

**PRIME**

Practices to Reduce Infant  
Mortality through Equity

**Practices to Reduce Infant Mortality through Equity  
(PRIME)**

**Final Narrative Report  
February 2015**

**Project Award # P3013047**

*Michigan Department  
of Community Health*



This final report highlight activities and accomplishments of the Practices to Reduce Infant Mortality through Equity (PRIME) project for the duration of the project covering the period from May 1, 2010 to November 30, 2014. It includes details on activities not previously reported during the period December 1, 2013 to November 30, 2014.

The project goals are to: 1) Develop and pilot a replicable workforce training and practice model for state Bureau of Family, Maternal and Child Health (BFMCH) staff to reduce racial disparities in infant mortality in Michigan, with a focus on African Americans and Native Americans; 2) Use a state/local partnership network to codify effective efforts that undo racism and improve infant health; and 3) Develop a sustainable quality improvement process.

Please note that we are finalizing three companion pieces to summarize our achievements and lessons learned. These documents will be shared with the W.K. Kellogg foundation in the Spring of 2015.

1. *Practices to Reduce Infant Mortality through Equity: Recommendations for State Health Departments. Lessons learned for transforming public health through education and action.* This document provides a rationale for a state level public health practice model to address racial disparities and discusses lessons we learned from developing and implementing an organizational capacity building intervention to promote health equity.
2. *Practices to Reduce Infant Mortality through Equity: A Guide for Public Health Professionals. An informational resource for transforming public health through equity education and action.* This document provides detailed information on how we developed a training model and resources that promote the understanding of the root causes of health inequities and staff development of equity workplans.
3. *Practices to Reduce Infant Mortality through Equity Program Outcomes: Perspectives on Changes in Organizational Policies and Practices.* This document shares staff accounts for practice and policy changes in the Bureau of Family, Maternal and Child Health.

## **A. Achievements, Outcomes and Lessons Learned**

### **I. Achievements**

#### **a. Structure**

An initial outcome of the project was in developing a structure to fulfill the goal of the initiative. A project manager was hired and the Steering Team and Workgroups were formed. The workgroups include: Intervention, Evaluation, Local Learning Collaborative and Ad-hoc Native American Data. The purpose, function and accomplishments of these groups have been described in detail in previous reports. Additionally, a summary of the meetings that were held in the final year of the project is provided in the separate evaluation report.

The Steering Team continued to engage in activities to learn more about racism and equity. Activities this year included: a) University of Michigan Health System's site – What is health care equity? and b) Dr. Neil DeGrasse Tyson – Look to root causes to understand inequalities.

In previous reports we have discussed holding two Steering Team retreats to focus on what was needed to continue to move the project forward and accomplish its goals. In addition to developing operating values and agreed upon responsibilities and expectations of members, the Team conducted a survey to assess members' understanding of the project goals and the level of communication and collaboration among members.

#### Intervention Workgroup

The Intervention Workgroup continued to lead efforts to identify curricula, workshops and resources needed to assist staff with developing new policies and practices that would result in a reduction of racial and ethnic disparities in birth outcomes. Workgroup members focused on understanding the curricula and trainings, both national and local, which are available in the areas of racism, health equity and social justice. Under the direction of the workgroup's leader and subject matter expert for the project, the workgroup finalized a paper (Green Paper) that outlined the intervention approach for PRIME. This group also oversaw the development of an organizational assessment designed to identify strengths, challenges and areas for staff capacity-building within the BFMCH. It was administered to Women's Infant and Children (WIC) and Children's Special Health Care Services (CSHCS) staff. This workgroup directed consultants and

workshop facilitators to conduct trainings with MDCH staff and staff from local health departments, healthy start projects and community-based organizations. These trainings are discussed later in this report. Finally, members of this workgroup drafted two of the project final documents: a) *Practices to Reduce Infant Mortality through Equity: Recommendations for State Health Departments. Lessons learned for transforming public health through education and action*; and b) *Practices to Reduce Infant Mortality through Equity: A Guide for Public Health Professionals. An informational resource for transforming public health through equity education and action*.

#### Evaluation Workgroup

The workgroup's primary activities focused on evaluating the numerous workshops that staff and community partners have engaged in since 2011. These workshops include: Undoing Racism, Health Equity and Social Justice, Native American History, Culture and Core Values, and three Health Equity Learning Labs with WIC staff, CSHCS staff and MDCH managers. The evaluation results for many of the workshops have been discussed in previous reports. An overview of results from workshops conducted in the last year of the grant is discussed later in this report.

This workgroup also revised the organizational assessment administered to WIC into a shorter version for CSHCS Division in January 2013.

Two manuscripts have been drafted by members of this workgroup. One is about the Nurse Family Partnership change in policy to require programs to utilize data to more effectively develop outreach plans to target populations most in need. A second manuscript evaluates the results of the Undoing Racism Workshop. During the Fall of 2014, members of this workgroup began to work with consultants from the Inter-Tribal Council (ITC) of Michigan to draft a manuscript to describe the approach used to develop the Native American History, Culture, and Core Values workshop.

The evaluator that leads this workgroup conducted two focus groups in the fall of 2014 to document efforts by MDCH staff to change policies and practices that could reduce racial disparities in infant mortality. One focus group was held with Steering Team members and a second focus group was held with managers in BFMCH. Staff described organizational changes in their work settings that were related to changes in maternal and child health program policies and practices. A summary of these focus groups is included in the final evaluation document for the project and is titled, *Practices to Reduce Infant Mortality through Equity Program Outcomes: Perspectives on Changes in Organizational Policies and Practices*. Many of the policy and practice changes are also included later in this report under project outcomes.

#### Local Learning Collaborative

The PRIME Local Learning Collaborative (LLC) was established in March 2011. Representatives from Local Health Departments, all six Michigan Healthy Start Projects and other community organizations that work in their local community to address racism, health equity and disparities make up the LLC. As described in previous reports, a booklet highlighting the health equity work in each of the LLC communities was produced and shared via conferences and on the PRIME website.

In August 2013, the group supported merging the LLC and the Partnership to Eliminate Disparities in Infant Mortality (PEDIM) Action Learning Collaborative. During the same month, the UM Evaluator for PRIME led the group through a descriptive evaluation process to capture what the LLC has been doing and what they have found to be valuable. Members reported building stronger partnerships with LLC members and MDCH, valuing participation in PRIME training activities and having the ability to share information and resources with one another.

Leadership of the group changed after the previous BFMCH Director retired. As of July 2014, the group has co-leadership from the current BFMCH Director and a local member from Ingham County Health Department. In September 2014, members identified priorities the collaborative will focus on in the next 1-3 years. The priorities are: 1) Equity Orientation for Legislators - Develop a plan and strategies to educate legislators on the business case for equity and how they can support equity work; 2) Historical Overview of MI (Racial Equity Scans) - Continue developing a historical overview of events, legislation, and court cases that occurred in Michigan and the United States. Each event directly

relates to six social determinants of health (economic stability, safety, housing, education, health services, and social cohesion) and effects on American Indian and African American populations in Michigan. Continue development of infographics, presentations & templates and issue briefs; and 3) Interview and Recruitment Practices - Identify and pilot use of health equity questions in the recruitment and interviewing process.

#### Native American Ad-Hoc Data Group

Members of this workgroup developed Michigan's first standalone Native American Pregnancy Risk Assessment Monitoring Survey (PRAMS). Questions on racism and social determinants of health were added to the survey. Workgroup members began to draft the "Native American PRAMS- Preliminary Indicator Tables 2012" report in August 2014. The report was completed in February, 2015 and is included in the separate evaluation report. MCH staff valued the data that was being collected and funded additional surveys for mothers who gave birth to a Native infant during the last 9 months of 2013. Combining data from 2012 and 2013 will hopefully allow for data to be shared with the local tribes, specific to their area. Starting with April 2013 births, NA PRAMS began offering moms the option to complete surveys online. Next steps include drafting fact sheets on some of the following topics: Safe Sleep, Reactions to Racism, Social Determinants of Health and Home Visiting.

#### **b. Organizational Assessment**

As mentioned in the Evaluation Workgroup and Intervention Workgroup sections, an organizational assessment was developed to gather self-rated perceptions from WIC and CSHCS staff about organizational capacity and practices in six competency areas: 1) Cultural competence; 2) Perceptions of bureau programs and services designed to build capacity of local health departments to reduce racial health disparities; 3) Information sources used to gather information about racial health disparities; 4) Division's application of key concepts like institutional racism, social determinants of health and life course theory; 5) Knowledge and Skills (e.g. use of epidemiological data for program development); and 6) Division's community engagement. Assessment findings were included in previous evaluation reports.

#### **c. Equity Training & Evaluation Tools**

Beginning in 2011, PRIME supported staff training to understand equity concepts and to focus programming and policy to consider historic, social, economic and environmental factors that impact maternal and child health outcomes. The following three workshops were provided to staff and partners. Detailed summaries of the first two workshops have been provided in previous reports. The third workshop was held in September 2014 with CSHCS staff and staff from the Division of Family and Community Health.

- 1) *Undoing Racism Workshops* (158 participants) – facilitated by the People's Institute for Survival and Beyond focused on understanding what racism is and the role of organizational gate keeping as a mechanism for perpetuating racism.
- 2) *Health Equity Social Justice Workshops* (188 participants) – facilitated by Ingham County Health Department stressed the necessity of addressing racism, classism, sexism, and other forms of oppression explicitly as root causes of health inequity.
- 3) *Native American History, Culture & Core Values* (53 participants) – facilitated by consultants from the Inter-Tribal Council of Michigan and piloted in PRIME to 1) increase staff knowledge of the culture of Michigan's tribes; 2) identify cultural barriers that impact communication between tribal, local, county and state governments and identify promising strategies to enhancing those relationships; and 3) increase understanding regarding Anishinaabek parenting skills and viewpoints regarding disabilities when developing programs that will be utilized by the Anishinaabek communities.

The Native American History, Culture and Core Values Workshop was a four-hour learning session in which the presenters provided their perspectives about the challenging historical interactions with federal and state governments and the effects of historical inter-generational trauma on their communities, families, cultural values and norms. The presenters also shared personal life experiences exemplifying their resiliency as Anishinaabek through the retention of their language, culture and ceremonies.

A total of 53 staff participated in the workshop. Workshop pre-post evaluation tools assessed changes in self-reported competencies. Participants showed statistically significant increases in all of the self-reported competencies. This was the only workshop provided by PRIME where 100% of staff indicated that they would recommend the workshop to their colleague without any reservations.

#### **d. Health Equity Learning Labs & Evaluation Tools**

PRIME developed and piloted the first Health Equity Learning Labs with 50 state WIC staff and local partners from November 2012 to April 2013. The goals of the Health Equity Learning Labs were: 1) To foster institutional change to develop policies and procedures that always promote, and never inhibit health equity; and 2) To incorporate equity thinking, perspectives and action into daily work assignments and responsibilities. Details on this learning lab were included in previous reports.

Between January to May 2014, 44 state CSHCS staff and local partners participated in a second iteration of the Health Equity Learning Labs. In addition, separate Health Equity Learning Labs were developed for managers from CHSCS and other MDCH Divisions.

The Health Equity Learning Labs for non-management and management staff were different from the WIC learning labs in three key ways:

- Less time was spent on health equity concepts, since these were an integral part of the Health Equity and Social Justice Workshop in which staff had already participated.
- While participants in the pilot learning labs included non-management and management staff in the same sessions, the Health Equity Learning Labs described in this section were developed as separate experiences for non-management and management staff.
- While the pilot version consisted of 36 hours of learning lab time, the Health Equity Learning Labs described in this section were shorter and involved 15 hours for non-management staff and 11 hours for management staff.

The Ingham County Health Department Health Equity and Social Justice Coordinator worked with the Intervention Workgroup to develop the curriculum for the learning labs. The PRIME Project Manager and the Health Equity Coordinator from MDCH's Health Disparities Reduction & Minority Health Section co-facilitated the staff sessions. The Health Equity Learning Labs for non-management staff involved five sessions (for a total of 15 hours). Sessions were held once a month.

The Learning Objectives of the Staff Learning Labs included: 1) Articulate in concrete terms the reasons why it is important to adopt a health equity framework for practice within CSHCS and to their day-to-day work; 2) Assess the degree to which their work unit currently applies health equity principles in carrying out their responsibilities, and identify changes that need to occur to apply those principles more fully; 3) Create realistic scenarios illustrating typical opportunities to apply a health equity framework within CSHCS; and 4) Commit, individually and collectively, to actions that will strengthen the application of a health equity framework to the future operation of CSHCS. Participants showed statistically significant increases in most of the self-competency ratings. There was not a significant increase in two self-competency ratings, "Assess the degree to which my work unit currently applies health equity principles in carrying out our responsibilities" and "Carry out, individually and collectively, actions that will strengthen the application of a health equity framework." Staff developed 5 health equity action plans at the end of the learning lab. The plans included the following: 1) Improve communication within the CSHCS Team through opportunities to collaborate and build effective partnerships across sections in order to promote a more efficient and seamless system of care for the client population; 2) Integrate all aspects of the CSHCS program within the database, to ensure CSHCS is serving its families equitably; 3) Build an inclusive and equitable committee membership that is diverse in representation; 4) Incorporate a "health equity review" process into the existing policy review process; and 5) Remove Medicaid barriers to cover medical foods and formula for life for clients with Phenylketonuria (PKU). After the learning labs, workgroups were formed for each action plan and meetings occurred during June to September 2014. Updates on actions taken to fully implement the plans and additional detail on the learning labs and finding can be found in the separate evaluation report.

The Health Equity Learning Labs with Managers Pilot was conducted from February to May 2014 with 21 managers from CSHCS, WIC, HDRMHS, Division of Family & Community Health, Chronic Disease, and Lifecourse Epidemiology & Genomics Division. Managers participated in the learning labs for a total of 11 hours and the sessions were facilitated by the CEO of the Michigan Premier Public Health Institute and the Health Equity and Social Justice Coordinator from the Ingham County Health Department. The learning objectives for the management learning labs were similar to the objectives for the learning labs with staff with the addition of these two objectives: 1) State their responsibility as leaders to facilitate needed changes that would enable staff to apply health equity principles more fully; and 2) Articulate concrete ways leaders can support staff in applying a health equity framework to their day-to-day work. Participants showed statistically significant increases in all but one reported self-competency rating. Staff reported increases in understanding and applying a health equity framework in their division, assessing current application of health equity principles and understanding how their leadership role could facilitate changes in their division. There was not a significant increase in confidence in being able to “Articulate in concrete terms the reasons why it is important to adopt a health equity framework for practice within my division of MDCH.”

Managers expressed that it was very beneficial to meet with colleagues outside of their respective divisions and they valued the sharing of ideas, approaches and practices to apply equity to their work. Managers were asked for their responses to the following questions related to their roles in supporting efforts to address health equity: 1) When staff see an example of injustice or inequity related to their work (either internal or external), what do you want them to do about it?; 2) When hiring and managing staff, how can you encourage challenges to “business as usual” that would heighten exploration of and action on unjust policies and practices?; and 3) When developing programs or assessing program performance, how can you routinely infuse a consideration of equity and justice? The session results are included in the separate evaluation report.

#### **e. Native American PRAMS Survey**

As mentioned earlier in the Native American Ad-hoc Data Workgroup, PRIME developed Michigan’s inaugural standalone Native American PRAMS. MCH used a revised definition of “Native infant” to include infants whose fathers were Native American. The approach resulted in a 108 percent increase in sampling size. Additionally, a culturally sensitive approach was developed that resulted in a response rate over 50 percent. More than 1,300 surveys were completed for 2012 births. The “Native American PRAMS- Preliminary Indicator Tables 2012” is included in the separate evaluation report.

#### **f. Website**

The PRIME website ([www.michigan.gov/dchprime](http://www.michigan.gov/dchprime)) was launched in January 2013. The website includes relevant data on infant mortality and definitions and videos that describe health equity, social determinants of health and racism. The Local Learning Collaborative members discuss their lessons learned and best practices in local health equity work. Additionally, areas within MDCH share their health equity work and initiatives. Finally, the website includes a variety of articles, reports and films that discuss infant mortality, health equity and racism. The monthly Google Analytics report from January 1<sup>st</sup>, 2014 to December 31<sup>st</sup>, 2014 indicates that the PRIME website had 2,823 visits with 5,778 page views. The number of visits in 2014 increased by 19% from 2013. There was a slight decline (7%) in the number of page views.

#### **g. Education & Outreach**

PRIME has had several presentations and poster sessions for many venues including: the American Public Health Association, Centers of Disease Control, Council of State and Territorial Epidemiologists, Michigan Premier Public Health Conference, Michigan Radio, and the University of Michigan Maternal and Child Health Community Training Program. Each year dissemination efforts have been include in our annual reports. Sessions that were held in the last year of the grant will be discussed more in the Dissemination Section.

1. Green Paper – as mentioned under the Intervention Workgroup section and in prior year reports, the Green Paper was completed in 2012 and outlined several critical questions to address in order to move forward in the intervention process. It was stimulus for considering, discussing and refining the PRIME project’s aims, goals, objectives, and next steps.

2. Health Equity Status Report – completed in 2013. It presents data for 14 indicators (psychosocial, socioeconomic position, basic needs, and healthcare access) on the social context in which women and children live in Michigan.
3. Three Final Reports - as mentioned in the introduction of this report, the following three documents will be finalized in Spring of 2015 and submitted to the W.K. Kellogg Foundation. The reports will be disseminated to other state health departments, divisions within MDCH and local health departments.
  - a. *Practices to Reduce Infant Mortality through Equity: Recommendations for State Health Departments. Lessons learned for transforming public health through education and action*
  - b. *Practices to Reduce Infant Mortality through Equity: A Guide for Public Health Professionals. An informational resource for transforming public health through equity education and action.*
  - c. *Practices to Reduce Infant Mortality through Equity Program Outcomes: Perspectives on Changes in Organizational Policies and Practices.*

## II. Outcomes

### a. Increased Dialogue on Equity Issues

During a Steering Team retreat members voiced that personnel are routinely engaging in conversations about equity and justice that they would not have previously. It was noted that PRIME did not focus on the development of a common language early in project, and that it took a considerable amount of time and energy to develop it, but it was essential to moving forward. An important element of this accomplishment is the adoption of common language and concepts that enable people to address phenomena that were sidestepped or ignored in the past. This allows people to avoid some of the misunderstandings that might otherwise occur because of their trepidation about discussing issues of race and racism explicitly.

### b. MDCH 2014 Strategic Priorities

Steering Team members advocated for the strategic priorities listed below. Members reported increased political will to address infant mortality and the social determinants of health.

- Ensure access to culturally and linguistically appropriate services for all Michigan residents
- Reduce disparities in health outcomes
- Utilize Michigan’s Infant Mortality Reduction Plan to support healthy babies growth and change in disparities

### c. Changes in Practices and Policy

1. **Nurse Family Partnership (NFP)** home visiting program - **contractual requirements to use specific data analysis (Kitagawa) to develop outreach plans** to enroll the most at risk moms into home visiting services. This method used data analyses of infant mortality disparities to identify minority populations with the greatest need and helped set recruitment goals. All nine NFP sites used the specialized strategy and have developed Outreach Plans that are consistent with the risk-based analysis identified in the Kitagawa analysis county profile for excess infant death rates provided by MDCH. Upon review of the outreach work plan reports, six categories or themes of strategies emerged: a) Direct contact, education and relationship building with providers; b) Outreach and education to Schools and Churches; c) Media campaigns; d) Direct contact with potential Clients; and e) Engaging Community Partners and raising awareness for the NFP Program. NFP enrollment since implementation of the Outreach Plans demonstrated progress toward achieving caseloads reflective of the at risk population.
2. Michigan’s first stand-alone **Pregnancy Risk Assessment Monitoring System (PRAMS) Survey for mothers of Native American infants**. Native American PRAMS - the plan is to collect data every 2 years. PRIME supported the initial year of data collection via W.K. Kellogg funding and the department supported the second year of data collection.
3. **Incorporated equity questions into staff interview process**. Human Resources hiring questions now include a question on health equity and are being utilized in the Lifecourse Epidemiology and Genomics Division, Division of Chronic Disease & Injury Control, HDRMHS and Division of Family and Child Health.
4. **Developed managerial annual performance evaluations that include a measure related to inclusion of equity work or addressing disparity in their program areas**: Assure promotion, exposure or participation in at least one

training or participation in a programmatic effort for health equity promotion within the responsibilities of the unit for self and unit staff members; Support a work environment that is diverse and supportive of ADA & EEO, preventive of harassment and that meets the Department's human resource requirements.

5. **Ongoing equity training to state and local agency staff**
6. Increased outreach to the Native American community; **Piloting WIC services at the American Indian Health and Human Services in Detroit** (renamed the Lawndale WIC Clinic at the Detroit Health and Wellness Program). WIC services on site one to two days (alternate weeks) to 261 enrolled clients; 168 of whom are fully participating. New southwest and northwest Michigan WIC clinics may be initiated soon.
7. **Efforts to increase Breast Feeding in the African American Community**
8. **Changes to the Advisory Committee of CSHCS to be inclusive, and diverse in representation:** Geographically; Diagnosis based; Culturally (race, ethnicity, class); Professionally; Service delivery types (i.e. children specialty centers, adult specialty centers); Family/client age ranges
9. **Child and Adolescent Health Centers (CAHCs) are required to select one health disparity that exists among their patient population, and submit a plan for how they might address it.** Created an analytic tool to help CAHC coordinators use risk assessment data to discover important health disparities within their patient populations. This tool has been piloted with a few CAHCs, and is now being shared with all funded centers in MI.
10. Michigan Healthy School Action Tools (HSAT) online assessment and action planning tools ask **school health teams to assess whether the health concerns identified in their schools are due to the existence of health disparities.** The online tools further provide best practice statements and suggested activities to address potential disparities and create a culturally sensitive learning environment.

**Strategies to address racial and ethnic disparities** (additional strategies shared in previous reports):

- **Safe Sleep** – Staff participated in the Native American History, Culture and Core Values workshop where presenters shared “digital stories” to educate and promote hope by exemplifying diverse journeys of healing. In FY2015 utilizing infant safe sleep mini-grant funds, Inter-Tribal Council of Michigan is producing two digital stories featuring Native families’ decisions about safe sleep; Infant safe sleep mini grant funds are being targeted to counties with high black/white Sudden Unexpected Infant Deaths (SUID) rate ratio. Grantees are required to work with local community advisory teams that reflect the racial and ethnic diversity in the community; in July 2014 issued a report “Michigan’s Top 12 Counties by Number of Sudden Unexpected Infant Deaths (SUID) Birth Cohort 2005-2011”
- **Women, Infants and Children** - The Outreach and Referral group established a PRIME workgroup that includes five local agency coordinators and several State WIC staff to determine best practice/methodologies for sharing information with other local agency Coordinators and their staff; State WIC staff continue to attend Tribal Council meetings; Breast Feeding staff participated in the U.S. Breastfeeding Committee Webinar- Structural Racial Equity; submitted a grant proposal to the WKKF to grow the field of minority lactation consultants
- **Oral Health** - Pursuing a grant to help reduce racial health disparities in the dental health and perinatal complications of at risk mothers and infants across the state
- **Reproductive Health** - Training at the Annual Family Planning Update conference titled “Bridges Out of Poverty”
- **Perinatal Care System** - Initiated “Birthing Hospital Mini-Grants” in FY 14 which supports birth hospitals linking families to home visitation programs that focus on health equity and reduction of disparities. The Michigan Collaborative Quality Initiative REDCAP data collection includes racial/ethnic data effective 1/1/2014
- **Local MCH Grant Funds** - Each local health department reports on disparities in their local region as part of the planning process for implementation of strategies in the local community
- **Michigan Maternal Mortality Surveillance (MMMS)** - An educational presentation entitled *Social Determinants of Health* was held June 18, 2014 for MMMS Medical and Injury expert advisory committees
- **Fetal Alcohol Spectrum Disorders** - The Five Year Plan, 2015-2020, include a focus on diversity across the Life Course and representation from populations of color; will develop culturally appropriate infrastructure, core prevention message(s) and an awareness campaign within the next two years.
- **Child and Adolescent School Health** - Michigan Model for Health staff have been planning methods to make funding equitable for grantees, including number of schools served, geographic considerations, etc.; Michigan

Adolescent Pregnancy and Parenting Program Grantees attended a two day Learning Institute that provided foundational training and introduction to health equity, health disparities, and social determinants of health; The CAHC program is piloting the use of public health questions (or social determinants of health) in the online RAAPS risk assessment screening in two CAHCs in northern Michigan

- **Maternal Infant Health Program** – New Agencies receive information regarding the Department’s focus on health equity and undoing racism in both the *New Provider Inquiry* meeting and in the *New Provider Orientation*. All new nurses, social workers, dietitians and infant mental health specialists must review the Root Causes of Infant Mortality and Health Disparities Definitions; Presentations on Adverse Child Experiences and Toxic Stress were offered to providers in September 2014
- **Health Disparities Reduction and Minority Health Section** – Manager participated in Health Equity Learning Labs; Held two 2-day “Developing Culturally and Linguistically Appropriate Services (CLAS) Through the Lens of Health Equity,” training workshops with 88 participants (42 were MDCH staff) between April to August 2014.; Collaborated with PRIME other MDCH Health Equity Steering Committee members and the Michigan Public Health Institute to develop an online equity training that will be mandatory for all MDCH staff; sponsored a standalone Behavior Risk Factor Survey (BRFS) for Arab/Chaldean Americans (2013) and results of the 2012 Hispanic/Latino BRFS published in 2014; developed and published the 2013 annual MDCH Health Equity Report to the Michigan Legislature
- **MDCH Cancer Prevention and Control Section** – Manager participated in PRIME Health Equity Learning Labs; Employees track and report participation in HESJ educational activities as part of routine annual performance review. This year an employee initiated a review and discussion of the “Roots of Health Inequity” modules; Requests for Proposals encourage MI Cancer Consortium members to address health equity and social justice issues. All cancer-related federally funded programs have incorporated objectives and strategies in their respective work plans to address health equity and social justice
- **Division of Chronic Disease & Injury Control** – Tobacco Section Manager participated in PRIME Health Equity Learning Labs; Quarterly Health Equity and Social Justice learning cohorts for new employees. Managers participated in the cohort learning from February through May, 2014; Monthly forums on Health Equity for division staff

**Collaborative efforts with other programs, agencies and organizations to reduce racial disparities** (additional efforts shared in previous reports):

- **WIC** - Joint training and data sharing with the Maternal Infant Health Program (MIHP) has potential to better identify, track and address the health inequities that exist among shared at-risk population; collaborate with local agency programs to encourage the use of peer counselors that reflect the population that they serve; partner with local coalitions, hospitals, MIHP and other programs. Phone application where mother can select her race to get more information on evidence based practices that support breastfeeding
- **Child and Adolescent Health** - The 2014 CAHC Annual Coordinators’ Training focused on racial disparities and health equity and was a joint effort between MDCH and MI Department of Education. The keynote speaker was Dr. Brian Smedley, Vice President and Director of the Health Policy Institute at the Joint Center for Political and Economic Studies
- **Maternal Infant Health Program** - Works with WIC and mental health programs at the state level and with the MI Home Visiting team, which includes representatives from the Department of Education and Department of Human Services, to assure collaborative efforts focus on reduction of disparities
- **MDCH Health Equity Steering Committee** – Held a Health Equity Brown Bag Series during 2014. There were four sessions. One session focused on PRIME

### III. Lessons Learned

The immediate past director of BFMCH, in consultation with the PRIME subject matter expert with Vanderbilt University, as well as other leaders who have been involved with PRIME, identified the following lessons learned in the project.

- a. Increase dialogue on equity and develop common terminology. It is critical to appreciate and communicate that health equity, racism and related issues are complex and sensitive topics. Leadership must be prepared to deal

with substantive differences in how people understand the terms and their implications. The organizational culture will play a key role in determining the organizational readiness to use certain vocabulary, incorporate specific strategies and address particular issues. Leaders must also have a solid understanding of key terms and concepts related to health equity so that they can reflect these within their formal communications and informal conversations.

- b. Assure open and frequent communication as part of creating a supportive environment. Ongoing communications from and among those in leadership positions about the importance of addressing these issues is paramount. While many staff and decision-makers may view efforts like PRIME as an “add-on” to the everyday work of a public health institution, leaders must consistently emphasize the value of using these efforts to change the ways that institutions carry out their missions and ways these changes can ultimately benefit all of us.
- c. Anticipate and create opportunities to address negative reactions. Leaders should be prepared to respond to push-back. It’s important to keep in mind that negative reactions from staff – particularly from those who are White – aren’t uncommon as they grapple with ways that racism has been perpetuated through the actions of individuals *and* through institutional practices and policies. Leaders must be willing to “stay the course” and articulate the value and importance of understanding that these life issues do exist and it is the responsibility of those in public health to address them.
- d. Focusing on specific racial and ethnic groups will be problematic for some. There needs to be an explicit, and ideally data-driven, reason for focusing efforts on improving the health of specific population groups. Create and review these choices and educate staff about these decisions, even if they do not ultimately agree with them.
- e. Avoid “mission creep” – expanding the scope, focus and goals of the project into areas that were not part of your original plan.
- f. Connect with peers doing this work. Leaders in efforts similar to PRIME should build a diverse pool of team members and collaborators – including those who have been most affected by health disparities – with expertise and experiences needed for addressing the complexity of health equity issues. PRIME sought the experience and expertise of the organizations represented on the Local Learning Collaborative and the Steering Team.
- g. Embrace the reality that this work will not be accomplished in a short time period. Staff must appreciate that that they will not have a “road map” to follow to accomplish the goal of reducing racial disparities in infant mortality. Many people – both those closely involved in efforts like PRIME and those who are watching these kinds of efforts unfold – may have unrealistic expectations about the speed with which changes in rates of health equities will occur. Leaders must be willing to respond to these concerns in ways that can help people understand the complexity of the issues and the ongoing investments of time and efforts needed for change to occur. Leaders should seek out experts and allies who can also be voices for responding to these kinds of concerns – and leaders can also draw from that expertise for help in regularly assessing work plans and timelines to assure that their goals and objectives are feasible and realistic.
- h. Evaluation is a key component and progress should be monitored consistently. Use data consistently to inform the process and focus the work. Making big ideas and complex constructs measurable is a necessary and important part of the work. Having evaluation data to document the process and impact of public health practice to address health equity is essential to demonstrating why this work is needed, beneficial and relevant over time. In order to sustain this work, it is essential to measure the positive impact of health equity on health status, economic indicators, and education outcomes, not just the processes and aspects of organizational change.
- i. Develop the “business case” for adopting a health equity framework for all public health practice, and present to government leaders. The business case for infant mortality, infant health, and life-course is likely to be a much stronger argument for some audiences than a moral argument about health equity.

## **B. Collaboration**

PRIME continues to have strong collaborative efforts with HDRMHS. The HDRMHS manager continues to lead the PRIME Steering Team and provide oversight of the project manager. PRIME staff collaborates with HDRMHS as they develop an

online health equity training that will be mandatory for all MDCH staff. Additionally, PRIME members and BFMCH staff continue to participate on the MDCH Health Equity Steering Committee that is chaired by the HDRMHS manager.

MDCH's Lifecourse Epidemiology and Genomics Division staff has partnered with PRIME to analyze data from the Native American PRAMS and analyzed Medicaid claims files for infant and maternal health care utilization (for example, continuity of enrollment, chronic conditions, use of preventive care) including exploration of disparities in this low income population by race/ethnicity. Findings are included in the separate evaluation report.

The partnership between the MDCH, Inter-Tribal Council of Michigan, Great Lakes Inter-Tribal Epidemiology Center, and the Michigan State University Office of Survey Research continues to work on the Native American PRAMS.

Two meetings were held in 2014 with three areas within MDCH: 1) Health Disparities Reduction and Minority Health Section; 2) the Bureau of Family and Maternal Child Health, and 3) the Division of Chronic Disease and Injury Control. The purpose of these meetings was to reflect on each of the respective projects and develop coordinated efforts to advance health equity and social justice through public health at the state level. Partners that had provided equity consultation and training from outside of MDCH also participated in the meeting.

The Local Learning Collaborative established in March 2011, continues to meet quarterly and efforts were described earlier in this report.

The PRIME project continued the collaboration with the University of Michigan Public Health Practice Office and will partner through Winter 2015. The PRIME Intervention Workgroup held several meetings with the Practice Office to develop the PRIME website to include the final PRIME documents. As discussed earlier in the report, these documents will highlight the accomplishments of PRIME since 2010.

PRIME Steering Team members from the Division of Family and Community Health are engaged in Region V's Collaborative Improvement & Innovation Network to Reduce Infant Mortality (CoIIN): Social Determinants of Health Workgroup.

### **C. Future Plans & Sustainability**

PRIME secured an additional Kellogg Award for one year in the amount of \$300,000. The overall goals of the one year grant are to: 1) Develop a plan to replicate the PRIME model (organizational assessment; initial equity training; develop and implement equity plans) within at least 3 other MDCH divisions (Chronic Disease, Epidemiology, Behavioral Health, Medicaid); 2) Partner with the Health Disparities Reduction Minority Health Section (HDRMHS) for the on-line equity training that would be required for all MDCH staff; 3) Partner with HDRMHS to provide training to our executive leadership on equity; 4) Provide technical assistance to BFMCH staff that have developed equity plans to fully implement the plans; and 5) Identify quality improvement measures.

PRIME will seek additional funding to implement the plan that is developed to replicate the PRIME model in other MDCH divisions. The various divisions will provide funding and resources to support the activities.

The pilot and refining of the Health Equity Learning Labs described earlier in this report will help to sustain PRIME efforts. The project is now able to direct staff on a process to incorporate equity into their daily work. Additionally, the three companion documents described in this report will aid in introducing the PRIME model to other divisions within the department that are interested in applying the model to their area to address racial and ethnic disparities. In particular, the *"Practices to Reduce Infant Mortality through Equity: A Guide for Public Health Professionals. An informational resource for transforming public health through equity education and action"*, will be instrumental in providing the guidance needed to promote understanding and action to impact health inequities.

Additionally, PRIME members have begun to co-facilitate some of the trainings and the project will continue to identify ambassadors to engage in and led equity training within the department. As we continue to build a strategy with other equity efforts in the department as discussed earlier in the report, this will help to sustain our efforts.

Finally, the project will utilize the new WKKF funding to focus on identifying quality improvement processes for developing and implementing equity plans.

#### **D. Dissemination**

PRIME has shared information on the project and evaluation findings via the PRIME website, at conferences and during webcasts. Please refer to the Website and Education/Outreach Sections of this report for more information. During the final year of the grant information on PRIME was shared with several groups as highlighted in the text below.

PRIME staff presented at the Association for Maternal & Child Health Programs (AMCHP) in January 2014 in Washington, DC. The title of the session was “Practices to Reduce Infant Mortality through Equity (PRIME) – New Approaches for Using Data”. Additionally, AMCHP mentioned PRIME’s work in a web post in April 2014.

WIC presented a webinar on PRIME in May 2014. The webinar included an overview of the PRIME project, data collection for small populations (e.g. Native Americans), the data collection methods used in the Native American PRAMS survey, and how to use data to inform program outreach.

The PRIME Project Manager facilitated the Life Course Game and discussed PRIME at five CSHCS regional meetings (180 participants) held throughout Michigan during May and June 2014. The PRIME Manager also facilitated the Life Course Game at the Michigan Adolescent Pregnancy & Parenting Program meeting on October 22, 2014 in which PRIME was discussed. The PRIME Project Manager also facilitated the Life Course Game at an all staff meeting for the BFMCH in June 2014.

The North Carolina Department of Health and Human services reached out to MDCH to learn more about the Kitagawa analysis used in NFP. The department also requested information about the PRIME project. The award winning epidemiologist that utilized the Kitagawa method in NFP invited the PRIME project manager to present a webinar for NC DHHS staff in June 2014.

MDCH released a news brief in July 2014 featuring the health equity brown bag series and featured the PRIME project as one of the BFMCH projects designed to reduce and prevent infant deaths. Additionally, the PRIME project manager and other PRIME steering team members participated in the MDCH Health Equity Steering Committee’s Brown Bag Series.

The PRIME Project Manager presented information on the PRIME project in August 2014 to the Detroit Institution for Equity in Birth Outcomes, which was launched in May 2014 as a citywide initiative to advance equity in Detroit birth outcomes and reduce the city’s high infant mortality rate.

The Mississippi State Health Department is looking to replicate the PRIME project in their state. In August 2014, the Mississippi MCH Director invited The PRIME Project Manager and previous BFMCH Director to Mississippi to discuss PRIME and how MDCH has worked to integrate equity into policy and programming. The Health Resources and Services Administration provided funding for the technical assistance visit to Mississippi.

In October 2014, a PRIME Steering Team member and Director of the Division of Family and Community Health presented at the National Academy for State Health Policy conference about health equity issues and what we have done in Michigan, including the works on PRIME.

Three documents will be finalized in Spring of 2015 and submitted to the W.K. Kellogg Foundation. The reports will be disseminated to other state health departments, divisions within MDCH and local health departments.

- I. *Practices to Reduce Infant Mortality through Equity: Recommendations for State Health Departments. Lessons learned for transforming public health through education and action*
- II. *Practices to Reduce Infant Mortality through Equity: A Guide for Public Health Professionals. An informational resource for transforming public health through equity education and action.*
- III. *Practices to Reduce Infant Mortality through Equity Program Outcomes: Perspectives on Changes in Organizational Policies and Practices.*

## **E. Project Director's Opinion**

### **What do you think are the most important outcomes and "lessons learned" from this project?**

The Bureau of Family, Maternal and Child Health paved the way for state employees to engage in health equity and health disparity training. Over the last several years and for some, prior to the inception of PRIME activities, the knowledge, awareness, and beliefs around these concepts may not have been known. However, there has been a shift over time, as we can see that it has really been infused throughout the organization. For example, in developing the mission, vision, and guiding priorities for the Bureau, many staff insisted that we incorporate health equity. Through this process of defining our mission, it was evident that we are beginning to see a culture change within our organization.

Other lessons we have learned, is that hiring practices should include some level of assessing the knowledge of health equity and social determinants of health. Many BFMCH interviews now include questions regarding knowledge or application of these concepts. We have learned through implementing this change in our hiring practices that there is such a wide distribution of knowledge from those both within and outside the Bureau.

One outcome is that we have started to open the door to conversations with our Michigan Department of Community Health leadership around these concepts of health equity, health disparity, and social determinants of health. Leadership has participated in our health equity workshops and strategized ways to encourage others outside of the Department to participate in these trainings.

Another outcome is that we have infused health equity and social determinants of health in the update of our Infant Mortality Plan. While it was always a strategy to include social determinants of health in this endeavor, never has it become more evident of how health equity plays a part and is interwoven throughout our entire plan.

Other important outcomes from this project include other states and organizations becoming aware of our advances in training members of our organization and overall recognizing the value of PRIME in our organization. We have visited other states to share our best practices and will soon be hosting a site visit so even more states can see the work we have done around health equity and health disparity.

### **What recommendations would you make to other project directors working in this area or to the Foundation?**

One thing I would suggest is working with your leadership early on to educate them on these concepts as a way to facilitate the infusion of equity principles in the strategic planning process, hiring practices and other areas. I think it is important for staff to see that leadership and management find these concepts important. I would also suggest that when staff implement these concepts within the organization, it should be acknowledged, recognized, and/or rewarded in some way. I think that would help build the culture and encourage others to do the same. I would try to build a network of trainers as well. We rely heavily on one particular group to run the workshops and since the popularity has grown, it is sometimes difficult to hold workshops, given the increasing demand. Perhaps if we had built in a train-the-trainer workshop, we could help build a network of trainers and infuse more of these trainings in and outside of the organization.

## **F. Evaluation**

Our project requires a separate evaluation report. Responses to the following questions are included in that report.

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?
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?

3. How has MDCH/BFMCH as an agency changes its policies and practices to strengthen racial equity and inclusivity?

### **G. Summary**

During this final year of this grant funding PRIME has focused on the following activities: 1) Developing a second iteration of the Health Equity Learning Labs for CSHCS staff and a separate Health Equity Learning Labs for managers from CHSCS and other MDCH Divisions; 2) Collaborating with the Inter-Tribal Council of MI to develop a Native American History, Culture and Core Values Workshop for BFMCH staff; 3) Disseminating information on PRIME via the website, conferences and webcasts; 4) Continuing the PRAMS survey and data analysis for Native Americans; 4) Analyzing Medicaid claims files for infant and maternal health care utilization; 5) Continuing to partner with local health departments, Healthy Start projects and community organizations to promote health equity practices in MI; and 6) Securing additional WKKF funding to replicate the PRIME model in other divisions in MDCH and to identify efforts to sustain the work in the project. All of these endeavors work to address racial and ethnic disparities in Michigan.