Practices to Reduce Infant Mortality through Equity (PRIME)
Organizational Assessment with
Division of Family and Community Health (DFCH)
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EXECUTIVE SUMMARY

The **Practices to Reduce Infant Mortality through Equity** (PRIME) Organizational Assessment is intended to identifying strengths, challenges, and areas for growth related to the capacity of the Michigan Department of Health and Human Services (MDHHS) 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 Native Americans.

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. The assessment can be modified and replicated with staff in other State Health Department bureaus focused on other racial health disparities.

The Division of Family and Community Health (DFCH) was the third BFMCH division to complete the organizational assessment. All staff were asked to complete a confidential online survey assessing basic demographic data and perceptions of organizational capacity and practices. Thirty-six of the 66 staff (54.5%) completed the assessment between August 24th and September 4th, 2015. The organizational assessment will provide an initial measure of DFCH staff's perceptions to be used for comparison with future iterations of the organizational assessment. It should be noted that a majority of DFCH staff (91.4%) who responded to this Organizational Assessment had attended one or more PRIME sponsored trainings, therefore this survey is not necessarily a baseline assessment.

The organizational assessment gathered self-rated perceptions from DFCH staff about the Division's organizational capacity and practices by asking statements that were grouped into eight competency areas (awareness of shared cultural practices is combined below). Summaries of the findings for these eight areas are listed below in descending order of the self-rated competency measures of the topic (based on level of agreement with competency statements):

- **Division Priorities to Reduce Racial Health Disparities:** This topic had the highest average self-rated competency score. On average, DFCH staff who responded to the assessment agreed that they clearly understood that DFCH has a priority to focus on reducing racial health disparities and that they understood how their work contributed to that priority. This topic had the highest average agreement; no respondents disagreed with understanding the Division's priority and 29 out of 30 respondents agreed that they understood how their work contributed to reducing racial health disparities.

- **Perception of DFCH's Promotion of Health Equity in Programs and Services:** DFCH staff respondents on average agreed that the Division's programs and services are designed to address racial health disparities, the social determinants of health, promote health equity, and build the capacity of DFCH partners.

- **Staff's Personal Application of Key Concepts:** Most staff agreed that they had a strong understanding of racism and discussed racism as a root cause of health disparities. Slightly fewer staff agreed that they applied a health equity framework and perspective to their work.

- **Division Staff's Application of Key Concepts:** DFCH staff on average agreed that Division staff apply health equity principles and methods to their work, and understand racial health disparities. A few respondents disagreed that Division staff discuss racism as a root cause of racial health disparities.

- **Staff Health Equity Knowledge and Skills:** Most staff agreed that they used data to identify racial health disparities and read publications on health equity. Staff were less likely to agree that they research best practices or programs to reduce racial health disparities and promote health equity.

- **Health Equity Information Sources Used By Staff:** The most common sources staff agreed that they used as health equity resources were webinars and conferences. Management staff were significantly more likely to use conferences than non-management staff. Other staff within BFMCH are also a resource used by most respondents.

- **African American and Native American Cultural Awareness:** On average, staff agreed that they understood more shared cultural practices among African Americans than Native Americans. Staff were more likely to agree that they understood trust/distrust issues when accessing government services for both African Americans and Native Americans compared to 11 other shared cultural practices.

- **Community engagement with African Americans and Native Americans:** Staff responsible for developing programs, services and policies were more likely to agree or strongly agree that they engaged with the African American community than the Native American community (64% vs. 24%).

The organizational assessment provides DFCH staff perceptions on a variety of topics, and how those perceptions relate to health equity and racial health disparities. The results from this assessment will be used by PRIME staff to tailor future health equity trainings to the needs of DFCH staff. The results will also assist PRIME in identifying DFCH staff needs to better address health disparities in infant mortality.

OBJECTIVES

Members from the Practices to Reduce Infant Mortality through Equity (PRIME) project distributed an organizational assessment survey to staff in the Division of Family and Community Health in the Michigan Department of Health and Human Services' (MDHHS) Bureau of Family, Maternal and Child Health (BFMCH). Staff used the organizational assessment to identify strengths, challenges, and areas for growth related to the capacity of the Division and its staff to address and eliminate infant mortality disparities in Michigan.

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 organizations and health departments, local contractors, professional consultants and university partners.

METHODS

The original organizational assessment was developed in 2012 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 included representatives from BFMCH, MDHHS 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 also developed to be modified and replicated with staff in other divisions within BFMCH. Eventually it is hoped that the organizational assessment will be used with other Michigan Department of Health and Human Services Bureaus in Michigan and elsewhere which may be focused on addressing racial health disparities other than infant mortality. The original organizational assessment was developed for the Women, Infants and Children Division. The PRIME Intervention and Evaluation Workgroups used results from the original organizational assessment to create a shortened version with half the number of statements (49 vs. 100) to reduce respondent burden. This shortened organizational assessment was used with the Children's Special Health Care Services (CSHCS) Division.

In the summer of 2015, the PRIME Evaluation Workgroup adapted the shortened organizational assessment used for the CSHCS Division for the Division of Family and Community Health (DFCH). A member of the Evaluation Workgroup worked as a manager in DFCH and provided insight into appropriate statement phrasing and response options for DFCH. Table 1, shown on the next page shows the topic areas covered in the original organizational assessment used in the WIC Division, and the changes to topic areas in the next two iterations with the CSHCS Division and DFCH.

Table 1. Changes in Topic Areas of the Organizational Assessment by Division

Topic Area	WIC 100 Statements	CSHCS 49 Statements	DFCH 60 Statements
Demographics			
Race	X	X	X
Ethnicity		X	X
Job Title	X	X	X
Employment Status (Full-time, Permanent)	X	X	
Division Section			X
Health Equity Trainings			X
Length of Time in Division			X
Perception of Bureau Programs	X	X[1]	X[1,2,3]
Employee Engagement	X		
African American Cultural Competence	X	X[1,2]	X[2,3]
Native American Cultural Competence	X	X[1,2]	X[2,3]
Knowledge and Skills	X	X[1,2]	X[1,2,3]
Information Sources Used	X	X[1,2]	X
Bureau Support for Professional Development	X		
General Community Engagement	X		
African American Community Engagement	X	X[1,2,4]	X[2]
Native American Community Engagement	X	X[1,2,4]	X[2]
Self-Rated Application of Key Concepts	X		X[1,2]
Division's Application of Key Concepts	X	X[1,2]	X[2]

1. Statements removed from previous survey; 2. Statement(s) or response(s) reworded from previous survey; 3. Statement(s) added; 4. Topic areas merged

In order to adapt the Organizational Assessment for the needs of the Division many statements had slight alterations. There still remains, however, a core set of statements within certain topic areas completed by each group that can be used for within Bureau comparison. A table of changes made to the Organizational Assessment for DFCH is provided in Appendix A. The Evaluation Workgroup made changes only when necessary to make the Organizational Assessment fit the needs of DFCH and to clarify terms. The final DFCH Organizational Assessment is provided in Appendix B.

The organizational assessment was web-based and used Qualtrics software. The DFCH organizational assessment included 60 close-ended items and was designed to take about 15 minutes to complete. Participants could skip all statements except one statement required for a skip pattern pertaining to if their work role included developing programs, policies or services. All items, except for the demographic questions, had response options ranging from 1 = Strongly Disagree to 4 = Strongly Agree. Two topics provide the additional response option of "I Do Not Know," for when respondents are asked to provide factual information they may not know or for which the "I Do Not Know" response option provides useful information for analysis.

Data Collection

The DFCH Organizational Assessment began August 24th, 2015 and ended September 4th, 2015. The Director of DFCH sent a message to staff providing an overview of the PRIME project, future PRIME workshops and informing staff that they would be receiving an invitation to complete an organizational assessment from a staff member at the University of Michigan.

After the Director's e-mail went out to staff the University of Michigan staff member sent out an e-mail invitation through Qualtrics to staff e-mail addresses provided by DFCH administrative support. Each e-mail contained a unique survey link associated with the participant. The survey was confidential but not anonymous, and this was clearly communicated to participants in the e-mail invitations sent to DFCH staff. University of Michigan research staff tracked who had and had not completed the assessment through Qualtrics. Participants were able to return to an uncompleted assessment as often as needed. The UM research staff sent one reminder e-mail and one deadline extension e-mail through Qualtrics to non-respondents.

Only the University of Michigan staff member had access to staff's results so that no one within MDHHS knew who did or did not 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. The results from the DFCH Organizational Assessment are presented in the following pages in aggregate form to protect confidentiality of survey respondents.

PRIME staff provided the DFCH staff with nine business days to complete the organizational assessment. UM staff kept the organizational assessment open on Qualtrics for an additional 2 business days while they encouraged non-responders to complete the assessment. The deadline for DFCH could not be extended further due to a PRIME workshop occurring the next week and a national holiday. The Organizational Assessment as a baseline assessment needed to be completed before the PRIME workshop.

The PRIME organizational assessment will be used with other Divisions later in the PRIME project, and may be used as a tool to measure changes in staff perceptions over time.

Data Analysis

UM staff downloaded all respondent data from Qualtrics and transferred the data to the quantitative software program, SPSS 22. For each statement, UM staff calculated the number of respondents, average score, standard deviation, and the percentage of participants who selected each response category (i.e. Strongly Agree, Agree, etc.). In addition, UM staff calculated mean scores for several topic areas. All topic area statements prompted participants to provide self-rated assessments or personal perceptions of Division activities. The topic areas are as follows:

- Staff understanding of DFCH's priority to address racial health disparities and how their work contributes to that priority (2 statements)
- Staff perceptions of the Division's promotion of health equity in programs and services (4 statements)
- Staff's perception of the division's application of key concepts to reduce health disparities and staff's personal assessment of their application of key concepts to their work (4 statements for the Division and 4 statements for personal assessment)
- Self-assessment of the staff member's health equity knowledge and skills to assess their capacity to use data and other resources to reduce racial health disparities (4 statements)
- Health Equity information sources that staff use to gather information on racial health disparities and health equity (6 statements)
- Personal awareness of shared cultural practices among African Americans and Native Americans (12 statements for each population)
- Community engagement with key representatives within the African American and Native American populations (2 statements)

Each topic area was composed of two to 12 items. These average scores corresponded to the average level of agreement staff had for the topic area, and ranged from 1.0 (low agreement) to 4.0 (high agreement). UM staff also investigated if responses varied among different groups: (A) administration/ management staff and non-management staff, (B) race groups, and (C) groups determined by length of time working at DFCH. UM staff used independent group t-tests for comparisons of two groups for all topic areas, and each individual statement. UM staff

also used Analysis of Variance (ANOVA) and F tests for comparisons involving more than two groups. UM staff found a few significant differences between the groups and those few significant differences are listed in the summary for each topic. More in-depth results of the DFCH Organizational Assessment are provided in the following pages.

Next Steps

The results from this organizational assessment will provide PRIME staff with insight on how to best tailor the health equity trainings for DFCH. The results will also assist PRIME in identifying DFCH staff needs to better address health disparities in infant mortality. In addition, the organizational assessment provides an initial measurement for the PRIME intervention in DFCH. It should be noted that some DFCH staff had attended Health Equity Trainings prior to this baseline Organizational Assessment. Eighty-six percent of DFCH staff who responded to the Organizational Assessment attended the Health Equity Social Justice Workshop. Staff in DFCH had the opportunity to attend a HESJ workshop in August 2011 and in February 2015. There were also DFCH staff who attended the Undoing Racism Workshop in 2011 (62.9%) and the Native American History, Culture and Core Values workshop in 2014 (22.9%). Future Organizational Assessments should take into account this previous training when interpreting these baseline results with future Organizational Assessment iterations. PRIME staff will share the results of the DFCH Organizational Assessment with DFCH staff.

FINDINGS

Participant Demographics

Thirty-six of the 66 staff members (54.5%) in the Division of Family and Community Health (DFCH) participated in the DFCH Organizational Assessment between August 24th and September 4th, 2015. Eighty-six percent completed the survey in 20 minutes or less, and 82.8% completed in 15 minutes or less. The DFCH staff respondent's self-reported racial and ethnic background are listed in Table 2. Survey participants also reported their job classification (Table 3), the DFCH section they worked in (Table 4), length of time working for DFCH (Table 5), participation in PRIME workshops or other health equity trainings (Table 6) and the total number of PRIME workshops attended (Table 7).

Table 2. Count and Percent of Participant race/ethnicity

Race/ethnicity	n	%
White (includes Hispanic, and Non-Hispanic)	28	87.5
Black, African-American (Non-Hispanic)	3	9.4
Biracial	1	3.1
Asian	0	0.0
Pacific Islander	0	0.0
Native American or Alaska Native	0	0.0
Other (Hispanic and Non-Hispanic)	0	0.0
Latino	0	0.0
Arab/Chaldean	0	0.0

Table 3. Count and Percent of Participant's by Job Classification

Description	n	%
Administration/Management	5	15.6
Administrative Support	3	9.4
Program Analyst/Coordinator/Specialist/Consultant	24	75.0

Table 4. Count and Percent of Participant's by DFCH Section

Description	n	%
Child & Adolescent and School Health Section	11	34.4
Women and Maternal Health Section	12	37.5
Early Childhood Health Section	9	28.1

Table 5. Count and Percent of Length of Work in the Division of Family and Community Health

Description	n	%
Less than 1 year	2	5.9
1-3 years	6	17.6
4-6 years	6	17.6
7-9 years	8	23.5
10-12 years	6	17.6
13-15 years	3	8.8
More than 15 years	3	8.8

Table 6. Count and Percent of Staff Reported Attendance at Health Equity Trainings

Trainings	n	%*
No Training	2	5.7
Undoing Racism	22	62.9
Health Equity Social Justice	30	85.7
Native American History, Culture and Core Values	8	22.9
Other Health Equity Trainings	20	57.1

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

Participants who reported attending Other Health Equity Trainings that did not include the PRIME sponsored trainings (Undoing Racism, Health Equity Social Justice Workshop, and the Native American History, Culture and Core Values Workshop) listed the following trainings:

- Webinars
- W.K. Kellogg Training
- Summit on Race and Inclusion
- Brown Bags
- Presentations
- Workshops at conferences
- Division of Family and Community Health Training
- Health Equity College Course
- Various

Table 7. Count and Percent of Staff Reported Attendance at PRIME Sponsored Trainings

Number of PRIME Training(s)	n	%
No PRIME Trainings	3	8.6
1	10	28.6
2	16	45.7
3	6	17.1

Average Topic Area Ratings

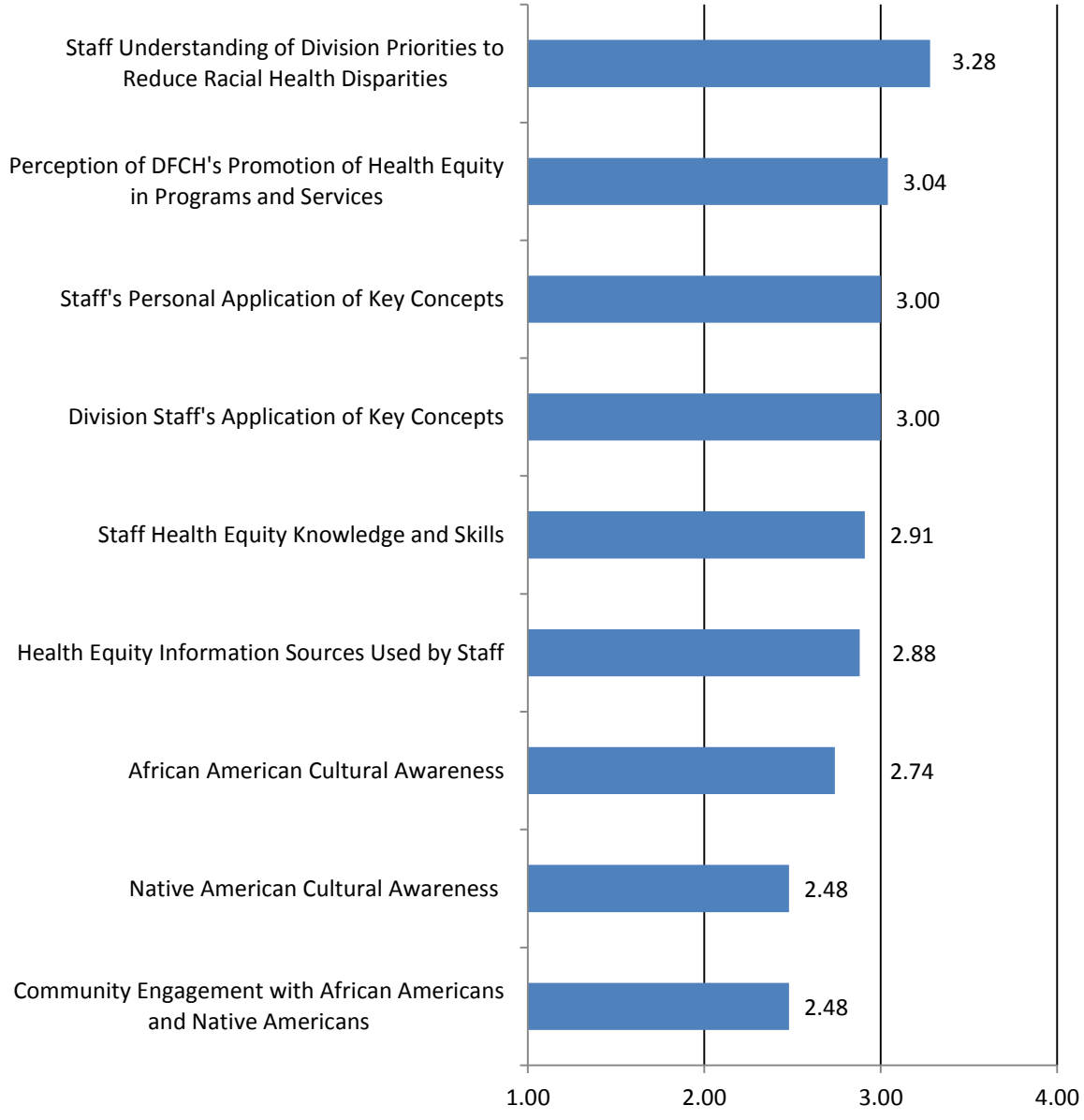
There were 9 different topic areas addressed within the DFCH Organizational Assessment. These topic areas contained between two to 12 statements. All topic area statements prompted participants to provide self-rated assessments or personal perceptions of Division activities. The topic areas are as follows:

- **Staff Understanding of Division Priorities to Reduce Racial Health Disparities:** Understanding of the Division's priority to reduce racial health disparities and how the survey respondent's work role was related to that priority (2 statements).
- **Perception of DFCH's Promotion of Equity in Programs and Services** and whether they promote health equity, address racial health disparities and use frameworks to achieve these changes (4 statements).
- **Staff's Personal Application of Key Concepts:** The survey respondent's personal application of key concepts to reduce health disparities (4 statements).
- **Division Staff's Application of Key Concepts:** Perception of other division staff's application of key concepts to reduce health disparities (4 statements).
- **Staff Health Equity Knowledge and Skills** to use data and other resources to reduce racial health disparities and health inequities (4 statements).
- **Health Equity Information Sources Used by Staff**: Resources that staff use to gather information on racial health disparities and health equity (6 statements).
- **African American and Native American Cultural Awareness:** Self-rated awareness of shared cultural practices among African American and Native American populations (12 statements for each population: 2 separate topics).
- **Community Engagement with African Americans and Native Americans**: State staff's engagement with key representatives in the African American and Native American community to develop new services, programs or policies (2 statements).

Average scores could range from 1 to 4 (1= Strongly Disagree, 2=Agree, 3=Disagree, 4=Strongly Agree), with higher scores representing more agreement for statements within a topic/subtopic. The average scores by topic area are listed on the next page in Figure 1. The topics "Perception of DFCH's Promotion of Equity in Programs and Services" and "Division Staff's Application of Key Concepts" contained the response option "I Do Not Know". Staff who did not feel comfortable assessing the activities within the Division may not be aware of these DFCH functions. During future iterations of the Organizational Assessment, the number of individuals responding "I Do Not Know" could be compared to the results from this iteration of the Organizational Assessment to see if more people are able to select a level of agreement. Statements that contained the response option, "I Do Not Know" did not include the "I Do Not Know" responses in the calculation of the average agreement. The count and percent of individuals who used the response option, "I Do Not Know" are listed in Tables 9 and 11.

DFCH respondents on average agree that they are aware that the Division is focusing on reducing racial health disparities, and that they personally are using key concepts in their work along with other division staff to address racial health disparities. None of the topic areas had significantly higher scores compared to other topic areas. Average agreement declined for topic areas reflecting cultural awareness and application of skills and knowledge such as using multiple sources to learn about racial health disparities and health equity.

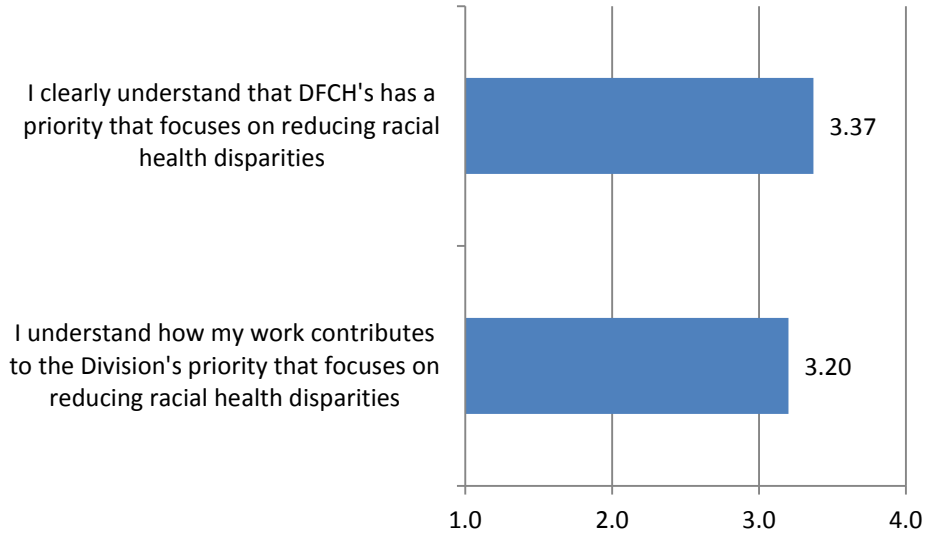
Figure 1. Average Participant Response Score by Topic Area (1= Strongly Disagree, 4=Strongly Agree)



Staff Understanding of Division Priorities to Reduce Racial Health Disparities

This topic area assesses respondents' understanding of the Division of Family and Community Health's priority to reduce racial health disparities, along with the respondent's understanding of how their work contributes to that priority. The two statements were framed as "Indicate your level of agreement with the following statements." Average scores could range from 1 to 4 (1= Strongly Disagree, 2=Agree, 3=Disagree, 4=Strongly Agree), with higher scores representing more agreement for statements within a topic/subtopic.

Figure 2. Average Participant Response Score by Item Regarding the Staff's Understanding of the Division's Priorities to Reduce Racial Health Disparities (1= Strongly Disagree, 4=Strongly Agree)



- The average score for all statements within this subtopic was 3.28 (SD: 0.45).
- Average scores from administration/management staff did not significantly differ from average scores of non-management staff.
- There were no significant differences in among White respondents and Black/ African American respondents.
- Staff working 10-12 years were significantly more likely to agree that they understand DFCH's priority to reduce racial health disparities than staff working less than 3 years.
- This section received the highest overall average score among DFCH staff.
- The vast majority of staff agree that they understand DFCH's priority to reduce racial health disparities and that they understand how their work contributes to that priority.

Table 8. Count, Average Rating, and Percentage of Participants by Response Categories in Regards to the Staff's Understanding of the Division's Priorities to Reduce Racial Health Disparities

As part of my job:	n	Average (SD)	Strongly Disagree	Disagree	Agree	Strongly Agree
I clearly understand that DFCH's has a priority that focuses on reducing racial health disparities	30	3.37 (0.49)	0.0%	0.0%	63.3%	36.7%
I understand how my work contributes to the Division's priority that focuses on reducing racial health disparities	30	3.20 (0.48)	0.0%	3.3%	73.3%	23.3%

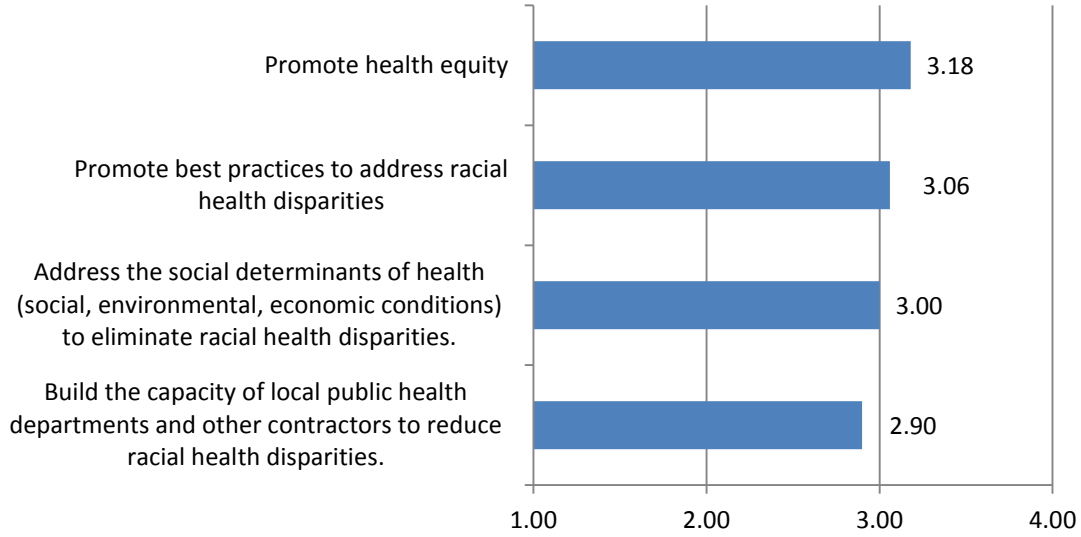
Note: 1-4 scale, with 1 indicating strongly disagree and 4 indicating strongly agree.

A majority of staff agreed or strongly agreed that they understood DFCH's priority to reduce racial health disparities. Similarly, most staff agreed or strongly agreed that they understood how their work contributes to the Division's priority of reducing racial health disparities.

Perception of the Division of Family and Community Health's Promotion of Health Equity in Programs and Services

This set of statements assessed staff perceptions of whether DFCH's programs and services are designed to address racial health disparities, the social determinants of health, promote health equity, and build the capacity of DFCH partners. The statements were framed as "Indicate your level of agreement with each of the following statements: The Division's programs and services are designed to…". Average scores could range from 1 to 4 (1= Strongly Disagree, 2=Agree, 3=Disagree, 4=Strongly Agree), with higher scores representing more agreement for statements within a topic/subtopic. This topic also had the response option of "I Do Not Know." Responses of "I Do Not Know" were coded as missing when calculating averages.

Figure 3. Average Participant Response Score by Item Regarding the Participant's Perception of DFCH's Promotion of Health Equity in Programs and Services (1= Strongly Disagree, 4=Strongly Agree)

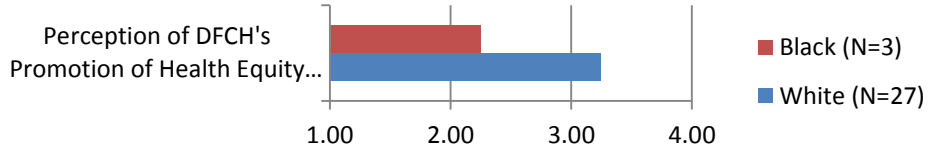


- The average score for all statements within this topic area was 3.04 (SD: 0.62).
- Average scores from administration/management staff did not significantly differ from average scores of non-management staff.
- Average scores among staff working different lengths of time at DFCH did not significantly differ.
- White respondents were significantly more likely to agree to each statement compared to Black/African American respondents (See Figures 4 and 5).

Perception of the Division of Family and Community Health's Promotion of Health Equity in Programs and Services Response by Race

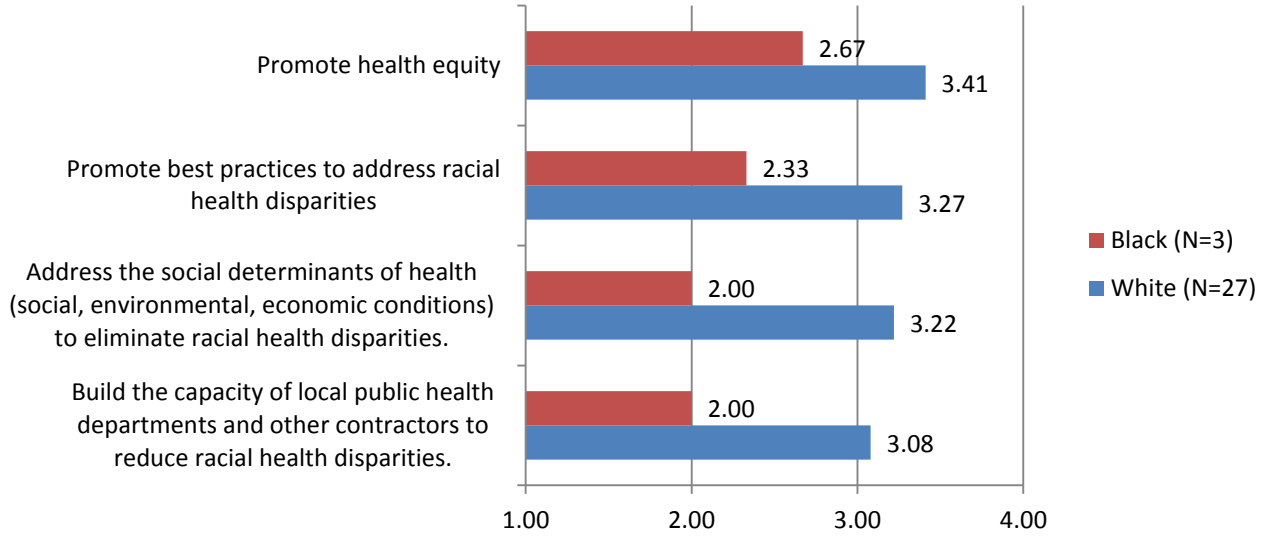
White and Black/African American participants had significantly different average response scores for the overall topic area, "Perception of the Division of Family and Community Health's Promotion of Health Equity in Programs and Services" and each item that comprised the Perception of the Division of Family and Community Health's Promotion of Health Equity in Programs and Services topic area. These response differences are presented below.

Figure 4. Participant Average Response Score by Respondents' Race Group Regarding the Participant's Overall Perception of DFCH's Promotion of Health Equity in Programs and Services (1= Strongly Disagree, 4=Strongly Agree)



The topic area, "Perception of the Division of Family and Community Health's Promotion of Health Equity in Programs and Services", included items regarding the Division's promotion of health equity, the Division's promotion of best practices to address racial health disparities, if the Division's programs and services addressed the social determinants of health and built the capacity of local public health departments and other contractors to reduce racial health disparities. The average response score for the topic area, "Perception of the Division of Family and Community Health's Promotion of Health Equity in Programs and Services" is comprised of the average of all four items within the topic area. Participants who identified themselves as White were more likely on average to agree that the Division promotes health equity in programs and services compared to Black/African American participants. It should be noted that the sample size of Black/African American participants was small (N= 3). It is not appropriate to generalize this result to all Black/African American staff within DFCH. However, the Evaluation Workgroup wanted to highlight these results due to the significant difference in responses between race groups to raise awareness of potential staff differences to DFCH leadership.

Figure 5. Average Participant Response Score by Respondents' Race Group Regarding the Participant's Perception of DFCH's Promotion of Health Equity in Programs and Services (1= Strongly Disagree, 4=Strongly Agree)



Black/African American respondents were less likely to agree than White respondents in all four items regarding the Division's promotion of health equity in programs and services. It may be helpful in future iterations of the organizational assessment to provide additional statements within the assessment to better understand these differences. The Division may find it beneficial to investigate these differences, perhaps through small group discussions. One must be careful in how they interpret the results; it would be misguided to apply these averages to one group of respondents without recognizing individual differences within a group. It is also important with a smaller group of respondents to maintain confidentiality of individual responses.

Table 9. Count, Average Rating, and Percentage of Participants by Response Categories in Regards to the Participant's Perception of DFCH's Promotion of Health Equity in Programs and Services

The DFCH's programs and services are designed to:	n	Average (SD)	Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know
Promote health equity	34	3.18 (0.77)	5.9%	2.9%	55.9%	32.4%	2.9%
Promote best practices to address racial health disparities	35	3.06 (0.70)	2.9%	11.4%	57.1%	22.9%	5.7%
Address the social determinants of health	35	3.00 (0.70)	2.9%	14.3%	60.0%	20.0%	2.9%
Build the capacity of local public health departments and other contractors to reduce racial disparities	35	2.90 (0.87)	2.9%	17.1%	54.3%	14.3%	11.4%

Note: 1-4 scale, with 1 indicating strongly disagree and 4 indicating strongly agree.

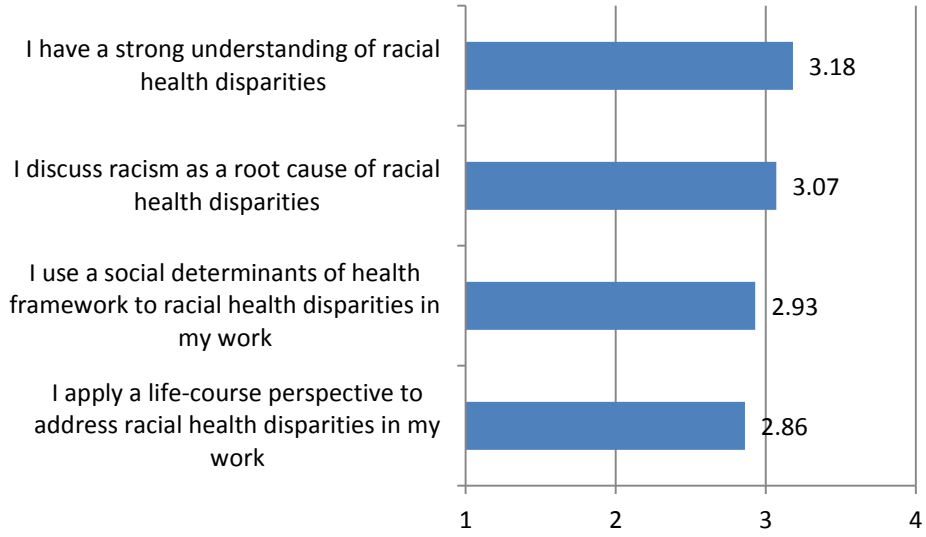
This is one of two topic areas which had the response option of "Do Not Know." Most participants felt knowledgeable enough about the Division's programs and services that they could answer statements about them, and did not use this response option. The statement with the highest response of 'Do Not Know' reflected a more specific action of building capacity with a specified group rather than the other three more broad statements. Even though more individuals selected 'Do Not Know' for this item, it was still a small subset of the respondents (4 out of 33).

Staff tended to agree or strongly agree that DFCH's programs and services focus on health equity and addressing racial health disparities. Almost all participants agreed or strongly agreed that the Division's programs and services are designed to promote health equity. A select few individuals disagreed with the other comments (3-5 respondents), but again the majority agreed.

Staff's Personal Application of Key Concepts

After evaluating other Division staff, participants were asked to indicate their level of agreement on their personal application of key concepts. Participants received the same statements to rate themselves as they had rating other Division staff members. The statements were framed as "Indicate your level of agreement with each of the following statements". Average scores could range from 1 to 4 (1= Strongly Disagree, 2=Agree, 3=Disagree, 4=Strongly Agree), with higher scores representing more agreement for statements within a topic/subtopic.

Figure 6. Average Participant Response Score by Item Regarding Staff's Personal Application of Key Concepts (1= Strongly Disagree, 4=Strongly Agree)



- The average score for all statements within this subtopic area was 3.00 (SD: 0.44).
- Average scores from administration/management staff did not significantly differ from average scores from non-management staff.
- There were no significant differences in among White respondents and Black/African American respondents.
- Average scores among staff working different lengths of time at DFCH did not significantly differ.

Table 10. Count, Average Rating, and Percentage of Participants by Response Categories in Regards to Staff's Personal Application of Key Concepts

Item	n	Average (SD)	Strongly Disagree	Disagree	Agree	Strongly Agree
I have a strong understanding of racial health disparities	28	3.18 (0.48)	0.0%	3.6%	75.0%	21.4%
I discuss racism as a root cause of racial health disparities	29	3.07 (0.59)	0.0%	13.8%	65.5%	20.7%
I apply a social determinants of health framework to address racial health disparities in my work	30	2.93 (0.58)	0.0%	20.0%	66.7%	13.3%
I apply a life-course perspective to address racial health disparities in my work	29	2.86 (0.52)	0.0%	20.7%	72.4%	6.9%

Note: 1-4 scale, with 1 indicating strongly disagree and 4 indicating strongly agree.

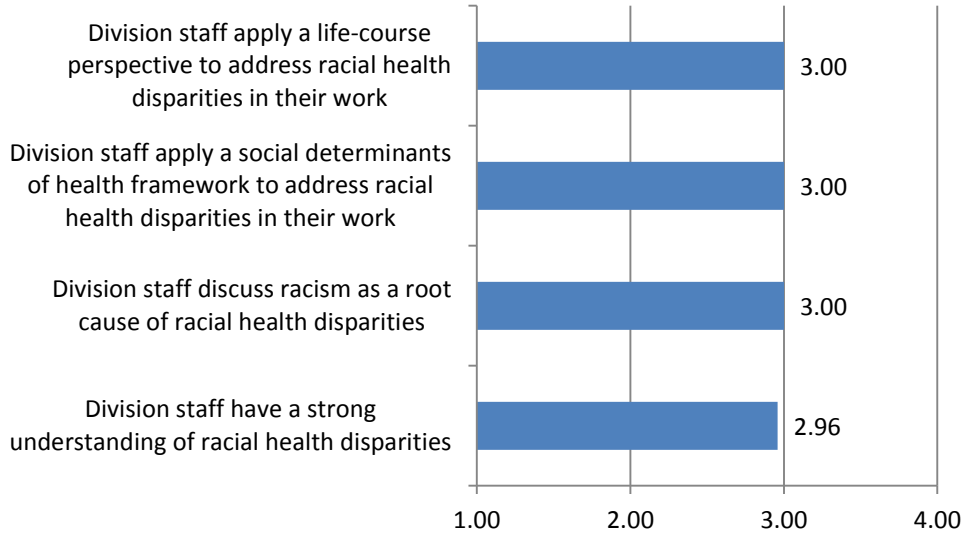
DFCH staff respondents' were more likely to agree in their self-assessment of personally having a strong understanding of racial health disparities compared to ratings of other DFCH staff's understanding (3.18 vs. 2.96). It may be beneficial to discuss with staff their personal understanding of racial health disparities to see how people understand this topic. An open discussion may build a more cohesive common understanding at the Division level. Discussion may also provide opportunities to identify additional training needs.

DFCH staff respondents' self-assessment compared to average ratings of Division staff that they personally applied a life-course perspective (2.86 vs. 3.00) or a social determinants of health framework to their work (2.93 vs. 3.00) was slightly lower than the average agreement as it related to Division staff. These differences may reflect that when assessing their personal work, DFCH staff may recognize that even though they apply a life-course perspective or social determinants of health framework to their work there may be more they could do. These differences are small, so this may reflect the views of only a few individuals.

Division Staff's Application of Key Concepts

Staff rated other DFCH staff's application of health equity principles and methods to their work, along with their understanding of racial health disparities. The statements were framed as "Indicate your level of agreement with each of the following statements regarding division staff…". Average scores could range from 1 to 4 (1= Strongly Disagree, 2=Agree, 3=Disagree, 4=Strongly Agree), with higher scores representing more agreement for statements within a topic/subtopic. This topic also had the response option of "I Do Not Know." Responses of "I Do Not Know" were coded as missing when calculating averages.

Figure 7. Average Participant Response Score by Item Regarding Division Staff's Application of Key Concepts (1= Strongly Disagree, 4=Strongly Agree)

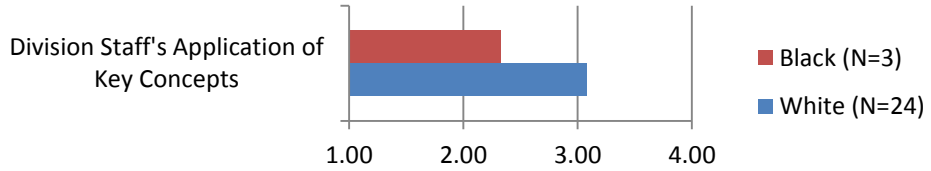


- The average score for all statements within this subtopic area was 3.00 (SD: 0.53).
- Average scores from administration/management staff did not significantly differ from average scores of non-management staff.
- White respondents were significantly more likely to agree on average that Division staff apply key concepts and that Division staff apply a life-course perspective to their work and use a social determinants of health framework compared to Black/African American respondents (See Figures 8 and 9).
- Average scores among staff working different lengths of time at DFCH did not significantly differ.
- There was little variation in the average scores within this section of statements (2.96-3.00), and on average staff agreed that division staff applied key concepts to address racial health disparities.

Division Staffs' Application of Key Concepts Participant Response by Race

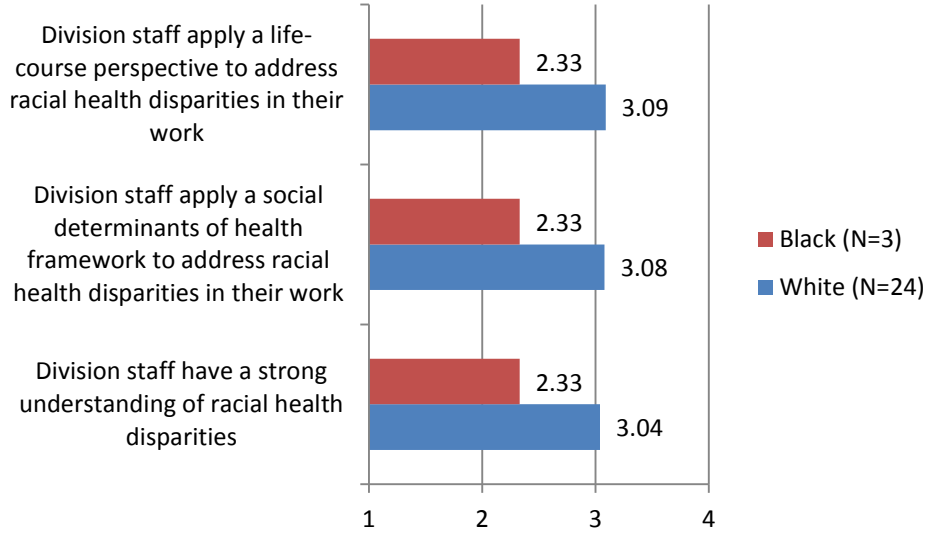
White and Black/African American participants had significantly different average response scores for the overall topic area, "Application of Key Concepts" and each item that comprised the Application of Key Concepts topic area. These response differences are presented below.

Figure 8. Average Participant Response Score by Respondents' Race Group Regarding the Division Staff's Application of Key Concepts (1= Strongly Disagree, 4=Strongly Agree)



The topic area, "Application of Key Concepts", included items regarding staff application of a life course perspective to their work, staff application of a social determinants of health framework to their work, that staff discussed racism as a root cause of racial health disparities and that staff have a strong understanding of racism. The average response score of all four items is the average response score for the topic area, "Application of Key Concepts." Participants who identified themselves as White were more likely on average to agree that division staff apply key concepts compared to Black/African American participants. It should be noted that the sample size of Black/African American participants was small (N= 3). It is not appropriate to generalize this result to all Black/African American staff within DFCH. However, the Evaluation Workgroup wanted to highlight these results due to the significant difference in responses between race groups to raise awareness of potential staff differences to DFCH leadership.

Figure 9. Average Participant Response Score by Respondents' Race Group Regarding the Division Staff's Application of Key Concepts (1= Strongly Disagree, 4=Strongly Agree)



White respondents were more likely to agree that division staff applied all four key concepts listed within the "Application of Key Concepts" topic area than Black/African American respondents. Similar to the perception of DFCH's promotion of health equity in their programs and services, it may be beneficial to discuss this difference and why it exists. Discussing these results may provide additional ideas for application of key concepts and an opportunity to solidify, as a department, expectations for a culture that understands, discusses and addresses health equity issues.

Table 11. Count, Average Rating, and Percentage of Participants by Response Categories in Regards to Division Staff's Application of Key Concepts

Item	n	Average (SD)	Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know
Division staff apply a life-course framework to address racial health disparities in their work	30	3.00 (0.56)	0.0%	13.3%	63.3%	13.3%	10.0%
Division staff apply a social determinants of health perspective to address racial health disparities in their work	30	3.00 (0.61)	0.0%	16.7%	60.0%	16.7%	6.7%
Division staff discuss racism as a root cause of racial health disparities	30	3.00 (0.72)	0.0%	23.3%	46.7%	23.3%	6.7%
Division staff have a strong understanding of racial health disparities	30	2.96 (0.58)	0.0%	16.7%	63.3%	13.3%	6.7%

Note: 1-4 scale, with 1 indicating strongly disagree and 4 indicating strongly agree.

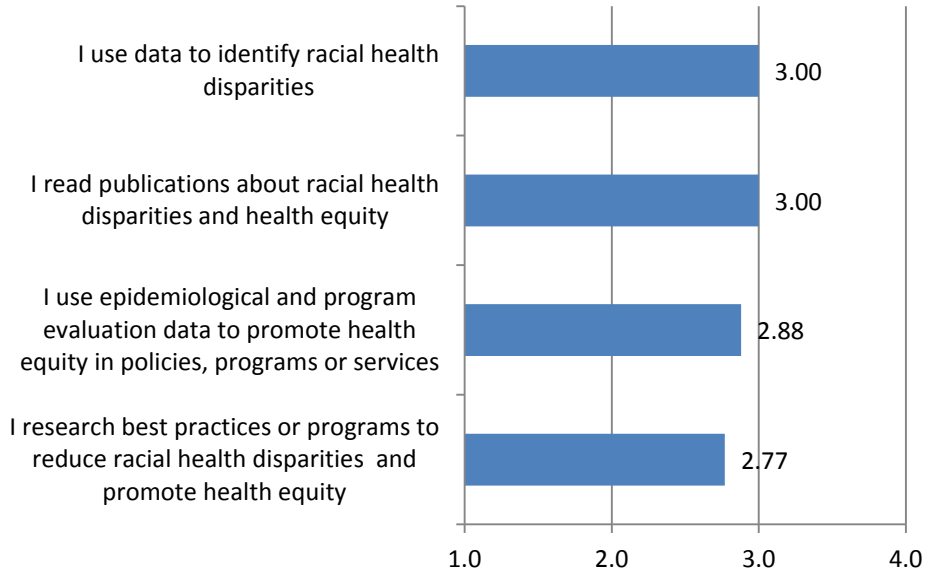
Most respondents are aware of other Division staff's application of key concepts and did not use the 'do not know' option.

Almost a quarter of respondents disagreed that Division staff discuss racism as a root cause of racial health disparities. This item had the highest rate of disagreement out of the four items. Yet this item also had close to a quarter of respondents strongly agree, which is the highest rate of strongly agree out of the four items. This may indicate different sections within the Division discussing racism more frequently.

Staff Health Equity Knowledge and Skills

This set of statements 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. In order to assess participants' capacity to use data and other published resources, they were asked to indicate their level of agreement with the statements listed in Figure 10. Average scores could range from 1 to 4 (1= Strongly Disagree, 2=Agree, 3=Disagree, 4=Strongly Agree), with higher scores representing more agreement for statements within a topic/subtopic.

Figure 10. Average Participant Response Score by Item Regarding Staff Health Equity Knowledge and Skills (1= Strongly Disagree, 4=Strongly Agree)



- The average score for all statements within this topic area was 2.91 (SD: 0.41).
- Average scores from administration/management staff did not significantly differ from average scores of non-management staff.
- There were no significant differences in among White respondents and Black/African American respondents.
- Average scores among staff working different lengths of time at DFCH did not significantly differ.

Table 12. Count, Average Rating, and Percentage of Participants by Response Categories in Regards to Staff Health Equity Knowledge and Skills

Item	n	Average (SD)	Strongly Disagree	Disagree	Agree	Strongly Agree
I use data to identify racial health disparities	29	3.00 (0.46)	0.0%	10.3%	79.3%	10.3%
I read publications about racial health disparities and health equity	29	3.00 (0.66)	3.4%	10.3%	69.0%	17.2%
I use epidemiological and program evaluation data to promote health equity in policies, programs or services	26	2.88 (0.43)	0.0%	15.4%	80.8%	3.8%
I research best practices or programs to reduce racial health disparities and promote health equity	26	2.77 (0.59)	0.0%	30.8%	61.5%	7.7%

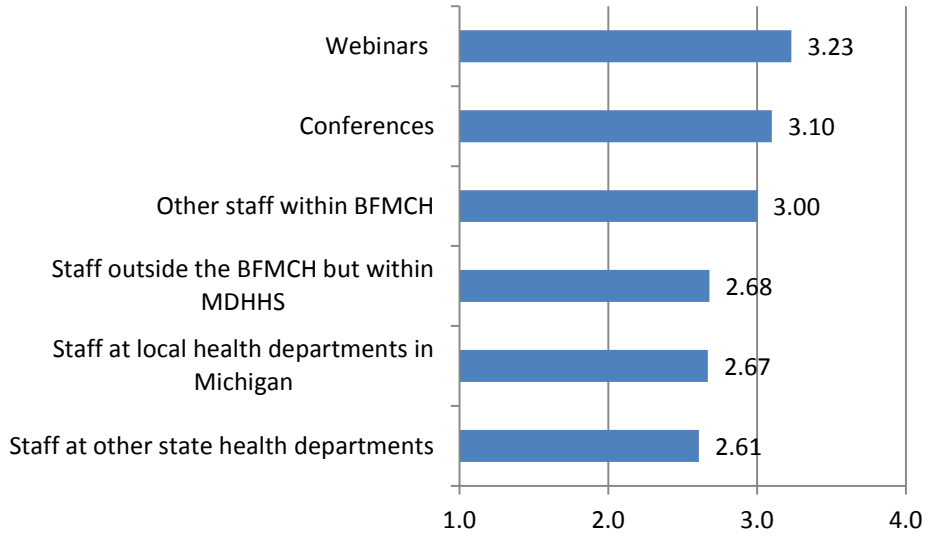
Note: 1-4 scale, with 1 indicating strongly disagree and 4 indicating strongly agree.

Two of the statements in this topic area were asked slightly differently depending on the respondent's work responsibilities. Participants answered a statement on the survey regarding their work role and if it included developing programs, practices or services. Participants who responded no were asked to rate their agreement to the statements as the statement related to other Division staff who were responsible for development of programs, practices or services. Only those who rated themselves are included in the table above. The responses between self-rated assessment and assessment of others in the division on the above items did not significantly differ.

Health Equity Information Sources Used by Staff

Statements in this section ask participants what type of resources they use to gather information about racial health disparities. The statements were framed as "Indicate your level of agreement with each of the following statements. To do my job, I use information about racial health disparities from…". Average scores could range from 1 to 4 (1= Strongly Disagree, 2=Agree, 3=Disagree, 4=Strongly Agree), with higher scores representing more agreement for statements within a topic/subtopic.

Figure 11. Average Participant Response Score by Item Regarding Health Equity Information Sources Used by Staff (1= Strongly Disagree, 4=Strongly Agree)



- The average score for all statements within this subtopic area was 2.88 (SD: 0.48).
- Administrators and management staff are significantly more likely to agree that they use conferences as a source of information compared to non-administration/management staff.
- There were no significant differences among White respondents and Black/African American respondents.
- Average scores among staff working different lengths of time at DFCH did not significantly differ.

Table 13. Count, Average Rating, and Percentage of Participants by Response Categories in Regards to Health Equity Information Sources Used by Staff

To do my job, I use information about racial health disparities from:	n	Average (SD)	Strongly Disagree	Disagree	Agree	Strongly Agree
Webinars	31	3.23 (0.62)	0.0%	9.7%	58.1%	32.3%
Conferences	30	3.10 (0.66)	0.0%	16.7%	56.7%	26.7%
Other staff within BFMCH	31	3.00 (0.68)	3.2%	12.9%	64.5%	19.4%
Staff outside the BFMCH but within MDHHS	31	2.68 (0.70)	3.2%	35.5%	51.6%	9.7%
Staff at local health departments in Michigan	30	2.67 (0.66)	0.0%	43.3%	46.7%	10.0%
Staff at other state health departments	31	2.61 (0.67)	0.0%	48.4%	41.9%	9.7%

Note: 1-4 scale, with 1 indicating strongly disagree and 4 indicating strongly agree.

Most participants agreed that they used professional resources (ie. Conferences and webinars) to learn about racial health disparities. Staff were less likely to use information from staff outside of the Michigan Department of Health and Human Services. Webinars may be a more convenient method for staff to learn about racial health disparities hence the higher agreement. Many DFCH staff are members of outside organizations that provide webinars on health equity. Webinars and other content sent through these agencies (e.g. HRSA, Office of Minority Health and Health Disparities, American Public Health Association) to subscribed DFCH staff are commonly shared with other DFCH staff.

Staff were less likely to agree that they used local health departments in Michigan as an information source to learn about racial health disparities. There are local health departments within Michigan that have been working on health equity issues before the PRIME project began. These local health departments may be a good resource due to their experience and knowledge of health equity. Other local health departments may also have health equity information that could help Michigan Department of Health and Human Services staff.

Managers were more likely to say that they used conferences as a method to get information about racial health disparities. Although managers and staff both attend conferences, managers may attend more conferences due to their role on a project.

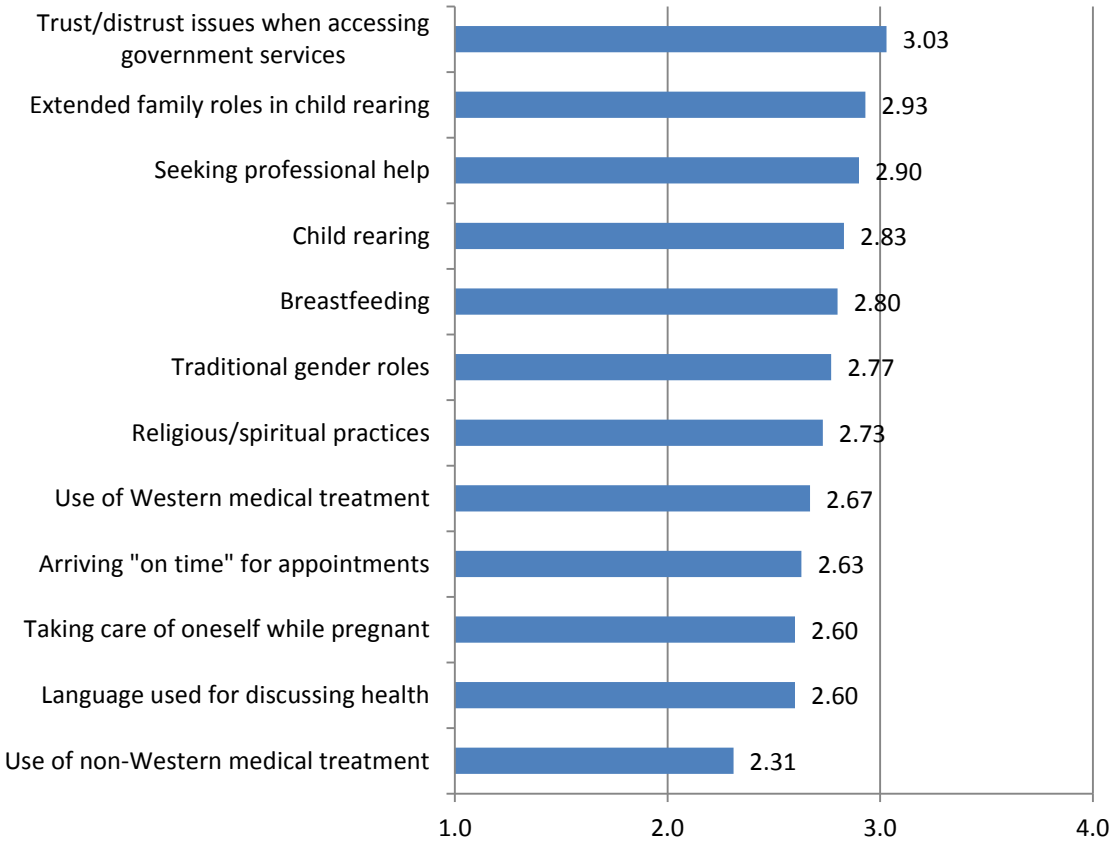
Awareness of Shared Cultural Practices

This topic includes two subsections assessing staff members' self-rated awareness of how a shared culture affects different aspects of African Americans' and Native Americans' lives, respectively.

African American Cultural Awareness

African American Cultural Awareness was measured by asking 12 statements assessing staff members' self-rated understanding of how culture affects different aspects of African Americans' lives. Statements were framed as, "I am aware of 'shared cultural norms' among African Americans regarding…" with 12 different practices (see the left side of Figure 12 for listed practices). Average scores could range from 1 to 4 (1= Strongly Disagree, 2=Agree, 3=Disagree, 4=Strongly Agree), with higher scores representing more agreement for statements within a topic/subtopic.

Figure 12. Average Participant Response Score by Item Regarding Participant Self-Rated Understanding of African American Culture on Life Practices (1= Strongly Disagree, 4=Strongly Agree)

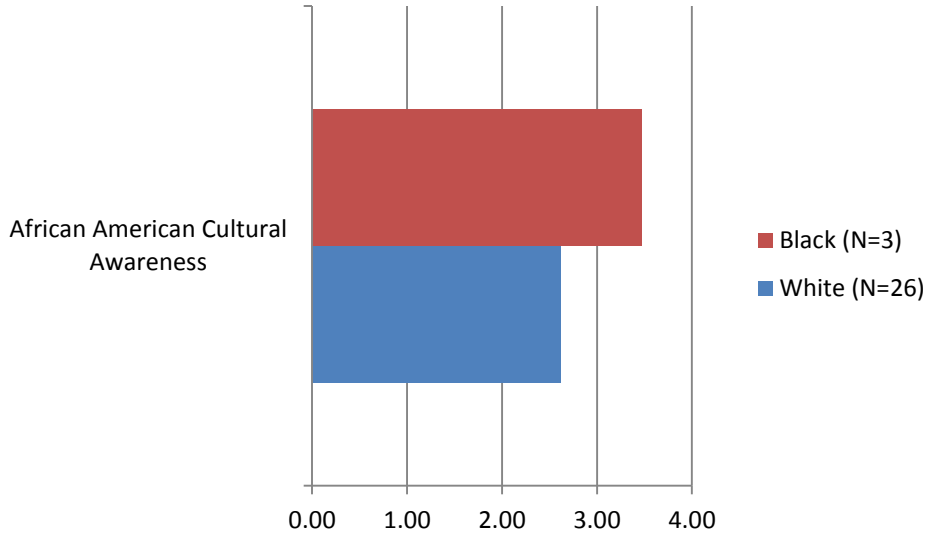


- The average score for all African American Cultural Awareness statements was 2.74 (SD: 0.42)
- Average scores from administration/management staff did not significantly differ from average scores of non-management staff.
- Black/African American respondents were significantly more likely to agree that they were aware of child rearing, seeking professional help, language used for discussing health, extended family roles in child rearing, arriving "on time" for appointments, use of Western medical treatment, breastfeeding, traditional gender roles, and use of non-Western medical treatment in African American shared culture than White respondents (See Figures 13 and 14).
- Average scores among staff working different lengths of time at DFCH did not significantly differ.

Understanding of African American Culture on Life Practices Participant Response by Race

White and Black/African American participants had significantly different average response scores for the overall topic area, "Understanding of African American Culture on Life Practices" and 9 of the 12 items that comprised the Understanding of African American Culture on Life Practices topic area. These response differences are presented below.

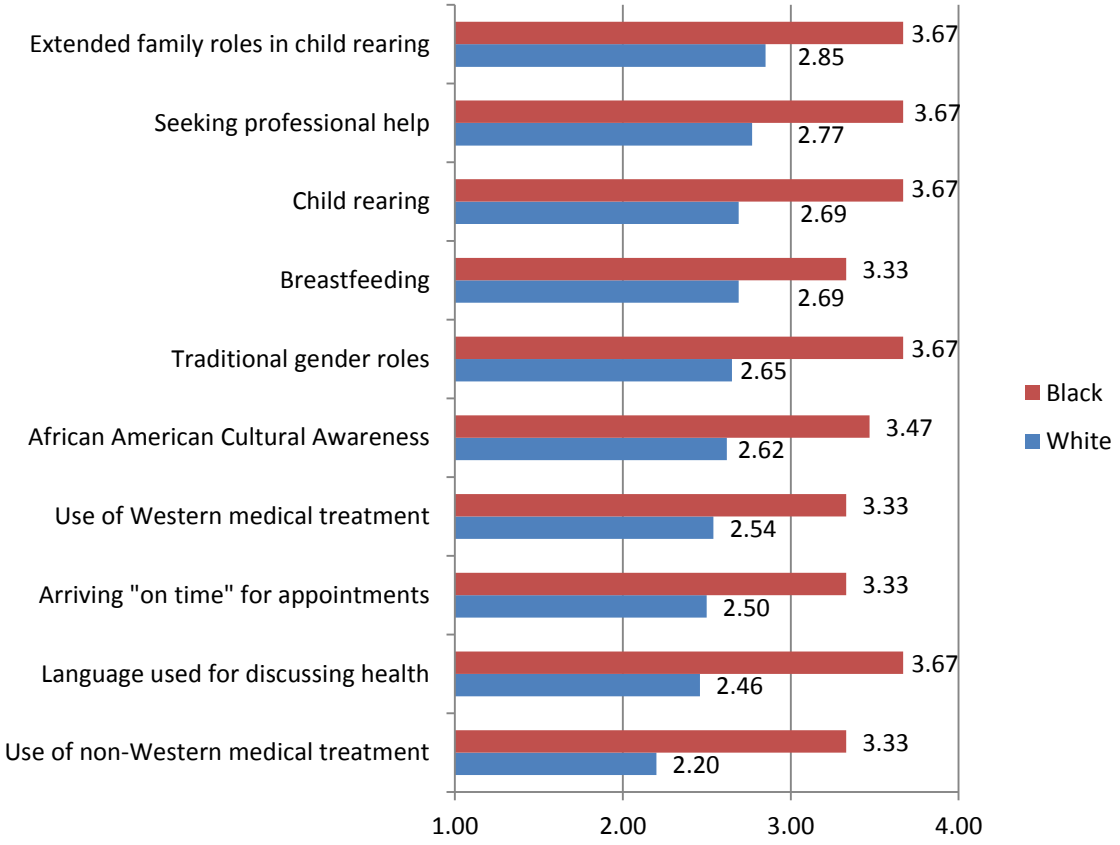
Figure 13. Average Participant Response Score by Item Regarding Participant's Overall Self-Rated Understanding of African American Culture on Life Practices by Race (1= Strongly Disagree, 4=Strongly Agree)



The topic area, "Understanding of African American Culture on Life Practices", included 12

items that may be influenced by cultural practices. The average response score of all 12 items is the average response score for the topic area, "Understanding of African American Culture on Life Practices." Participants who identified themselves as Black/African American were more likely on average to agree that they had an understanding of African American culture on life practices compared to White participants.

Figure 14. Average Participant Response Score by Item Regarding Participant Self-Rated Understanding of African American Culture on Life Practices by Race (1= Strongly Disagree, 4=Strongly Agree)



Black/African American respondents were more likely to agree that they had awareness of 9 out of 12 items that may be influenced by cultural practices shared by African Americans compared to White respondents. It is important that staff understand the balance between understanding shared practices versus conforming to stereotypes. Guided discussions that open communication may be helpful to increase understanding and awareness of shared cultural practices within African American communities. This may be particularly helpful for those who develop programs, policies and services that impact African Americans.

Table 14. Count, Average Rating, and Percentage of Participants by Response Categories in Regards to Participant Self-Rated Understanding of African American Culture on Life Practices

I understand how culture impacts African Americans' lives, such as:	n	Average (SD)	Strongly Disagree	Disagree	Agree	Strongly Agree
Trust/distrust issues when accessing government services	30	3.03 (0.62)	0.0%	16.7%	63.3%	20.0%
Extended family roles in child rearing	30	2.93 (0.45)	0.0%	13.3%	80.0%	6.7%
Seeking professional help	30	2.90 (0.61)	0.0%	23.3%	63.3%	13.3%
Child-rearing	30	2.83 (0.65)	0.0%	30.0%	56.7%	13.3%
Breastfeeding	30	2.80 (0.55)	0.0%	26.7%	66.7%	6.7%
Traditional gender roles	30	2.77 (0.63)	0.0%	33.3%	56.7%	10.0%
Religious/spiritual practices	30	2.73 (0.74)	3.3%	33.3%	50.0%	13.3%
Use of Western medical treatment	30	2.67 (0.66)	3.3%	33.3%	56.7%	6.7%
Arriving "on time" for appointments	30	2.63 (0.72)	3.3%	40.0%	46.7%	10.0%
Language used for discussing health	30	2.60 (0.62)	0.0%	46.7%	46.7%	6.7%
Taking care of oneself while pregnant	30	2.60 (0.56)	0.0%	43.3%	53.3 %	3.3%
Use of non-Western medical treatment	29	2.31 (0.54)	0.0%	72.4%	24.1%	3.4%

Note: 1-4 scale, with 1 indicating strongly disagree and 4 indicating strongly agree.

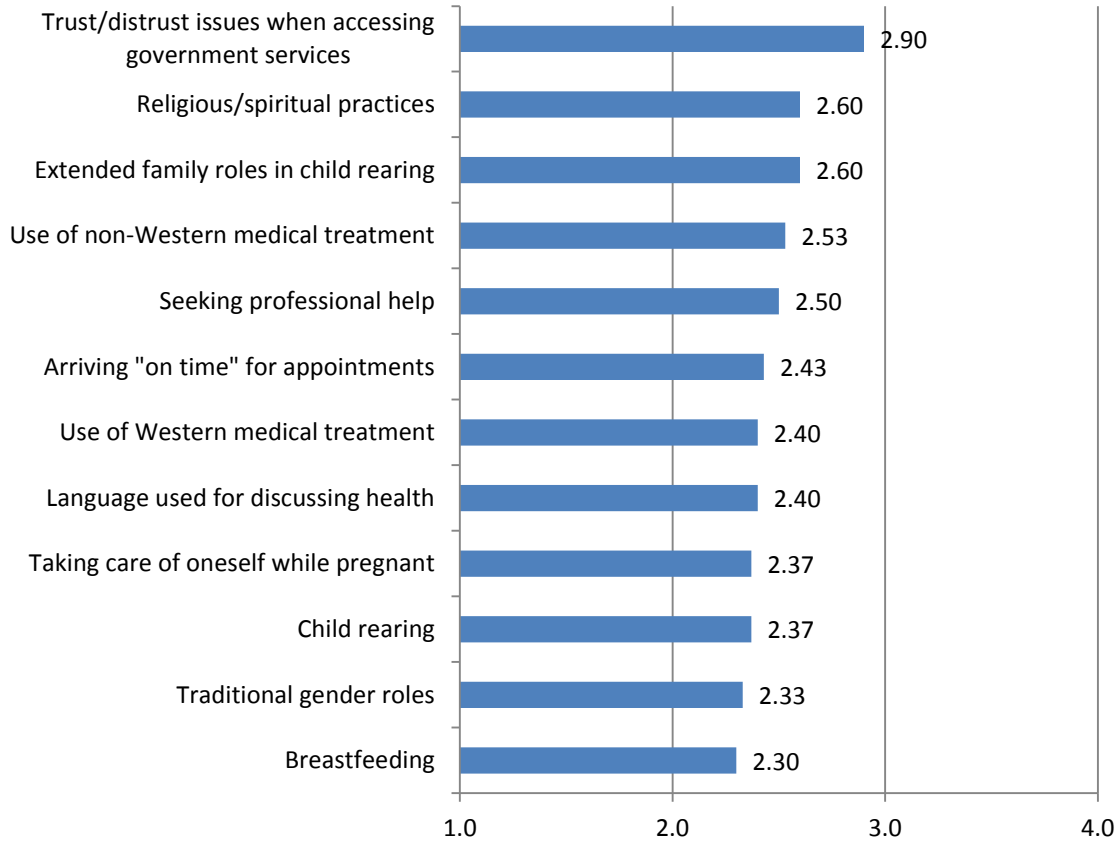
A majority of DFCH staff respondents' agreed that they were aware how 11 out of 12 practices were influenced by African American shared culture. Only three out of the 12 practices had a participant respond strongly disagree.

It may be beneficial to hold trainings on shared African American culture to help staff become more aware of how various cultural views within the African American community impact various practices. On average staff were more likely to agree that they were aware of shared African American practices compared to Native American shared practices.

Native American Cultural Awareness

Native American Cultural Awareness was measured by asking 12 statements assessing staff members' self-rated understanding of how culture affects different aspects of Native Americans' lives. Statements were framed as, "I am aware of 'shared cultural norms' among Native Americans regarding…" with 12 different practices (see the left side of Figure 15 for listed practices). Average scores could range from 1 to 4 (1= Strongly Disagree, 2=Agree, 3=Disagree, 4=Strongly Agree), with higher scores representing more agreement for statements within a topic/subtopic.

Figure 15. Average Participant Response Score by Item Regarding Participant Self-Rated Understanding of Native American Culture on Life Practices (1= Strongly Disagree, 4=Strongly Agree)



- The average score for all statements within this subtopic area was 2.48 (SD: 0.35).
- Average scores from administration/management staff did not significantly differ from average scores of non-management staff.
- There were no significant differences in among White respondents and Black/African American respondents.
- Average scores among staff working different lengths of time at DFCH did not significantly differ.

Table 15. Count, Average Rating, and Percentage of Participants by Response Categories in Regards to Participant Self-Rated Understanding of Native American Culture on Life Practices

I understand how culture impacts Native Americans' lives, such as:	n	Average (SD)	Strongly Disagree	Disagree	Agree	Strongly Agree
Trust/distrust issues when accessing government services	30	2.90 (0.66)	0.0%	26.7%	56.7%	16.7%
Extended family roles in child rearing	30	2.60 (0.56)	3.3%	33.3%	63.3%	0.0%
Religious/spiritual practices	30	2.60 (0.50)	0.0%	40.0%	60.0%	0.0%
Use of non-Western medical treatment	30	2.53 (0.63)	0.0%	53.3%	40.0%	6.7%
Seeking professional help	30	2.50 (0.57)	3.3%	43.3%	53.3%	0.0%
Arriving "on time" for appointments	30	2.43 (0.63)	3.3%	53.3%	40.0%	3.3%
Language used for discussing health	30	2.40 (0.50)	0.0%	60.0%	40.0%	0.0%
Use of Western medical treatment	30	2.40 (0.50)	0.0%	60.0%	40.0%	0.0%
Child rearing	30	2.37 (0.56)	3.3%	56.7%	40.0%	0.0%
Taking care of oneself while pregnant	30	2.37 (0.56)	3.3%	56.7%	40.0%	0.0%
Traditional gender roles	30	2.33 (0.48)	0.0%	66.7%	33.3%	0.0%
Breastfeeding	30	2.30 (0.54)	3.3%	63.3%	33.3%	0.0%

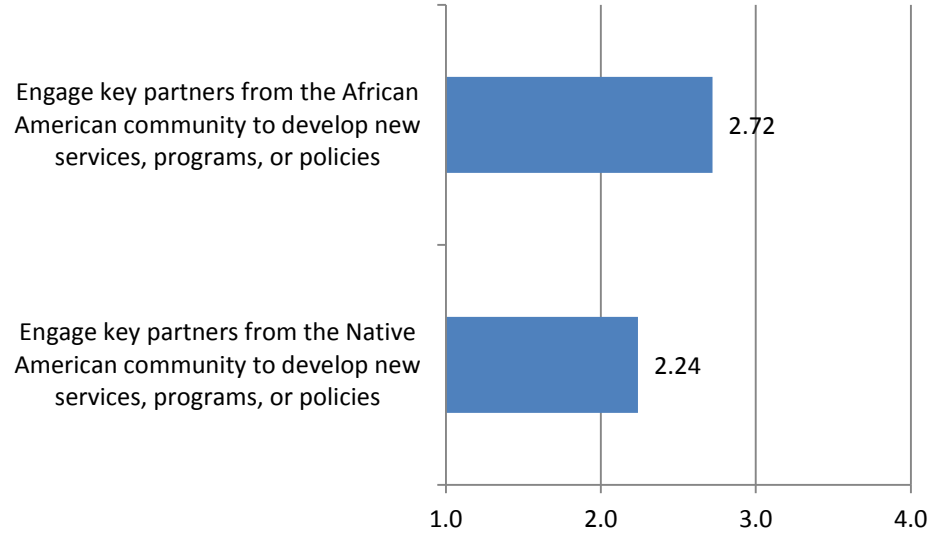
Note: 1-4 scale, with 1 indicating strongly disagree and 4 indicating strongly agree.

Staff were more likely to strongly agree that they were aware of shared Native American cultural practices and the trust/distrust issues of government services than any other of the listed practices. DFCH staff were more likely to disagree that they were aware of how shared culture among Native Americans impacted 8 out of 12 listed practices. Additional trainings in Native American shared cultural practices may be helpful for DFCH staff.

Community Engagement with African Americans and Native Americans

This topic area assesses participants' perspectives on their Division's community engagement efforts with African Americans, and with Native Americans. The statements were framed as "Indicate your level of agreement with each of the following statements: As part of my job, I engage key partners from…". Average scores could range from 1 to 4 (1= Strongly Disagree, 2=Agree, 3=Disagree, 4=Strongly Agree), with higher scores representing more agreement for statements within a topic/subtopic.

Figure 16. Average Participant Response Score by Item Regarding Community Engagement with African Americans and Native Americans (1= Strongly Disagree, 4=Strongly Agree)



- The average score for all statements within this subtopic was 2.48 (SD: 0.68).
- Average scores from administration/management staff did not significantly differ from average scores of non-management staff.
- There were no significant differences in among White respondents and Black/ African American respondents.
- Average scores among staff working different lengths of time at DFCH did not significantly differ.

Table 16. Count, Average Rating, and Percentage of Participants by Response Categories in Regards to Community Engagement with African Americans and Native Americans

As part of my job:	n	Average (SD)	Strongly Disagree	Disagree	Agree	Strongly Agree
I engage key partners from the African American community to develop new services, programs, or policies	25	2.72 (0.74)	4.0%	32.0%	52.0%	12.0%
I engage key partners from the Native American community to develop new services, programs, or policies	25	2.24 (0.83)	12.0%	64.0%	12.0%	12.0%

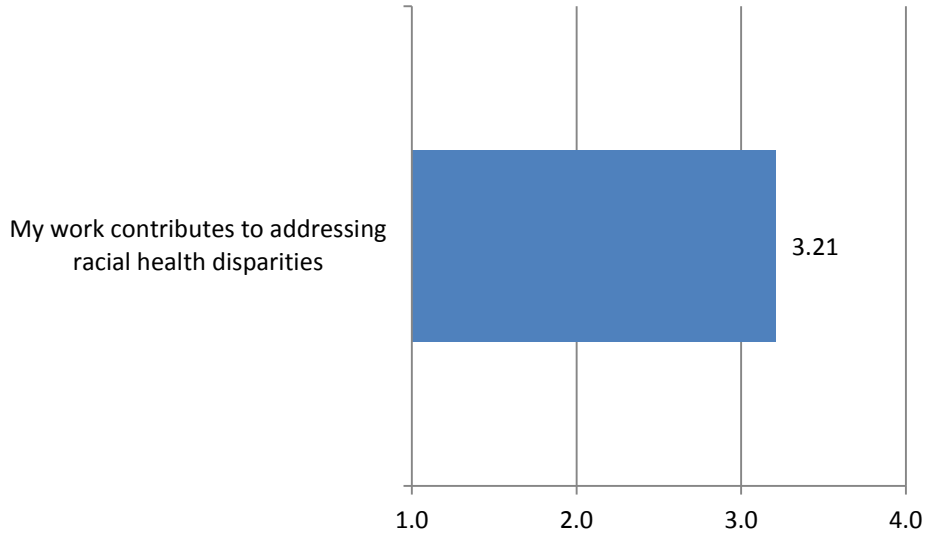
Note: 1-4 scale, with 1 indicating strongly disagree and 4 indicating strongly agree.

A majority of DFCH staff involved in program, service or policy development agreed or strongly agreed that they engaged with African American communities in the development process. The opposite was found with Native American communities. Seventy six percent of staff disagreed or strongly disagreed that they engaged with Native American communities. Staff may benefit from opportunities to develop partnerships with key Native American partners to increase community engagement.

Work Contribution to Policies and Programs Addressing Racial Health Disparities

Participants were asked to assess how they felt their work contributed to policies and programs that address racial health disparities. Since this statement did not have other related statements, it was not included in the comparison of the topic areas listed above. The statement was framed as "Indicate your level of agreement with the following statement: My work contributes to policies and programs that address racial health disparities. Average scores could range from 1 to 4 (1= Strongly Disagree, 2=Agree, 3=Disagree, 4=Strongly Agree), with higher scores representing more agreement for statements within a topic/subtopic.

Figure 17. Average Participant Response Score Regarding Work Contribution to Policies and Programs Addressing Racial Health Disparities (1= Strongly Disagree, 4=Strongly Agree)



- This statement was originally part of a set of 3 statements in the WIC Organizational Assessment.
- Again, this statement was not included in the comparison of topics listed above since it was one statement. If one were to compare the average of this statement to the topics above, it would have the third highest average rating.
- Average scores from administration/management staff did not significantly differ from average scores of non-management staff.
- There were no significant differences in among White respondents and Black/ African American respondents.
- Average scores among staff working different lengths of time at DFCH did not significantly differ.

Table 17. Count, Average Rating, and Percentage of Participants by Response Categories in Regards to Work Contribution to Policies and Programs Addressing Racial Health Disparities

Item	n	Average (SD)	Strongly Disagree	Disagree	Agree	Strongly Agree
My work contributes to policies and programs that address racial health disparities	28	3.21 (0.50)	0.0%	3.6%	71.4%	25.0%

Note: 1-4 scale, with 1 indicating strongly disagree and 4 indicating strongly agree.

Almost all DFCH staff agreed or strongly agreed that their work contributes to policies and practices that address racial health disparities. This high level of agreement is also seen in the statements regarding Division priorities and if the staff member understood how their work contributed to reducing racial health disparities. It may be informative to further investigate how DFCH staff use their work to address racial health disparities.

Appendix A

DFCH Organizational Assessment Instrument Changes and Rationale

Topic Area	Changes	Rationale
Demographics	Removed Staff Employment characteristics of full-time or permanent position	Almost all staff listed themselves as full time and permanent and therefore not a useful variable
Demographics	Add Length of Time with Division	DFCH intensified health equity efforts in recent years; wanted to see if time worked in DFCH impacted responses
Demographics	Added PRIME Trainings and Other	Some DFCH attended previous PRIME workshops; to see if PRIME workshops impacted responses
Demographics	Added work section within Division	To see if results differed by work section
Perception of Division's Programs	Focused statements on health equity, included contractors in capacity building	PRIME has shifted to have more of a focus on health equity; DFCH works with local contractors
African American and Native American Cultural Awareness	Changed statement to be: 'I am aware of "shared cultural norms" among…'	The Evaluation Workgroup decided that awareness was more appropriate than understanding, the term used in previous organizational assessments. The Workgroup also added the term "shared" to indicate that among groups there may be shared cultural practices, but not every individual may participate in these practices.
African American and Native American Cultural Awareness	Added statement regarding trust/distrust issues when accessing government services	The issues of trust/distrust are discussed in the PRIME sponsored workshop on Native American History, Culture and Core Values.
Knowledge and Skills	Added statement to distinguish if the participant's work role included program development	Statements regarding program development could be tailored for the respondent based on their work role
African American and Native	Added statement to	Statements regarding

American Community Engagement	distinguish if the participant's work role included program development	community engagement in program development could be tailored for the respondent based on their work role
Division's Application of Key Concepts	Changed the wording for the following: 1. "Apply a SDOH perspective" to be "Use a SDOH framework" 2. "Discuss racism as a barrier" to "Discuss racism as a root cause"	Workgroup Team changed the wording to be more accurate
Self-Application of Key Concepts	Same as changes in Division's Application of Key Concepts	Workgroup Team changed the wording to be more accurate

Appendix B

PRIME Organization Assessment for the Division of Family and Community Health (DFCH)
Aug 2015

Thank you for taking the time to complete the Practices to Reduce Infant Mortality through Equity (PRIME) Project's Organizational Assessment Survey. You will be asked to share your perspective on the Division's programs and services. You will also be asked about your knowledge regarding health equity and racial health disparities, and work skills to address these issues along with a few demographic questions.

This survey will take approximately 20 minutes to complete. Please answer all questions to the best of your knowledge. If needed, you may start, then return to the survey at a later time by using the link you received by email. Your responses are automatically saved.

All surveys will be confidential. Only University of Michigan staff will have access to your individual responses. Results will be reported in an aggregate format only.

Please complete this survey by noon (12pm) Wednesday, September 2nd, 2015.

1. Which of the following PRIME trainings have you attended? Check all that apply:

   ❑ Undoing Racism (facilitated by Diana Dunn of the People's Institute in 2011 at Cleary University in Howell)

   ❑ Health Equity Social Justice Workshop (facilitated by Doak Bloss. Workshops occurred between 2012 through 2015)

   ❑ Native American History, Culture and Core Values Workshop (facilitated by Arlene Kashata and Linda Woods in June 2014)

2. Have you attended other trainings on racial health disparities or health equity:

❍ Yes
❍ No

If yes, please list:

_____

3. What section of the Division of Family and Community Health are you in? (Check one answer)

- ❍ Child & Adolescent and School Health
- ❍ Women and Maternal Health
- ❍ Early Childhood Health

4. What is your classification? (Check one answer)

- ❍ Administrator/Manager
- ❍ Program Analyst/Consultant/Coordinator/Specialist
- ❍ Administrative Support (Departmental Technician/General Office Assistant/Secretary/Student Assistant)

5. How long have you worked in the Division of Family and Community Health?

- ○ Less than 1 year
- ○ 1-3 years
- ○ 4-6 years
- ○ 7-9 years
- ○ 10-12 years
- ○ 13- 15 years
- ○ More than 15 years

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

❍ Yes

❍ No

7. Are you a person of Arab or Chaldean origin? (Check one answer)

❍ Yes

❍ No

8. What is your race (Check all that apply)

❑ White

❑ Black, African American

❑ Asian

❑ Pacific Islander (e.g. Hawaiian, Samoan)

❑ Native American or Alaska Native

❑ Other Race Group: _____

Indicate your level of agreement with each of the following statements. The Division's programs and services are designed to:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Do Not Know
9. Promote best practices to address racial health disparities	❍	❍	❍	❍	❍
10. Address the social determinants of health (social, environmental, economic conditions) to eliminate racial health disparities.	❍	❍	❍	❍	❍
11. Promote health equity	❍	❍	❍	❍	❍
12. Build the capacity of local public health departments and other contractors to reduce racial health disparities.	❍	❍	❍	❍	❍

Indicate your level of agreement with each of the following statements. To do my job, I use information about racial health disparities from:

13. Other staff within BFMCH.
14. Staff outside the BFMCH but within MDHHS.
15. Staff at other state health departments.
16. Staff at local health departments in Michigan.
17. Webinars
18. Conferences

Indicate your level of agreement with each of the following statements. I am aware of "shared cultural norms" among African Americans regarding:

19. child rearing.
20. seeking professional help.
21. language used for discussing health.
22. extended family roles in child rearing.
23. religious/spiritual practices.
24. traditional gender roles.
25. arriving "on time" for appointments.
26. use of Western medical treatment.
27. taking care of oneself while pregnant.
28. breastfeeding.
29. use of non-Western medical treatment.
30. Trust/distrust issues that may arise when accessing government services

Indicate your level of agreement with each of the following statements. I am aware of "shared cultural norms" among Native Americans regarding:

31. child rearing.
32. seeking professional help.
33. language used for discussing health.
34. extended family roles in child rearing.
35. religious/spiritual practices.
36. traditional gender roles.
37. arriving "on time" for appointments.
38. use of Western medical treatment.
39. taking care of oneself while pregnant.
40. breastfeeding.
41. use of non-Western medical treatment.
42. Trust/distrust issues that may arise when accessing government services

43. My work role includes developing, monitoring or evaluating policies, programs or services

- ❍ Yes [go to question 55]
- ❍ No [go to question 44]

If Respondent answers: No, I do NOT develop, evaluate or monitor programs, policies or services they will receive the following questions in "division staff" form

Indicate your level of agreement with each of the following statements regarding the work of division staff responsible for the development, monitoring or evaluation of programs, policies and services

44. Division staff use epidemiological and program evaluation data to promote health equity in policies, programs or services
45. Division staff research best practices or programs to reduce racial health disparities and promote health equity.

Indicate your level of agreement with each of the following statements regarding the your work

46. I use data to identify racial health disparities
47. I read publications about racial health disparities and health equity
48. My work contributes to addressing racial health disparities

Indicate your level of agreement with the following statements regarding engagement of African American and Native American community representatives in the development, evaluation or monitoring of DFCH's programs, policies or services...

	Strongly Agree	Agree	Disagree	Strongly Disagree
49. As part of their job, division staff engage key partners from the African American community to develop new services, programs, or policies.	❍	❍	❍	❍
50. As part of their job, division staff engage key partners from the Native American community to develop new services, programs, or policies.	❍	❍	❍	❍

If Respondent answers: Yes, I do develop, evaluate or monitor programs, policies or services

51. I use epidemiological and program evaluation data to promote health equity in policies, programs or services
52. I research best practices or programs to reduce racial health disparities and promote health equity.
53. I use data to identify racial health disparities
54. I read publications about racial health disparities and health equity
55. My work contributes to addressing racial health disparities

Indicate your level of agreement with each of the following statements regarding engagement of African American and Native American community representatives.

	Strongly Agree	Agree	Disagree	Strongly Disagree
56. As part of my job, I engage key partners from the African American community to develop new services, programs, or policies.	❍	❍	❍	❍
57. As part of my job, I engage key partners from the Native American community to develop new services, programs, or policies.	❍	❍	❍	❍

ALL Respondents receive the following questions

Indicate your level of agreement with each of the following statements regarding division staff

	Strongly Agree	Agree	Disagree	Strongly Disagree	Do not know
58. Division staff have a strong understanding of racial health disparities.	❍	❍	❍	❍	❍
59. Division staff use a social determinants of health framework to address racial health disparities in their work.	❍	❍	❍	❍	❍
60. Division staff apply a life-course perspective to address racial health disparities in their work	❍	❍	❍	❍	❍
61. Division staff discuss racism as a root cause of racial health disparities.	❍	❍	❍	❍	❍

Indicate your level of agreement with each of the following statements

	Strongly Agree	Agree	Disagree	Strongly Disagree	Do not know
62. I have a strong understanding of racial health disparities.	❍	❍	❍	❍	❍
63. I use a social determinants of health framework to address racial health disparities in my work.	❍	❍	❍	❍	❍
64. I apply a life-course perspective to address racial health disparities in my work	❍	❍	❍	❍	❍
65. I discuss racism as a root cause of racial health disparities.	❍	❍	❍	❍	❍

Indicate your level of agreement with the following statements

	Strongly Agree	Agree	Disagree	Strongly Disagree
66. I clearly understand that DFCH's has a priority that focuses on reducing racial health disparities.	❍	❍	❍	❍
67. I understand how my work contributes to the Division's priority that focuses on reducing racial health disparities.	❍	❍	❍	❍

You have completed the PRIME Organization Assessment survey. Thank you for your time!