal, interpersonal, institutional, cultural

  Appreciate target vs non-target groups, earned vs. unearned privileges, levels of oppression

  Again the levels of oppression are very valuable

- **Communication skills**

  The tools for dialogue are most helpful in recognizing my intent vs. impact. I feel hopeful!

  Vocabulary & conversation skills
Communication (dialogue) techniques

Know how to communicate effectively, better.

Language skills to help promote dialogue and not to use offensive descriptors

Being able to speak and listen with an open mind and heart

Language to describe & articulate health inequity.

It provided me with a vocabulary to use and the confidence to use it

Increased understanding of how to talk to others.

Techniques for discussions that may allow for change/influence

Ability to listen and respond thoroughly.

Silence is powerful and reflective.

identifying how to approach/address people

How to deal/guidelines to start conversations

New perspective/awareness
Skills= awareness

Identifying where I have power

Understanding the virtually all of us experience some form of unearned privilege. This is a helpful example to help people understand inequity. I will keep that as a "back pocket" example.

Awareness of underserved privilege and improve sensitivity to minorities.

The recognition of privilege and power can be used every day at work (and at home!)

Health Equity & Social Justice Workshop: was something in the back of my mind but this workshop brought things into perspective.

Gave me a better understanding of the issue with food deserts in urban area & opened my eyes why this was happening.

It helped me be able to recognize and have words for topics of unearned privilege, health inequities and health disparities
situations, institutions related to health inequity

Keep other peoples thoughts/feelings in mind. Think of the 6 feelings...

being able to understand why vendors/clients act the way they do without jumping to conclusions about their worth/abilities.

Made me more aware of the levels of oppression

• **Ideas for Change**
  Advocate for target groups

Advocacy

1st line phone responders need to take other people’s needs into consideration.

Targeting areas for addressing health inequities.

Through contact and communication with co-workers

• **Tools/Skills to take action**
  How to apply interpersonal observations & interactions at work

Recognize strategies I can use to effect change.

The awareness of the various groups. Will help with being able to work with all groups effectively.

How to identify and approach them (levels of oppression)

• **Workshop provided practice**
  Practicing becoming a change-agent through role play

The opportunity to engage in these conversations

Able to reapply insights aimed from first introduction related to useful language, useful approaches in the topic

• **Self reflection**
  It allowed for reflection on areas for personal growth and how to talk with others to enable them the same opportunity for reflection.

ways of feeling empowered

Put "perspective" in my face; helps me to understand some of the ways that my
words/actions in my job impact actions by others.

Also knowing where I fit in, as a target group member
• **Other Comments**
  I anticipate this affecting my future employment. It did not

Learning about the high rate of infant mortality in African American population. I am a new analyst for Maternal Infant Health and this helps me better understand the reasons our program exists.

• **None**
  Did not
30. In what ways did this workshop disappoint you or fail to meet your expectations?

Summary: Most participants reported that the workshop did not disappoint or fail to meet their expectations. Several participants wished that the workshop be longer. A few participants had concerns about the facilitators not allowing time for participants to process the information and develop their own perspective.

(38 responses)

- **Workshop Content/Itinerary**
  The action oriented activities on Day 3 were great, and I would have liked more of them on Day 2. Also more partner conversations throughout for introverted people.

  No lunch on the 3rd day

  Some of the scenarios were more difficult than others

  I would like more time to delve into the personal process my internal privilege & biases as well as how they impact how I move through the world, and learn from my colleagues who attended the workshop.

  Need more days & input from the institutional side would be helpful

- **Facilitation**
  Certain comments made by facilitator

  Some questions/issues I had I felt were dismissed as the wrong perspective or interpretation of concept. Made me hesitate to share.

  Perhaps because the workshop was only 2 days- but at times it seemed as though the facilitators "pushed" too hard to have us "admit" to or meet some objective they wanted us to meet, rather than just let the group discussion have time to get there.

- **Workshop length**
  Not the workshop but MDCH...should have been 3 days.

  Not long enough- I felt less focused on this last day, knowing that I'm headed back to the office

  only in length, wish it was 4 days.

- **Personal Regrets**
  I participated in this workshop one year ago and could complete the 2nd 2 days. I am disappointed that this was only 2 1/2 days
so in essence I missed lots of the last 2 days again!

I was at the disadvantage for having missed day 2 - the crux of the workshop.

- **Exceeded Expectations**
The workshop actually exceeded my expectations. I learned far more than I expected.

- **Other Comments**
I know this was a difficult date to have a training but it got very political

The disappointment is that nothing will change

- **None**
Did not disappoint at all

None. Well done.

None (9)

N/A (4)

0 (2)

None- I was pleasantly surprised all around because I came in with few expectations and skepticism. I wish I hadn't came in with the poor attitude.

It didn't
31. What would have made this workshop more successful?

Summary: Most respondents felt the workshop was successful and offered no suggestions. Others suggested to go through topics with multiple perspectives and to include more variety in presentation techniques. To make the workshop more successful, several participants requested that the workshop be longer.

(35 responses)

- **Workshop Itinerary/content**
  - Videos showing examples
  - Use of more media and other presentation techniques
  - Less group work
  - A method of following up on progress in the workplace
  - Talking more about how to change American cultural and societal norms, from the individual & organizational perspective (aka- how can an org achieve change in the culture outside of its walls?)
  - Looking at the different inst. policy from the various individuals.

- **More time**
  - More time (4)

  -> 4 or more full days

Make it longer- This was one of the best workshops I have attended

I would have liked the workshops to be longer

More time per the reasons state in #25 (I would like more time to delve into the personal process my internal privilege & biases as well as how they impact how I move through the world, and learn from my colleagues who attended the workshop.)

If we had two full days of workshop instead of one day and a half.

Requiring participation in the full 4 day workshop instead of the 2 1/2 day

- **Participation**
  - I really appreciated the different perspectives everyone brought from different workplaces, though.

There were people who did not engage much. If there is a gentler, respectful way to draw out those people I would like to see that.
Not to make it mandatory

Consistent attendance

- **Other Comments**

  ?

  I am not with WIC, and would love to go through this with my colleagues.

  Due to unforeseen situation it would have been better served to have had the 3 consecutive days

  - **None**
    
    No suggestions. It went over my expectations

  This workshop was excellent.

  I cannot think of any improvements- the workshop was great all around. Thank you!

  There is nothing needed to be done to this workshop. The people are great.

  I really have no suggestions. I feel this has been a very effective workshop.

  Nothing. Well done!

  I think the workshop was successful. There was no beat missed, even though there was a big gap between day 1 and day 2.

  Nothing comes to mind.

  0 (2)
On a five-point scale, how useful was this workshop for your work?

Circle one answer:

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Mean Rating for the WIC HESJ Workshop: 4.18
Mean Rating for the HESJ Workshop: 4.14
Mean Rating for the UR Workshop: 3.96

Standard Deviation: .30 (UR: .93)

Participants of the Health Equity Social Justice Workshop rated the usefulness of the workshop as 4.18 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 Training Events for Public Health Professionals.

This project is supported by Grant # P3013047 from the W.K. Kellogg Foundation.
32. 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>
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<tbody>
<tr>
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<td>3.9%</td>
</tr>
<tr>
<td>Recommend with reservations</td>
<td>12.8%</td>
</tr>
<tr>
<td>Recommend with NO reservations</td>
<td>82.1%</td>
</tr>
</tbody>
</table>

82.1% of the participants would recommend this workshop without reservations, versus 73.8% of Undoing Racism Workshop Participants.

Comparison of this Mean Usefulness Rating with Mean Usefulness Ratings of 83 Other Training Events for Public Health Professionals.
Practices to Reduce Infant Mortality through Equity (PRIME)*
Organizational Assessment with Women, Infant and Children (WIC) Division, April/May 2012

Derek M. Griffith, PhD, Kau’i Baumhofer, MA, MPH, Julie Ober Allen, MPH


*This project is supported by Grant #P3016224 from the W.K. Kellogg Foundation
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EXECUTIVE SUMMARY

The Practices to Reduce Infant Mortality through Equity (PRIME) organizational assessment is intended to identify strengths, challenges, and areas for growth related to the capacity of the Michigan Department of Community Health’s (MDCH) Bureau of Family, Maternal and Child Health (BFMCH) and its staff to address and eliminate infant mortality disparities in Michigan, specifically focusing on reducing infant mortality rates among African Americans and American Indians.

The results of this assessment will inform the development of the PRIME intervention, which will provide resources, staff training, technical assistance, practice and policy changes, building on resources and lessons learned from collaborations with local public health, professional consultant and university partners. The organizational assessment will allow the intervention components to be customized to fulfill the needs of different groups within the Bureau and of the Bureau as a whole. In addition, the organizational assessment will provide a baseline for the PRIME intervention. The assessment can be modified and replicated with staff in other State Health Department bureaus focused on other racial health disparities.

The Women, Infant, and Children (WIC) Division was the first group to pilot the assessment. All staff were asked to complete a confidential online survey assessing basic demographic data and perceptions of organizational capacity and practices. Forty-two of the 45 staff completed the assessment between April 30 and May 18, 2012.

The organizational assessment gathered perceptions from WIC staff about organizational capacity and practices in seven areas:

- **Bureau programs and services**: This topic received the highest overall rating. WIC staff agreed that BFMCH provided programs and services that met the needs of all Michigan residents but appeared less certain about the Bureau’s role in addressing health disparities, specifically.

- **Employee engagement in addressing racial health disparities**: This topic received the second highest overall rating. Most WIC staff reported that they understand how their work contributes to MDCH’s mission and to addressing health disparities.

- **Cultural competence**: The majority of WIC staff reported a moderate level of African American cultural competence. Staff reported lower American Indian cultural competence, and this subsection received the lowest average score of all topic areas assessed.

- **Knowledge and skills**: Half of the respondents reported that they understood how to use data and other published material to learn about, develop and evaluate programs to address racial health disparities; few indicated a high level of confidence, and a sizable percent (30-50) reported low confidence in their capacity in this area. This section received the second lowest overall rating.

- **Professional development**: WIC staff reported using conferences, internal trainings, webinars and other BFMCH staff to gather information about racial health disparities more than other methods. Management staff reported using resources to learn about racial health disparities significantly more than non-managers. Between 30-45% of WIC staff indicated they did not
think or know if the Bureau allocated resources for staff interpersonal and professional skill development.

- **Division’s community engagement:** The majority of staff indicated that the WIC Division was engaged with community groups, but considerably fewer reported that the WIC Division had the capacity for and actively worked to engage African American and American Indian communities. Many staff indicated they were unaware of Division efforts to engage African Americans and American Indians, including whether WIC monitored whether local health departments were addressing barriers to program participation for African Americans and American Indians.

- **Understanding and application of key concepts:** Staff rated their own and the Division’s collective understanding and knowledge of key concepts including racial health disparities, social determinants of health approach, life-course perspective, and racism, first in general and then for infant mortality in particular. Average ratings for self and for the Division were roughly the equal, though managers reported a more significant difference between self (higher) and the Division (lower) when compared to non-managers. WIC staff reported a basic understanding of racial health disparities in general and in infant mortality, specifically, but challenges with applying a social determinants of health or life-course perspective and with discussing the role of racism in health disparities.

The organizational assessment highlights several topics that may benefit from additional staff training, technical assistance, and policy/practice clarification as part of the PRIME project in order to enhance WIC staff’s capacity to effectively address disparities in infant mortality. It also produces a number of questions that require further discussion with WIC staff before we can determine appropriate next steps.
OBJECTIVES

As part of the Practices to Reduce Infant Mortality through Equity (PRIME) project, we developed an organizational assessment. Staff in the Michigan Department of Community Health’s (MDCH) Bureau of Family, Maternal and Child Health (BFMCH) will complete a self-assessment survey identifying strengths, challenges, and areas for growth related to the capacity of the Bureau and its staff to address and eliminate infant mortality disparities in Michigan, specifically focusing on reducing infant mortality rates among African Americans and American Indians.

The results of this assessment will inform the development of the PRIME intervention, which will provide resources, staff training, technical assistance, practice and policy changes, building on resources and lessons learned from collaborations with local public health, professional consultants and university partners. The organizational assessment will allow the intervention components to be customized to fulfill the needs of different groups within the Bureau and of the Bureau as a whole. In addition, the organizational assessment will provide a baseline for the PRIME intervention.

METHODS

Assessment Tool Description

The organizational assessment was developed by members of the PRIME Intervention Workgroup in collaboration with staff from the University of Michigan Health System’s Program for Multicultural Health. The PRIME Intervention Workgroup includes representatives from BFMCH, MDCH Health Disparities Reduction and Minority Health Section, the University of Michigan School of Public Health, and a local Health Department.

Although the organizational assessment was designed for the PRIME project to gauge the capacity of the BFMCH to address disparities in infant mortality, it was developed so that is can be modified and replicated with staff in other State Health Department bureaus in Michigan and elsewhere who may be focused on addressing racial health disparities other than infant mortality.

The organizational assessment collects basic demographic information about participants, their employment characteristics, and their perceptions of organizational capacity and practices in seven areas:

- Bureau programs and services
- employee engagement in addressing racial health disparities
- cultural competence for African American and American Indian cultures
- knowledge and skills
- professional development: information sources used and Division support
- Division’s community engagement in general and of African Americans and American Indians
- Self-rated and Division staff’s collective understanding and application of key concepts

In the organizational assessment, racial health disparities is defined as “differences in health outcomes that exist among racial/ethnic groups in the U.S., and that have roots in unequal access or exposure to social determinants of health such as education, healthcare, and healthy living and working conditions.”
The assessment is web-based and was developed using Qualtrics software. It contains 100 closed-ended items and is designed to take 20-30 minutes to complete. Participants can skip questions if they choose. All items, except for the demographic questions, have Likert-scale response options ranging from 4 = Strongly Agree to 1 = Strongly Disagree. Some items provide the additional response option of “Don’t Know,” for when respondents are asked to provide factual information they may not know or have an opinion about and for which the “Don’t Know” response option provides useful information for analysis.

The survey is confidential but not anonymous, and this is clearly communicated to participants. University of Michigan staff are the only people with access to individual responses. Results will be shared with MDCH staff only in aggregate form. University of Michigan staff are able to track who has and has not completed the assessment, so they can provide managers with a list of individuals who may benefit from additional encouragement to participate. The decision to make the assessment confidential but not anonymous was made to balance the desire for participants to be comfortable providing honest responses with a need for a high response rate so the findings can confidently be interpreted as representative of the group surveyed.

Data Collection

A communication strategy was developed to raise awareness about the assessment before and while it was available for staff. Several brief information emails were sent to staff, and the assessment was discussed at Division-wide and other meetings. The objectives, approach, and rationale for PRIME were reiterated. The value and anticipated benefits of staff input were described. The confidential nature of the survey and anticipated time commitment were also shared. Management, including Bureau and Division Directors and other managers, expressed their support of the assessment and encouraged all staff to complete the survey, which was described as “required.”

The names and email addresses of individuals intended to complete the survey were entered into the Qualtrics program, which emailed each participant a unique link with which to access and complete the survey at his or her leisure. Participants were able to return to an uncompleted survey as often as needed. Qualtrics was also used to email reminders to those who did not complete the survey within the given timeframe.

Staff were initially given two weeks to complete the survey, and those who did not complete the survey during this time were given an additional two weeks.

The PRIME organizational assessment was initially administered to the Women, Infant, and Children (WIC) Division within BFMCH. It will be used with other Divisions later in the project.

Data Analysis

All data were downloaded from Qualtrics and entered into the quantitative software program, SPSS 19. For each item, the number of respondents, average score, standard deviation, and percentage of respondents indicating each response items were analyzed. In addition, scales were developed for each topic area, made up of between two and 18 items, by weighting each item equally and creating an average score ranging from 1.0 (low) to 4.0 (high). In order to ascertain if the perspectives of staff who described themselves as administration/management differed from the perspectives of non-management staff, we conducted t-tests to detect significant differences in average scores for each topic area.
FINDINGS

Participant Demographics

Forty-two of the 45 staff members in the WIC Division completed the organizational assessment between April 30 and May 18, 2012. Sixty-four percent completed the survey in 30 minutes or less, and the remainder completed the survey over the course of several hours or days, suggesting that they did not complete the survey in one sitting.

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*Column may not total to 100% as some respondents may have chosen more than one category

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<tbody>
<tr>
<td>Administration/Management</td>
<td>7</td>
<td>17.1</td>
</tr>
<tr>
<td>Administrative Support</td>
<td>6</td>
<td>14.6</td>
</tr>
<tr>
<td>Program Coordinator/Specialist</td>
<td>7</td>
<td>17.1</td>
</tr>
<tr>
<td>Program Consultant</td>
<td>15</td>
<td>36.6</td>
</tr>
<tr>
<td>Vendor Consultant</td>
<td>4</td>
<td>9.8</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td>Full-time</td>
<td>41</td>
<td>97.6</td>
</tr>
<tr>
<td>Permanent</td>
<td>35</td>
<td>83.3</td>
</tr>
</tbody>
</table>
Overall Topic Ratings

We created a bar chart (below) to depict the average scores for all topic/subtopic areas. Scores could range from 1.0 to 4.0, with higher scores representing higher ratings for a topic/subtopic. Perceptions of Bureau programs and services (3.41) and employee engagement in addressing racial health disparities (3.30) received the highest overall scores. American Indian cultural competence (2.65), knowledge and skills (2.68), and information sources used (2.71) received the lowest overall scores.
Perceptions of Programs and Services within the Bureau of Family, Maternal and Child Health

This set of questions ascertains staff perceptions of whether Bureau programs are designed to meet the needs of Michigan residents generally and address racial health disparities in particular.

- The average score for all questions within this topic area was 3.41 (SD: 0.49), with a range from 2.50 to 4.00.
- This topic received the highest average scores out of all the topics assessed.
- Average scores from administration/management staff did not significantly differ from average scores from non-management staff.
- WIC staff reported that BFMCH programs provided services met the needs of Michigan residents and were designed to improve the quality of life for all children and families.
- WIC staff were less likely to agree that BFMCH programs were designed or intended to address racial health disparities. Out of the six questions in this section, the four that specifically mentioned health disparities were the only ones to receive “Don’t Know” responses. This suggests that some staff were uncertain of the Bureau’s role in addressing health disparities.
- These findings suggest that BFMCH’s role in addressing racial health disparities needs clarification. While the programs and services offered by the Bureau may indeed be designed to help all Michigan residents to some extent, disparate health outcomes between racial groups must be specifically addressed.

| Build capacity of local public health depart. to reduce racial health disparities | 3.25 |
| Address the social determinants of health to eliminate racial health disparities | 3.22 |
| Promote best practices to address racial health disparities | 3.34 |
| Address racial health disparities | 3.36 |
| Improve quality of life for all infants, children, adolescents and their families | 3.65 |
| Provide programs and services to meet the needs of Michigan residents | 3.58 |
The Bureau's programs and services are designed to:

<table>
<thead>
<tr>
<th>Description</th>
<th>n</th>
<th>Average^ (SD)</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide programs and services to meet the needs of Michigan residents</td>
<td>40</td>
<td>3.58 (0.501)</td>
<td>57.5%</td>
<td>42.5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Improve quality of life for all infants, children, adolescents and their families</td>
<td>40</td>
<td>3.65 (0.533)</td>
<td>67.5%</td>
<td>30.0%</td>
<td>2.5%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Address racial health disparities</td>
<td>40</td>
<td>3.36 (0.487)</td>
<td>32.5%</td>
<td>57.5%</td>
<td>0%</td>
<td>0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Promote best practices to address racial health disparities</td>
<td>39</td>
<td>3.34 (0.591)</td>
<td>35.9%</td>
<td>48.7%</td>
<td>5.1%</td>
<td>0%</td>
<td>10.3%</td>
</tr>
<tr>
<td>Address the social determinants of health (social, environmental, economic conditions) to eliminate racial health disparities</td>
<td>40</td>
<td>3.22 (0.712)</td>
<td>35.0%</td>
<td>42.5%</td>
<td>15.0%</td>
<td>0%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Build the capacity of local public health departments to reduce racial health disparities</td>
<td>40</td>
<td>3.25 (0.732)</td>
<td>37.5%</td>
<td>37.5%</td>
<td>15.0%</td>
<td>0%</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

^ 4-1 range, with 4 indicating strongly agree and 1 indicating strongly disagree
Employee Engagement in Addressing Racial Health Disparities

This set of questions assesses whether staff perceive their individual work and MDCH’s mission address racial health disparities (RHD).

- The average score for all questions within this topic area was 3.30 (SD: 0.54), with a range from 2.00 to 4.00.
- This topic received the second highest average scores compared to all other topics.
- Average scores from administration/management staff did not significantly differ from average scores from non-management staff.
- Most respondents reported that they understand how their work contributed to MDCH’s mission and addressing health disparities.
- All but three WIC staff strongly agreed or agreed that they understood how MDCH’s mission is consistent with a focus on reducing health disparities.

<table>
<thead>
<tr>
<th>Item</th>
<th>n</th>
<th>Average (SD)</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I clearly understand how MDCH’s mission is consistent with a focus on reducing RHD</td>
<td>40</td>
<td>3.25 (0.588)</td>
<td>32.5%</td>
<td>60.0%</td>
<td>7.5%</td>
<td>0%</td>
</tr>
<tr>
<td>I understand how my work contributes to the MDCH’s mission &amp; eliminating RHD</td>
<td>40</td>
<td>3.33 (0.616)</td>
<td>40.0%</td>
<td>52.5%</td>
<td>7.5%</td>
<td>0%</td>
</tr>
<tr>
<td>My work contributes to developing or administering policies/programs that help to eliminate RHD</td>
<td>40</td>
<td>3.33 (0.694)</td>
<td>45.0%</td>
<td>42.5%</td>
<td>12.5%</td>
<td>0%</td>
</tr>
</tbody>
</table>

^ 4-1 range, with 4 indicating strongly agree and 1 indicating strongly disagree
Cultural Competence

This topic includes two subsections assessing staff members’ self-rated understanding of how culture affects different aspects of African Americans’ and American Indians’ lives, respectively.

African American Cultural Competence

- The average score for all questions within this subtopic area was 2.98 (SD: 0.47), with a range from 2.00 to 4.00.
- Average scores from administration/management staff did not significantly differ from average scores from non-management staff.
- The majority of WIC staff reported a moderate level of African American cultural competence for all the areas assessed. Using a cutoff of 20% disagree, respondents reported lower understanding of how African American culture affects self-help skills, religion and faith-based practices, perceptions of time, use of Western and non-Western medical treatments, body language, decision making, and infant mortality.
  - Clarifying question: We were surprised at the relatively high disagree rates for use of non-Western medical treatment and infant mortality categories, in particular, as these seem more relevant to the WIC program than some of the other areas with lower scores. How can these results be explained?
Use of non-Western medical treatment 2.62
Use of Western medical treatment 2.82
Health behaviors 3.13
Use of body language 2.85
Decision making 2.90
Pregnancy 3.08
Breastfeeding 3.05
Infant mortality 3.03
Use of body language 2.85
Decision making 2.90
Pregnancy 3.08
Breastfeeding 3.05
Infant mortality 3.03
Use of non-Western medical treatment 2.62
Expectations for the future 3.05
Communication 2.95
Education 3.13
Family roles 3.08
Religion/faith-based practices 3.10
Gender roles 3.05
Perceptions of time 2.74
Views on wellness 3.00
Use of Western medical treatment 2.82
Health behaviors 3.13
Use of body language 2.85
Decision making 2.90
Pregnancy 3.08
Breastfeeding 3.05
Infant mortality 3.03
Use of non-Western medical treatment 2.62
I understand how culture impacts African Americans’ lives, such as:

<table>
<thead>
<tr>
<th>Topic</th>
<th>n</th>
<th>Average (SD)</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child-rearing</td>
<td>39</td>
<td>3.10 (0.552)</td>
<td>20.5%</td>
<td>69.2%</td>
<td>10.3%</td>
<td>0%</td>
</tr>
<tr>
<td>Self-help skills</td>
<td>40</td>
<td>2.95 (0.597)</td>
<td>15.0%</td>
<td>65.0%</td>
<td>20.0%</td>
<td>0%</td>
</tr>
<tr>
<td>Expectations for the future</td>
<td>40</td>
<td>3.05 (0.597)</td>
<td>20.0%</td>
<td>65.0%</td>
<td>15.0%</td>
<td>0%</td>
</tr>
<tr>
<td>Communication</td>
<td>40</td>
<td>2.95 (0.552)</td>
<td>12.5%</td>
<td>70.0%</td>
<td>17.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Education</td>
<td>40</td>
<td>3.13 (0.607)</td>
<td>25.0%</td>
<td>62.5%</td>
<td>12.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Family roles</td>
<td>40</td>
<td>3.08 (0.656)</td>
<td>25.0%</td>
<td>57.5%</td>
<td>17.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Religion/faith-based practices</td>
<td>40</td>
<td>3.10 (0.709)</td>
<td>30.0%</td>
<td>50.0%</td>
<td>20.0%</td>
<td>0%</td>
</tr>
<tr>
<td>Gender roles</td>
<td>39</td>
<td>3.05 (0.647)</td>
<td>23.1%</td>
<td>59.0%</td>
<td>17.9%</td>
<td>0%</td>
</tr>
<tr>
<td>Perceptions of time</td>
<td>39</td>
<td>2.74 (0.715)</td>
<td>12.8%</td>
<td>51.3%</td>
<td>33.3%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Views on wellness</td>
<td>39</td>
<td>3.00 (0.607)</td>
<td>17.9%</td>
<td>64.1%</td>
<td>17.9%</td>
<td>0%</td>
</tr>
<tr>
<td>Use of Western medical treatment</td>
<td>39</td>
<td>2.82 (0.601)</td>
<td>7.7%</td>
<td>69.2%</td>
<td>20.5%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Health behaviors</td>
<td>40</td>
<td>3.13 (0.516)</td>
<td>20.0%</td>
<td>72.5%</td>
<td>7.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Use of body language</td>
<td>40</td>
<td>2.85 (0.622)</td>
<td>12.5%</td>
<td>60.0%</td>
<td>27.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Decision making</td>
<td>40</td>
<td>2.90 (0.632)</td>
<td>15.0%</td>
<td>60.0%</td>
<td>25.0%</td>
<td>0%</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>39</td>
<td>3.08 (0.580)</td>
<td>20.5%</td>
<td>66.7%</td>
<td>12.8%</td>
<td>0%</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>40</td>
<td>3.05 (0.552)</td>
<td>17.5%</td>
<td>70.0%</td>
<td>12.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>40</td>
<td>3.02 (0.660)</td>
<td>22.5%</td>
<td>57.5%</td>
<td>20.0%</td>
<td>0%</td>
</tr>
<tr>
<td>Use of non-Western medical treatment</td>
<td>39</td>
<td>2.62 (0.673)</td>
<td>7.7%</td>
<td>48.7%</td>
<td>41.0%</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

^ 4-1 range, with 4 indicating strongly agree and 1 indicating strongly disagree

American Indian Cultural Competence

o The average score for all questions within this subtopic area was 2.65 (SD: 0.54), with a range from 1.17 to 3.83.
o Average scores from administration/management staff did not significantly differ from average scores from non-management staff.
o This section received the lowest average score of all topic and subtopic areas assessed and had the highest overall rate of disagree/strongly disagree responses.
o While this was expected based on previous discussions with Bureau staff, these consistently low scores suggests the need to provide staff with a broad range of information on the basics of American Indian culture, history, life and health as a foundation for training that helps them to identify and address modifiable determinants of American Indian infant mortality.
  ▪ Clarifying question: What would be the most effective way to convey this information? For example, would historical information be useful? Would a workshop examining the effects of Bureau programs, policies, and practices on American Indians in Michigan be useful?
Use of non-Western medical treatment

Infant mortality

Breastfeeding

Pregnancy

Decision making

Health behaviors

Use of body language

Use of Western medical treatment

Religion/faith-based practices

Gender roles

Perceptions of time

Views on wellness

Use of body language

Communication

Education

Family roles

Religion/faith-based practices

Gender roles

Perceptions of time

Views on wellness

Use of Western medical treatment

Health behaviors

Use of body language

Decision making

Pregnancy

Breastfeeding

Infant mortality

Use of non-Western medical treatment
<table>
<thead>
<tr>
<th>I understand how culture impacts American Indians’ lives, such as:</th>
<th>n</th>
<th>Average^ (SD)</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child-rearing</td>
<td>40</td>
<td>2.72 (0.599)</td>
<td>5.0%</td>
<td>65.0%</td>
<td>27.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Self-help skills</td>
<td>39</td>
<td>2.67 (0.701)</td>
<td>7.7%</td>
<td>56.4%</td>
<td>30.8%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Expectations for the future</td>
<td>40</td>
<td>2.68 (0.764)</td>
<td>12.5%</td>
<td>47.5%</td>
<td>35.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Communication</td>
<td>40</td>
<td>2.73 (0.784)</td>
<td>15.0%</td>
<td>47.5%</td>
<td>32.5%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Education</td>
<td>40</td>
<td>2.78 (0.660)</td>
<td>10.0%</td>
<td>60.0%</td>
<td>27.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Family roles</td>
<td>38</td>
<td>2.71 (0.654)</td>
<td>7.9%</td>
<td>57.9%</td>
<td>31.6%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Religion/faith-based practices</td>
<td>38</td>
<td>2.74 (0.715)</td>
<td>12.8%</td>
<td>51.3%</td>
<td>33.3%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Gender roles</td>
<td>40</td>
<td>2.78 (0.698)</td>
<td>12.5%</td>
<td>55.0%</td>
<td>30.0%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Perceptions of time</td>
<td>39</td>
<td>2.54 (0.756)</td>
<td>7.7%</td>
<td>46.2%</td>
<td>38.5%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Views on wellness</td>
<td>39</td>
<td>2.64 (0.778)</td>
<td>7.7%</td>
<td>59.0%</td>
<td>23.1%</td>
<td>10.3%</td>
</tr>
<tr>
<td>Use of Western medical treatment</td>
<td>40</td>
<td>2.58 (0.781)</td>
<td>10.0%</td>
<td>45.0%</td>
<td>37.5%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Health behaviors</td>
<td>40</td>
<td>2.78 (0.577)</td>
<td>5.0%</td>
<td>70.0%</td>
<td>22.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Use of body language</td>
<td>38</td>
<td>2.54 (0.682)</td>
<td>2.6%</td>
<td>56.4%</td>
<td>33.3%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Decision making</td>
<td>40</td>
<td>2.62 (0.740)</td>
<td>10.0%</td>
<td>47.5%</td>
<td>37.5%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>40</td>
<td>2.65 (0.700)</td>
<td>7.5%</td>
<td>55.0%</td>
<td>32.5%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>40</td>
<td>2.68 (0.694)</td>
<td>7.5%</td>
<td>57.5%</td>
<td>30.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>40</td>
<td>2.37 (0.740)</td>
<td>10.0%</td>
<td>47.5%</td>
<td>37.5%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Use of non-Western medical treatment</td>
<td>40</td>
<td>2.55 (0.783)</td>
<td>10.0%</td>
<td>42.5%</td>
<td>40.0%</td>
<td>7.5%</td>
</tr>
</tbody>
</table>

^ 4-1 range, with 4 indicating strongly agree and 1 indicating strongly disagree
Knowledge and Skills

This set of questions asks respondents about their capacity to use data and other published resources to learn about and inform the planning and evaluation of programs to reduce racial health disparities.

- The average score for all questions within this topic area was 2.68 (SD: 0.59), with a range from 1.25 to 3.75.
- This question set received the second lowest average score compared to other topics assessed.
- Average scores from administration/management staff did not significantly differ from average scores from non-management staff.
- While approximately half of the respondents reported that they understood how to use data and other published material to learn about, develop and evaluate programs to address racial health disparities, few indicated a high level of confidence in their ability to do so; a sizable percent (30-50) were not confident in their capacity in this area.
  - Clarifying question: Why did approximately one third of respondents indicate that they were not able to use data and other published resources to learn about, develop and evaluate programs related to reducing racial health disparities? Is this due challenges in accessing data and other published material (and would therefore require a technical solution), challenges that are more conceptual in nature, or job specialization?
- 52% of respondents indicated that they were not able to evaluate existing health disparity reduction programs.
  - Clarifying question: Responses indicate more challenges with program evaluation compared to program development or strategic planning. We need to clarify whether this is because program evaluation is the primary responsibility of only a few staff members or if staff would benefit from additional training in this area.
<table>
<thead>
<tr>
<th>Item</th>
<th>n</th>
<th>Average^ (SD)</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have the ability to search electronic databases to gather information about effective racial health disparities reduction programs</td>
<td>40</td>
<td>2.70 (0.791)</td>
<td>15.0%</td>
<td>45.0%</td>
<td>35.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>I know how to evaluate racial health disparities reduction programs</td>
<td>40</td>
<td>2.45 (0.597)</td>
<td>2.5%</td>
<td>42.5%</td>
<td>52.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>I have the ability to utilize data to inform program development</td>
<td>40</td>
<td>2.80 (0.758)</td>
<td>15.0%</td>
<td>55.0%</td>
<td>25.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>I know how to obtain and evaluate published information to inform strategic planning related to racial health disparities</td>
<td>40</td>
<td>2.75 (0.742)</td>
<td>15.0%</td>
<td>47.5%</td>
<td>35.0%</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

^ 4-1 range, with 4 indicating strongly agree and 1 indicating strongly disagree
Professional Development

This topic includes two subsections—one on information sources staff use for professional development and the other on Bureau support of professional development.

Information Sources Used

Questions in this section ask participants what type of resources they use to gather information about racial health disparities.

- The average score for all questions within this subtopic area was 2.71 (SD: 0.46), with a range from 1.82 to 3.82.
- Staff who described their roles as administration/management had a significantly higher average score on this section when compared to non-management staff (p=0.031).
- WIC staff reported using conferences, internal trainings, webinars and other BFMCH staff to gather information regarding racial health disparities more than other methods.
- This suggests that, in general, gathering of information on racial health disparities among WIC staff can be improved.
- Specifically, we should make sure that the approach of PRIME encourages and promotes staff communicating with and learning from one another within the Bureau and health department. In addition, we may want to consider exploring ways to help staff communicate across state health departments to facilitate sharing of strategies and information.

<table>
<thead>
<tr>
<th>Source</th>
<th>Average ^ (SD)</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Journal articles</td>
<td>2.90</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conferences, symposiums</td>
<td>3.10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal trainings, in-services, brown bags</td>
<td>2.90</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State-level databases</td>
<td>2.68</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Webinars</td>
<td>2.75</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialized online courses</td>
<td>2.45</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academic courses</td>
<td>2.47</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other staff within BFMCH</td>
<td>2.95</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff outside the BFMCH but within MDCH</td>
<td>2.58</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff at other state health departments</td>
<td>2.48</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff at local health departments in Michigan</td>
<td>2.58</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To do my job, I use information about racial health disparities from:
Journal articles | 40 | 2.90 (0.778) | 22.5% | 47.5% | 27.5% | 2.5%
Conferences, symposiums | 40 | 3.10 (0.672) | 27.5% | 55.0% | 17.5% | 0%
Internal trainings, in-services, brown bags | 40 | 2.90 (0.744) | 20.0% | 52.5% | 25.0% | 2.5%
State-level databases | 40 | 2.68 (0.656) | 10.0% | 47.5% | 42.5% | 0%
Webinars | 40 | 2.75 (0.543) | 5.0% | 65.0% | 30.0% | 0%
Specialized online courses | 36 | 2.45 (0.724) | 7.9% | 34.2% | 52.6% | 0%
Academic courses | 38 | 2.47 (0.797) | 13.2% | 26.3% | 55.3% | 5.3%
Other staff within BFMCH | 39 | 2.95 (0.686) | 17.9% | 61.5% | 17.9% | 2.6%
Staff outside the BFMCH but within MDCH | 40 | 2.58 (0.712) | 10.0% | 40.0% | 47.5% | 2.5%
Staff at other state health departments | 40 | 2.48 (0.679) | 7.5% | 35.0% | 55.0% | 2.5%
Staff at local health departments in Michigan | 40 | 2.58 (0.712) | 10.0% | 40.0% | 47.5% | 2.5%

^ 4-1 range, with 4 indicating strongly agree and 1 indicating strongly disagree

Bureau Support of Professional Development

Questions in this section ask if the Bureau supplies resources for interpersonal and professional skill development.

- The average score for all of these questions within this subtopic area was 2.96 (SD: 0.80), with a range from 1.00 to 4.00.
- Average scores from administration/management staff did not significantly differ from average scores from non-management staff.
- Responses for these questions were fairly spread out over the Strongly Agree, Agree, and Disagree response options.
  - Clarifying question: Are resources available, and how can staff awareness of them be increased?
<table>
<thead>
<tr>
<th></th>
<th>40</th>
<th>2.85 (0.857)</th>
<th>3.03 (0.799)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal skills</td>
<td>20.0%</td>
<td>37.5%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Professional skills</td>
<td>27.5%</td>
<td>42.5%</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

^ 4-1 range, with 4 indicating strongly agree and 1 indicating strongly disagree
Division’s Community Engagement

There are three subsections assessing participants’ perspectives on their Division’s community engagement efforts: in general, with African Americans, and with American Indians.

- A sizable majority of respondents indicated that the WIC Division was engaged with community groups, but considerably fewer WIC staff reported that the WIC Division had the capacity for and actively worked to engage African American and American Indian communities.
- A majority of respondents reported that the WIC Division provided resources to both the African American and American Indian communities to address racial health disparities, but many staff members selected the “Don’t Know” response when asked if the Division had policies to monitor whether local health departments were addressing barriers to Division program participation by African American and American Indian community members.
  - Clarifying question: What types of resources have been provided for African American and American Indian communities? Are these resources geared towards addressing individual, community or fundamental determinants of health? What types of monitoring policies are currently in place?

Division’s General Community Engagement

- The average score for all questions within this subtopic was 2.94 SD: 0.53), with a range from 1.50 to 4.00.
- Average scores from administration/management staff did not significantly differ from average scores from non-management staff.
- A strong majority of respondents indicated that their Division is engaged with community groups who advocated for policies to address racial health disparities and that staff were able to adapt to changes within the populations served by the BFMCH.

<table>
<thead>
<tr>
<th>Item</th>
<th>n</th>
<th>Average (SD)</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division staff is involved with community groups who advocate for policies that address racial health disparities</td>
<td>39</td>
<td>2.85 (0.670)</td>
<td>10.3%</td>
<td>69.2%</td>
<td>15.4%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Division staff is able to adapt to changes within the populations we serve</td>
<td>39</td>
<td>3.03 (0.537)</td>
<td>12.8%</td>
<td>79.5%</td>
<td>5.1%</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

^ 4-1 range, with 4 indicating strongly agree and 1 indicating strongly disagree

Division’s Community Engagement of African Americans
The average score for all questions within this subtopic was 2.94 (SD: 0.44), with a range from 1.67 to 4.00.
Average scores from administration/management staff did not significantly differ from average scores from non-management staff.

- Division staff understand African Americans’ major social and health concerns
  - Average: 2.97 (SD: 0.547)
  - Strongly Agree: 7.5%
  - Agree: 62.5%
  - Disagree: 5.0%
  - Strongly Disagree: 2.5%
  - Don’t Know: 22.5%

- Division staff is familiar with the strengths & resources in African American communities in Michigan
  - Average: 2.87 (SD: 0.629)
  - Strongly Agree: 7.5%
  - Agree: 52.5%
  - Disagree: 12.5%
  - Strongly Disagree: 2.5%
  - Don’t Know: 25.0%

- My division has provided resources to African American communities to reduce racial health disparities
  - Average: 3.16 (SD: 0.448)
  - Strongly Agree: 15.0%
  - Agree: 62.5%
  - Disagree: 2.5%
  - Strongly Disagree: 0%
  - Don’t Know: 20.0%

- My division has strategies in place to monitor whether local health departments address barriers to African American participation
  - Average: 2.84 (SD: 0.554)
  - Strongly Agree: 5.0%
  - Agree: 42.5%
  - Disagree: 15.0%
  - Strongly Disagree: 0%
  - Don’t Know: 37.5%

- My division involves key partners in the African American community to develop new services, programs and policies
  - Average: 2.92 (SD: 0.572)
  - Strongly Agree: 7.5%
  - Agree: 42.5%
  - Disagree: 12.5%
  - Strongly Disagree: 0%
  - Don’t Know: 37.5%

^ 4-1 range, with 4 indicating strongly agree and 1 indicating strongly disagree
Division’s Community Engagement of American Indians

- The average score for all questions within this subtopic area was 2.77 (SD: 0.70), with a range from 1.00 to 4.00.
- Average scores from administration/management staff did not significantly differ from average scores from non-management staff.

<table>
<thead>
<tr>
<th>Item</th>
<th>n</th>
<th>Average^ (SD)</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division staff understand American Indians' major social and health concerns</td>
<td>40</td>
<td>2.86 (0.705)</td>
<td>7.5%</td>
<td>50.0%</td>
<td>7.5%</td>
<td>5.0%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Division staff is familiar with the strengths &amp; resources in American Indian communities in Michigan</td>
<td>40</td>
<td>2.73 (0.778)</td>
<td>7.5%</td>
<td>37.5%</td>
<td>15.0%</td>
<td>5.0%</td>
<td>35.0%</td>
</tr>
<tr>
<td>My division has provided resources to American Indian communities to reduce racial health disparities</td>
<td>39</td>
<td>2.93 (0.730)</td>
<td>10.3%</td>
<td>48.7%</td>
<td>5.1%</td>
<td>5.1%</td>
<td>30.8%</td>
</tr>
<tr>
<td>My division has strategies in place to monitor whether local health departments address barriers to American Indian participation</td>
<td>40</td>
<td>2.65 (0.813)</td>
<td>5.0%</td>
<td>27.5%</td>
<td>12.5%</td>
<td>5.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>My division involves key partners in the American Indian community to develop new services, programs and policies</td>
<td>40</td>
<td>2.67 (0.796)</td>
<td>5.0%</td>
<td>30.0%</td>
<td>12.5%</td>
<td>5.0%</td>
<td>47.5%</td>
</tr>
</tbody>
</table>

^ 4-1 range, with 4 indicating strongly agree and 1 indicating strongly disagree
Understanding and Application of Key Concepts

This topic area includes three subsections. The first subsection asks respondents to self-rate their understanding and knowledge of key concepts including racial health disparities, social determinants of health approach, life-course perspective, and racism, first in general and then for infant mortality in particular. The second subsection asks respondents to rate the understanding and application of these same key concepts for staff within the Division, as a whole. Finally, we compare managers versus non-managers’ ratings of themselves and the Division.

Self-Rated Understanding and Application of Key Concepts

- The average score for all questions within this subtopic area was 2.90 (SD: 0.61), with a range from 1.44 to 4.00.
- Average scores from administration/management staff did not significantly differ from average scores from non-management staff.
- WIC staff reported a basic understanding of racial health disparities in general and in infant mortality, specifically. A deeper understanding of the problem and potential solutions appears still needed.
- Respondents reported challenges with their ability to apply a social determinants of health approach and a life-course perspective, and to discuss racism as a barrier to racial health disparities and disparities in infant mortality. This is consistent with findings described above that staff are unsure of the role that BFMCH should play in addressing health disparities.
<table>
<thead>
<tr>
<th>Item</th>
<th>n</th>
<th>Average (SD)</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am knowledgeable at a basic level about racial health disparities</td>
<td>40</td>
<td>3.22 (0.530)</td>
<td>27.5%</td>
<td>67.5%</td>
<td>5.0%</td>
<td>0%</td>
</tr>
<tr>
<td>I am knowledgeable at a basic level about racial health disparities in infant mortality</td>
<td>40</td>
<td>3.10 (0.672)</td>
<td>25.0%</td>
<td>62.5%</td>
<td>10.0%</td>
<td>2.5%</td>
</tr>
<tr>
<td>I have more than a basic level of understanding about racial disparities</td>
<td>40</td>
<td>2.95 (0.749)</td>
<td>25.0%</td>
<td>45.0%</td>
<td>30.0%</td>
<td>0%</td>
</tr>
<tr>
<td>I have more than a basic level of understanding about racial health disparities in infant mortality</td>
<td>39</td>
<td>2.87 (0.864)</td>
<td>25.6%</td>
<td>41.0%</td>
<td>28.2%</td>
<td>5.1%</td>
</tr>
<tr>
<td>I know how to use a social determinants of health perspective of racial disparities in infant mortality in my work</td>
<td>39</td>
<td>2.82 (0.683)</td>
<td>12.8%</td>
<td>59.0%</td>
<td>25.6%</td>
<td>2.6%</td>
</tr>
<tr>
<td>I know how to use a social determinants of health perspective of racial disparities in infant mortality in my work</td>
<td>39</td>
<td>2.77 (0.706)</td>
<td>10.3%</td>
<td>61.5%</td>
<td>23.1%</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

104
I know how to apply a life-course perspective of racial health disparities in my work

<table>
<thead>
<tr>
<th>Rating</th>
<th>Mean (SD)</th>
<th>12.8%</th>
<th>48.7%</th>
<th>33.3%</th>
<th>5.1%</th>
</tr>
</thead>
<tbody>
<tr>
<td>39</td>
<td>2.69 (0.766)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I know how to apply a life-course perspective of racial disparities in infant mortality in my work

<table>
<thead>
<tr>
<th>Rating</th>
<th>Mean (SD)</th>
<th>12.5%</th>
<th>50.0%</th>
<th>30.0%</th>
<th>7.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>2.68 (0.797)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I am competent discussing racism as a barrier to racial disparities in infant mortality

<table>
<thead>
<tr>
<th>Rating</th>
<th>Mean (SD)</th>
<th>25.6%</th>
<th>48.7%</th>
<th>25.6%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>39</td>
<td>3.00 (0.725)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I am competent discussing racism as a barrier to racial disparities in infant mortality

<table>
<thead>
<tr>
<th>Rating</th>
<th>Mean (SD)</th>
<th>25.6%</th>
<th>41.0%</th>
<th>30.8%</th>
<th>2.6%</th>
</tr>
</thead>
<tbody>
<tr>
<td>39</td>
<td>2.90 (0.821)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

^ 4-1 range, with 4 indicating strongly agree and 1 indicating strongly disagree

Ratings of Division Staff’s Collective Understanding and Application of Key Concepts

- The average score for all questions within this subtopic area was 2.87 (SD: 0.40), with a range from 2.00 to 3.70.
- Average scores from administration/management staff did not significantly differ from average scores from non-management staff.
- Respondents overwhelmingly reported that Division staff were knowledgeable at a basic level about racial health disparities in general and disparities in infant mortality specifically. However, when asked if Division staff had more than a basic knowledge of racial health disparities in general and disparities in infant mortality specifically, agreement dropped for both topics.
- When asked if Division staff were able to apply a social determinants of health or life course perspective to their work, 70% of respondents chose the “Strongly Agree” or “Agree” responses, while approximately 30% of respondents chose “Disagree” or “Strongly Disagree”. Approximately 80% of respondents agreed that Division staff as a whole were competent in discussing racism as a barrier to racial health disparities, while 20% disagreed.
<table>
<thead>
<tr>
<th>Item</th>
<th>n</th>
<th>Average (SD)</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division staff is knowledgeable at a basic level about racial health disparities</td>
<td>39</td>
<td>3.15 (0.432)</td>
<td>17.9%</td>
<td>79.5%</td>
<td>2.6%</td>
<td>0%</td>
</tr>
<tr>
<td>Division staff are knowledgeable at a basic level about racial health disparities in infant mortality</td>
<td>38</td>
<td>3.13 (0.472)</td>
<td>18.4%</td>
<td>76.3%</td>
<td>5.3%</td>
<td>0%</td>
</tr>
<tr>
<td>Division staff have more than a basic level of understanding about racial health disparities</td>
<td>39</td>
<td>2.90 (0.598)</td>
<td>12.8%</td>
<td>64.1%</td>
<td>23.1%</td>
<td>0%</td>
</tr>
<tr>
<td>Division staff have more than a basic level of understanding about racial health disparities in infant mortality</td>
<td>39</td>
<td>2.97 (0.668)</td>
<td>20.5%</td>
<td>56.4%</td>
<td>23.1%</td>
<td>0%</td>
</tr>
<tr>
<td>Division staff know how to use a social determinants of health perspective of racial disparities in infant mortality</td>
<td>39</td>
<td>2.82 (0.601)</td>
<td>7.7%</td>
<td>69.2%</td>
<td>20.5%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Division staff know how to apply a social determinants of health perspective of racial disparities in infant mortality in my work</td>
<td>39</td>
<td>2.84 (0.552)</td>
<td>7.9%</td>
<td>69.2%</td>
<td>21.9%</td>
<td>0%</td>
</tr>
<tr>
<td>Division staff know how to apply a life-course perspective of racial health disparities in my work</td>
<td>39</td>
<td>2.74 (0.475)</td>
<td>12.8%</td>
<td>64.1%</td>
<td>23.1%</td>
<td>0%</td>
</tr>
<tr>
<td>Division staff know how to apply a life-course perspective of racial disparities in infant mortality in my work</td>
<td>39</td>
<td>2.87 (0.638)</td>
<td>12.8%</td>
<td>64.1%</td>
<td>23.1%</td>
<td>0%</td>
</tr>
<tr>
<td>Division staff know how to apply a life-course perspective of racial health disparities in infant mortality in my work</td>
<td>39</td>
<td>2.84 (0.552)</td>
<td>7.9%</td>
<td>69.2%</td>
<td>21.9%</td>
<td>0%</td>
</tr>
<tr>
<td>Division staff know how to use a social determinants of health perspective of racial disparities in infant mortality</td>
<td>39</td>
<td>2.82 (0.601)</td>
<td>7.7%</td>
<td>69.2%</td>
<td>20.5%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Division staff are knowledgeable at a basic level about racial health disparities in infant mortality</td>
<td>38</td>
<td>3.13 (0.472)</td>
<td>18.4%</td>
<td>76.3%</td>
<td>5.3%</td>
<td>0%</td>
</tr>
<tr>
<td>Division staff know how to apply a social determinants of health perspective of racial disparities in infant mortality in my work</td>
<td>39</td>
<td>2.84 (0.552)</td>
<td>7.9%</td>
<td>69.2%</td>
<td>21.9%</td>
<td>0%</td>
</tr>
<tr>
<td>Division staff know how to use a social determinants of health perspective of racial disparities in infant mortality</td>
<td>39</td>
<td>2.82 (0.601)</td>
<td>7.7%</td>
<td>69.2%</td>
<td>20.5%</td>
<td>2.6%</td>
</tr>
</tbody>
</table>
Division staff know how to apply a social determinants of health perspective of racial disparities in infant mortality in their work

- 39
- 2.87 (0.767)
- 17.9%
- 56.4%
- 20.5%
- 5.1%

Division staff know how to apply a life-course perspective to work of racial health disparities in their work

- 39
- 2.36 (0.743)
- 7.7%
- 56.4%
- 28.2%
- 7.7%

Division staff know how to apply a life-course perspective to work of racial disparities in infant mortality in their work

- 39
- 2.74 (0.785)
- 12.8%
- 56.4%
- 23.1%
- 7.7%

Division staff is competent discussing racism as a barrier to racial health disparities

- 38
- 2.84 (0.679)
- 10.5%
- 68.4%
- 15.8%
- 5.3%

Division staff is competent discussing racism as a barrier to racial disparities in infant mortality

- 39
- 2.90 (0.718)
- 15.4%
- 64.1%
- 15.4%
- 5.1%

^ 4-1 range, with 4 indicating strongly agree and 1 indicating strongly disagree

Comparison of Manager versus Non-Manager Ratings for Self and for the Division

We conducted an additional analysis for the self-rated and Division-rated competency in understanding and applying key concepts in order to determine whether and how rating made by management staff may have differed from ratings made by non-management staff members.

The bar chart below compares managers’ versus non-managers’ average self-rating and Division-rating of understanding and application of these key concepts.

○ Managers’ self-rating on these key concepts did not significantly differ from non-mangers’ self-rating. We also did not detect differences between managers’ and non-managers’ rating of the Division as a whole.

○ There were, however, distinctions when comparing how each group rated themselves versus their rating of the Division. Staff who did not categorize themselves as administration/management rated the Division’s collective abilities higher, though not significantly so, than their own capacity. The opposite pattern was found for administration/management. Management staff rated their individual understanding and application of these concepts significantly higher than they rated the collective abilities of the Division staff.

Clarifying question: Does the bulk of the Division’s capacity related to these key concepts primarily lie in management? Is this due to their increased access to training on these topics, their increased expertise and experience (why they have risen to the management level), or some other reason? What do non-managers need in order to increase their competency in these areas?
IMPLICATIONS FOR NEXT STEPS

- Clarify the role of a State health department in addressing health disparities.
- While improvement of every individual’s health is an important goal, the BFMCH also needs to specifically improve the health of whole populations. A focus on improving population health, including the capacity to apply social determinants of health and life course perspectives, is essential to reducing and eliminating health disparities—the goal of both the Michigan Health Equity Roadmap and the Health People initiatives.
- Provide focused training on determinants of African American infant mortality.
- Provide a comprehensive training on American Indian history, culture, and determinants of infant mortality.
- Increase the use of data and published materials in programmatic and strategic planning to reduce racial health disparities and disparities in infant mortality. Staff need to be able to critically examine data quality and collection techniques in state databases and published literature. They also need to be aware of the inherent challenges in collecting data from small, highly diverse populations such as American Indians.
- Increase the use of data and published materials in evaluation of existing racial health disparity reduction programs, including both evaluation of the Division’s own programs and evaluation of the quality and potential for replication of programs that have been carried out elsewhere.
- Increase staff awareness of Division efforts to engage African American and American Indian communities. Determine the optimal level of community engagement for State WIC staff given the roles and responsibilities of State WIC staff, competing priorities, and capacity to effectively engage African American and American Indian communities given their diversity across Michigan.
- Provide further training to develop understanding and application of skills relating to social determinants of health and the life-course perspective in order to effectively reduce racial health disparities in general and specifically racial disparities in infant mortality.
Sign Up for the "Roots of Health Inequity" Online Course

Go to [http://members.rootsofhealthinequity.org](http://members.rootsofhealthinequity.org) and log in with your current NACCHO email and password.

If you are not registered at NACCHO, then go to [http://www.naccho.org/](http://www.naccho.org/) and sign up there. When your registration is complete, use the same email and password to log into the "Roots of Health Inequity" course.

Once you log in, you will see your "Dashboard" with personal information. From here you can join our group – PRIME Intervention Workgroup. **You must be a member of at least one group to access the educational content in the course units.**

For quick access to the course units, join the "General Group." On the group page you will see the titles of each unit under the heading "Units." Click on one of these to see that unit.

General Guidelines & Expectations

Outlined below are some minimum activities for us to participate in within the units. There are several activities under each of the 5 units. However, we will only participate in a few activities from 3 of the units.

At a minimum, you are responsible for adding two comments: ONE original comment and ONE response to another group member. **Please do this at least twice a week.**

Please keep in mind that we are participating as a group to test the site and to increase our own growth and development. Please share your comments and try to be concise.

As a group we will discuss some sensitive issues. Let’s agree to keep what is discussed in the group confidential.
Week 1 – Monday, June 18 – Sunday, June 24

Unit 1 – Where do we start?

➢ Review the content under *Workforce Capacity – Let’s Start*
➢ Post comments under the discussion area for *Envision New Possibilities*. You can choose to respond to any of the three questions.

1. What would “effectively addressing health inequity” mean for your organization? What would it look like now, in five years, and in ten years?
2. What are the costs to you, your organization, and your community if you adopt a plan to tackle racism and other forms of oppression explicitly?
3. What are the costs of not adopting an explicit approach to addressing health inequities?

➢ Review the content under *Community Engagement – Authentic Community Engagement*
➢ Under additional resources, Print & Complete *Community Relationships – A Self Assessment*
   o Click on BARHII_SelfAssessment.pdf
   o The questions are written for Local Health Departments but we ask that you answer the questions as best as you can for your agency.

➢ Review content under *Leadership – Competing Interests and Political Pressures*
➢ Post comments under the discussion area for *Political Pressure Points*. You can choose to respond to either question.

1. What political pressures exist within your department’s work? How do these pressures impact your daily work? How are they reflected in your department’s structure and operations? As you answer, share specific examples with the group.
2. What types of trade associations, industries, and other organized groups are likely to oppose your work at federal level and in your state and jurisdiction? What specific pressures must your organization balance and negotiate?
Week 2 – Monday, June 25 – Sunday, July 1

Unit 4 – Root Causes

- Review the content under Class Oppression – Richard Wolff Examines Class
- Post comments under the discussion area for this section. You can choose to respond to any of the four questions.

1. What do you see as the potential health consequences of the class structure described by Wolff?
2. Consider the ways in which the health consequences of class may be related to or different from the idea of “exposure” or “exposure pathway.”
3. Reflect on the stresses created by economic inequality generally and economic crises specifically. How can the anticipation of serious health effects enable you to plan more effectively?
4. What existing inequities in your community are likely to be exacerbated by the mortgage crisis and ongoing high unemployment?

- Review the content under Racism – Hurricane Katrina – The Unnatural Disaster?
- Post comments under the discussion area for this section. You can choose to respond to any of the four questions.

1. What was most striking to you as you reviewed the maps?
2. How is the displacement caused by Hurricane Katrina an issue of social injustice? In what ways was social justice an issue long before the hurricane arrived?
3. What role does political power, or the lack of it, play in the production of health?
4. For public health, how is Katrina an issue of long-term preparedness? In what ways is preparedness a question of setting the foundations for health, independent of any potential disaster?

- Review content under Gender Inequity – Discussion, Gender and Relations of Power
- Watch the Video – Employment Discrimination: Paid Sick Days
- Use the discussion box under Gender Inequity – Discussion, Gender and Relation of Power to add comments about the content under this area or the video.
Unit 5 – Social Justice

- Review the content under Developing Strategies – Interactive: Elements & Characteristics of this Approach
- Post Comments under the discussion area for this section and respond to any of the four questions.

1. What are some ways in which your department is taking some of the actions described?
2. What other actions would you like your LHD to address and what benchmarks would you establish to evaluate how well your LHD did on these dimensions?
3. What changes in policy, organizational culture, or institutional processes and practices would show alignment with and manifestation of social justice principles?
4. What would need to happen for public health practice in your jurisdiction to be transformed to act on social injustice and its root causes?

Monday, September 17 – Sunday, September 23

Unit 1 – Where do we start?
- Review the content under Community Engagement – Authentic Community Engagement
- Under additional resources, Print & Complete Community Relationships – A Self Assessment
  - Click on BARHII_SelfAssessment.pdf
  - The questions are written for Local Health Departments but we ask that you answer the questions as best as you can for your agency.

Monday, September 24 – Sunday, September 30

Unit 1 – Where do we start?
- Review content under Leadership – Competing Interests and Political Pressures
- Post comments under the discussion area for Political Pressure Points. You can choose to respond to either question.

1) What political pressures exist within your department’s work? How do these pressures impact your daily work? How are they reflected in your department’s structure and operations? As you answer, share specific examples with the group.
2) What types of trade associations, industries, and other organized groups are likely to oppose your work at federal level and in your state and jurisdiction? What specific pressures must your organization balance and negotiate?
Monday, October 1 – Sunday, October 7

Unit 4 – Root Causes

- Review the content under *Class Oppression – Richard Wolff Examines Class*
- Post comments under the discussion area for this section. You can choose to respond to any of the four questions.

1) What do you see as the potential health consequences of the class structure described by Wolff?
2) Consider the ways in which the health consequences of class may be related to or different from the idea of “exposure” or “exposure pathway.”
3) Reflect on the stresses created by economic inequality generally and economic crises specifically. How can the anticipation of serious health effects enable you to plan more effectively?
4) What existing inequities in your community are likely to be exacerbated by the mortgage crisis and ongoing high unemployment?

Monday, October 22 – Sunday, October 28

Unit 4 – Root Causes

- Review the content under *Racism – Hurricane Katrina – The Unnatural Disaster?*
- Post comments under the discussion area for this section. You can choose to respond to any of the four questions.

1. What was most striking to you as you reviewed the maps?
2. How is the displacement caused by Hurricane Katrina an issue of social injustice? In what ways was social justice an issue long before the hurricane arrived?
3. What role does political power, or the lack of it, play in the production of health?
4. For public health, how is Katrina an issue of long-term preparedness? In what ways is preparedness a question of setting the foundations for health, independent of any potential disaster?
Monday, October 29 – Sunday, November 4

- Review content under *Gender Inequity – DISCUSSION: Gender and Relations of Power*
- Watch the *Video – Employment Discrimination: Paid Sick Days*
- Use the discussion box under Gender Inequity – DISCUSSION: Gender and Relation of Power to add comments about the content under this area or the video.

You can add your own comments about the content/video and/or choose to respond to one of the questions below:

1. What are some of the dimensions or sectors of life (other than health) where you witness differential power relations based on gender today?
2. What are the possible health consequences of discrimination and bias resulting from these power relations?
3. Are there laws and policies in place that ostensibly prevent these forms of discrimination and bias? If so, why do they continue to occur?

Tuesday, November 27 – Monday, December 4

Unit 5 – Social Justice

- Review the content under *Developing Strategies – Interactive: Elements & Characteristics of this Approach*
- Post Comments under the discussion area for this section and respond to any of the four questions.

5. What are some ways in which your department is taking some of the actions described?
6. What other actions would you like your LHD to address and what benchmarks would you establish to evaluate how well your LHD did on these dimensions?
7. What changes in policy, organizational culture, or institutional processes and practices would show alignment with and manifestation of social justice principles?
8. What would need to happen for public health practice in your jurisdiction to be transformed to act on social injustice and its root causes?
Based on participant feedback, the PRIME pre-conference session was well received. Table 1 illustrates that respondents agreed that the PRIME session was helpful in understanding more about health equity and the activities at state and local departments related to the improvement of infant health and promotion of health equity. In addition, respondents were very satisfied overall with pre-conference presenters and the flow of the presentation. Participants provided positive feedback about the presentation and felt that it was very informative and their time was well spent. Participants also appreciated the honest and candid conversations about health equity.

To improve future conference sessions, one participant indicated more specific examples need to be provided in order to make the information clearer. An addition of a break was desired among participants because the 3 hour time period was considered too long. Additionally, one participant suggested having the panel sitting together in the front, in order to encourage more dialogue between panelists. Lastly, one participant suggested giving clearer examples of health equity resources.

**Table 1. – Summary Statistics of Evaluation Results**

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<th>Maximum</th>
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**See Appendix A for the list of questions to correspond to Table 1.**
Appendix A

PRIME
Michigan’s Premier Public Health Conference
Pre-Conference Session Evaluation Questions

1.) How satisfied were you with the overall PRIME pre-conference presentation?

2.) How satisfied were you with the pre-conference presenters?

3.) The panel was helpful in understanding state and local activities related to the improvement of infant health and promotion of health equity.

4.) The review of health equity resources will be useful in my understanding of health equity.

5.) After this session you have a better understanding of how institutional policy and structures can impact infant health disparities in Michigan?