Practices to Reduce Infant Mortality through Equity (PRIME) Green Paper

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# Table of Contents

Executive Summary .................................................. p. 3
Section 1: Overview and Justification for PRIME Intervention .............. p. 5
Section 2: Roles and Responsibilities of Public Health ......................... p. 12
Section 3: Existing Training Resources and Models ............................... p. 15
Section 4: Proposed PRIME Intervention Components ......................... p. 18
Section 5: Process for Reviewing the Green Paper .............................. p. 31
Section 6: PRIME Next Steps .......................................... p. 33
References ....................................................................... p. 35
Appendix A: Key Terms .................................................. p. 40
Appendix B: Green Paper Discussion Summary .................................... p. 43
Appendix C: Key Questions: Ranked and Revised ................................. p. 45
Executive Summary

Practices to Reduce Infant Mortality through Equity (PRIME) is a 3-year, W.K. Kellogg Foundation-funded project to enhance the capacity of the Michigan Department of Community Health’s (MDCH) Bureau of Family, Maternal & Child Health (BFMCH) to reduce racial disparities in infant mortality between Blacks and Whites and between American Indians and Whites in Michigan. The primary goal of PRIME is to create a public health practice model that can help BFMCH and its staff more effectively address the racial disparities in infant mortality by enhancing the effectiveness of BFMCH’s current programs, projects and policies. We seek to achieve this aim by collaborating with staff, local public health, professional consultants and university partners to create resources, training and technical assistance materials that build on the expertise and lessons learned from the PRIME team. If successful, this project will not only refine the state-wide effort to reduce racial disparities in infant mortality but provide a model curriculum and tool-kit that MDCH and local/state health departments may use to address disparities in other health outcomes.

This green paper is designed to serve as a springboard for discussion and was used at an all-day retreat attended by the project’s Steering Team as a stimulus for considering, discussing and refining the PRIME project’s aims, goals, objectives, and next steps.

In Michigan, there are significant disparities in the infant mortality rates when comparing Blacks and American Indians to Whites (15.5, 8.8 and 5.6 deaths per 1,000 live births, respectively) (MDCH, 2010). Although infant mortality rates for all three groups have decreased over time, disparities persist. Analysis of Michigan fetal-infant mortality data using the Perinatal Periods Of Risk (PPOR) framework documents the profiles of fetal-infant deaths for different groups: the Black fetal-infant mortality rate is heavily weighted toward the Maternal Health/Prematurity category, whereas the American Indian fetal-mortality rate is evenly distributed across the Maternal Care, Newborn Care and Infant Health categories. These data illustrate that there are factors that vary by race differentially affecting the rates of infant mortality among Blacks and American Indians and highlights the need to develop population-specific strategies to reduce infant mortality in each racial group.

Although several models outline the roles and functions of the public health system, these models tend to lack clarity in 1) differentiating state health departments’ roles from the roles of local and federal public health, especially how state departments should fulfil their day-to-day responsibilities, and 2) explicit guidelines on the role of state public health departments in our national strategy to eliminate health disparities. A review of existing training and intervention approaches shows that their content, intensity and level of intervention do not meet the needs of PRIME, thus we must create a model that addresses the unique needs of a state health department in addressing racial disparities in infant mortality.

As we move forward with designing PRIME, we acknowledge a few basic assumptions that underlie our work:

- determinants of health disparities are complex and rooted in historical, political and cultural factors
- the cognitive development of individuals is necessary but insufficient for addressing racial health disparities
education and training must help staff perform their day-to-day jobs in a way that is consistent with the mission and vision of MDCH and is conducive to reducing disparities.

high quality data is needed to better understand how and where to intervene to reduce health disparities.

data should be used to document disparities, evaluate the effectiveness of interventions and policies, and help guide where and how MDCH intervenes.

We propose an intervention that involves a baseline organizational assessment; an initial, bureau-wide training; targeted training, tools and technical assistance to refine organizational policies and practices; an ongoing process of identification and prioritization of group needs; and additional recommended resources. We identified five levels at which PRIME could intervene: state-level policy; intraorganization (MDCH/BFMCH); linkages to local health departments; data systems; and BFMCH programs and activities. We organized potential types of intervention for PRIME into four key areas:

- **Conceptual** – the explicit or implicit theories that people use to explain health outcomes, why health disparities exist and what should be done about health issues or health disparities in Michigan

- **Practical** – the application of experience, knowledge and skills to addressing a particular issue, job role or professional task that staff must address in their typical, day-to-day work

- **Technical** – the specific skills, resources and information staff marshal to systematically justify and address racial disparities in infant mortality

- **Organizational** – the social, cultural, institutional and contextual aspects of MDCH, BFMCH and the divisions of BFMCH that facilitate and hinder the ability of staff to create, implement and evaluate the most effective strategy to address racial disparities in infant mortality in Michigan

The PRIME Green Paper outlines the breadth of issues and questions that we identified, yet we cannot address all of these in the scope of this project. We must determine how to prioritize key questions, issues and focus areas for PRIME, both for work with BFMCH staff as well as for developing tools for staff and others to use. Our next steps in implementing PRIME are to:

1. Review findings from Organizational Assessment
2. Create Division-Specific Plans
   a. Prioritize program and policy needs and interests
   b. Identify relevant focus areas and intervention components
   c. Identify timeline, resource needs, and consultation supports
   d. Determine what resources/ components exist vs. ones that need to be created within PRIME
3. Create a communication strategy about the project for staff and internal and external stakeholders
4. Use LLC products as a resource for MCH program development/policy
5. Implement, complete and evaluate plan
6. Develop a quality assurance process
7. Determine next steps to be completed in the course of the grant and after
Section 1: Overview and Justification for PRIME Intervention
Overview of the PRIME project

Practices to Reduce Infant Mortality through Equity (PRIME) is a 3-year, W.K. Kellogg Foundation-funded project to enhance the capacity of the Michigan Department of Community Health’s (MDCH) Bureau of Family, Maternal & Child Health (BFMCH) to reduce racial disparities in infant mortality between Blacks and Whites and between American Indians and Whites in Michigan. The focus of PRIME is consistent with MDCH’s mission and vision, and the mission of BFMCH. More specifically, PRIME is consistent with all of the explicit recommendations of the Michigan Health Equity Roadmap Priority Recommendations and Strategies:

Recommendation 1: Improve race/ethnicity data collection/data systems/data accessibility.

Recommendation 2: Strengthen the capacity of government and communities to develop and sustain effective partnerships and programs to improve racial and ethnic health inequities.

Recommendation 3: Improve social determinants of racial/ethnic health inequities through public education and evidence-based community interventions.

Recommendation 4: Ensure equitable access to quality healthcare.

Recommendation 5: Strengthen community engagement, capacity, and empowerment.

This project builds on a partnership between the BFMCH, the MDCH Health Disparities Reduction and Minority Health Section (HDRMHS), the University of Michigan, School of Public Health (UM-SPH), the UM-SPH Center on Men’s Health Disparities, local health departments, community-based organizations, public health professionals, and community members.

PRIME includes the following eight activities:

1. assessment of policies & practices
2. review existing models & curricula
3. examine the determinants of infant mortality & racial disparity in infant mortality
4. create a curriculum & tool-kit for increasing organizational capacity to address social determinants of health disparities
5. train BFMCH staff using the new curriculum
6. draft documents outlining potential policies & guidelines for BFMCH; utilizing lessons learned from local communities
7. conduct a process & outcome evaluation of these efforts
8. Develop a quality assurance process

If successful, this project will not only refine the state-wide effort to reduce racial disparities in infant mortality but provide a model curriculum & tool-kit that MDCH & local/state health departments may use to address disparities in other health outcomes. PRIME has three explicit goals:
• Develop a training model and resources that promote understanding of practices that support institutional racism & help to eliminate racial disparities\(^1\) in infant mortality

• Use state/local partnership network to codify effective efforts that undo racism and help to eliminate racial disparities in infant mortality

• Establish a sustainable quality assurance process for these efforts within the BFMCH

\(^1\) We use the term “health disparities” in this document because it is consistent with Healthy People 2010 and 2020 and because it is the most commonly used term in the US to refer to racial differences in health.
Goals and Objectives of this Document

A green paper is a document designed to frame a discussion and debate on a particular topic (CDC, 2008). A green paper usually represents a range of ideas and is typically meant to invite interested individuals or organizations to share their views, perspectives and expertise on a given topic. A green paper may be followed by a white paper that outlines the official guidelines that are used for policy development. Definitions of terms used in this document are provided in Appendix A. The purpose of the PRIME Green Paper is to:

- Characterize the nature of racial health disparities in infant mortality in Michigan between Blacks and Whites and American Indians and Whites;
- Describe how social determinants of health shape the patterns and persistence of these disparities;
- Distinguish the roles and responsibilities of a state health department from that of other institutions and entities in our public health system;
- Provide an overview of existing training and intervention approaches and argue for the need to create a model that addresses the unique needs of a state health department in addressing racial disparities in infant mortality;
- Serve as a springboard for discussion among the PRIME team to refine the project’s aims, goals and objectives; and
- Suggest a series of next steps to describe how BFMCH and the PRIME Steering Team will move forward to create a new strategy to reduce racial disparities in infant mortality in Michigan.

Epidemiology of Racial Disparities in Infant Mortality in Michigan

In Michigan, there are significant disparities in the infant mortality rates when comparing both Blacks and Whites and American Indians and Whites. For 2007-2009, the rate of infant mortality for Whites was 5.6 deaths per 1,000 per live births, while the rates for Blacks and American Indians were 15.5 and 8.8, respectively. These disparities have remained relatively constant for the past decade (see Figure 1).

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This trend has not been confined to the last few years. Figure 2 shows that we have made significant progress over time in reducing the rates of infant mortality, yet we have made little progress in addressing the disparity in infant mortality. The rate of infant mortality in the Black population has remained much higher than the rate for Whites for at least the last 40 years. Similar data for American Indians over this same time period is unsuitable for comparison due to the relatively small number of American Indian infant deaths. Although Figure 2 shows an overall decrease in the rates for both races, Figure 3 shows that the ratio between the two rates has, in fact, grown during this same time period.

Figure 2. Black & White Infant Mortality Rates, MI 1970-2009

Figure 3. Black/White Infant Mortality Ratio: MI, 1970-2009

Despite increased attention and concern about racial disparities in infant mortality over the past decade, the ratio between Black/White and American Indian/White rates of infant mortality has remained stable (see Figure 4).

These figures illustrate the fundamental question facing the PRIME project: What does BFMCH need to do differently to reduce racial disparities in infant mortality beyond what it does to address infant mortality in general? The persistence of these disparities is evidence that there is some factor or factors that vary by race that is having a differential effect on Blacks and on American Indians when compared with Whites. Reducing or eliminating this disparity requires identifying and addressing these factors.

Figure 4. Black/White & American Indian/White Infant Mortality Ratios, 3-Year Moving Averages in Michigan 2000-2009

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PPOR Analysis of Determinants of Infant Mortality

The Perinatal Periods Of Risk (PPOR) framework has been used to guide national and international efforts to monitor and investigate fetal-infant mortality (City MatCH website, 2011). PPOR divides fetal-infant mortality into four problem areas that also map onto strategic prevention areas: maternal health/prematurity, maternal care, newborn care, and infant health. PPOR mapping of fetal-infant mortality facilitates the identification and investigation of in-depth information to guide targeted prevention efforts to address fetal and infant mortality (City MatCH website, 2011). In the PPOR approach, these four groups are given labels that suggest the primary preventive direction for the deaths for that group.

<table>
<thead>
<tr>
<th>PPOR Label</th>
<th>Problem Area</th>
<th>Prevention Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Health/</td>
<td>• Very low birth weight-related deaths generally caused by prematurity or</td>
<td>• Preconception health</td>
</tr>
<tr>
<td>Prematurity</td>
<td>poor maternal health</td>
<td>• Unintended pregnancy</td>
</tr>
<tr>
<td></td>
<td>• Deaths with birth weights from 500 to 1499 grams</td>
<td>• Smoking</td>
</tr>
<tr>
<td></td>
<td>• Preconception health</td>
<td>• Drug abuse</td>
</tr>
<tr>
<td></td>
<td>• Unintended pregnancy</td>
<td>• Specialized perinatal care</td>
</tr>
<tr>
<td></td>
<td>• Smoking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Drug abuse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Specialized perinatal care</td>
<td></td>
</tr>
<tr>
<td>Maternal Care</td>
<td>• High birth weight-related deaths</td>
<td>• Early continuous prenatal care</td>
</tr>
<tr>
<td></td>
<td>• Fetal deaths from 24 to 40 weeks gestation</td>
<td>• Referral of high risk pregnancies</td>
</tr>
<tr>
<td></td>
<td>• Influenced by such factors as prenatal and obstetric care</td>
<td>• Good medical management of diabetes, seizures, post maturity or other medical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>problems</td>
</tr>
<tr>
<td>Newborn Care</td>
<td>• Neonatal deaths</td>
<td>• Advanced neonatal care</td>
</tr>
<tr>
<td></td>
<td>• Infant deaths from birth to four weeks</td>
<td>• Treatment of congenital anomalies</td>
</tr>
<tr>
<td></td>
<td>• Influenced by perinatal care</td>
<td></td>
</tr>
<tr>
<td>Infant Health</td>
<td>• Post-neonatal deaths</td>
<td>• Infant Safe Sleep activities such as sleep position education or breast-feeding</td>
</tr>
<tr>
<td></td>
<td>• Deaths from four weeks to one year</td>
<td>promotion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Access to medical homes and injury prevention</td>
</tr>
</tbody>
</table>

Compared to the reference group, the Black fetal-infant mortality rate shows a very strong weight towards the Maternal Health/Prematurity category, while the rate in other three categories is more evenly distributed (see Figure 5). In fact, the rate of Black fetal-infant deaths attributed to Maternal Health/Prematurity is over three times as high as the same rate for Whites. This allows for the conclusion that much of the Black fetal-infant rate is attributable to preconception maternal health and health behaviors.

**Figure 5. Black/White PPOR Comparison 2006-2008**

<table>
<thead>
<tr>
<th>Black, Non-Hispanic</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Health/Prematurity</td>
<td>Maternal Health/Prematurity</td>
</tr>
<tr>
<td>Maternal Care</td>
<td>Newborn Care</td>
</tr>
<tr>
<td>1.9</td>
<td>2.0</td>
</tr>
</tbody>
</table>

Overall IMR= 14.1  Overall IMR= 5.3  Overall Excess: 8.8

PPOR is especially useful for the analysis of American Indian fetal-infant mortality because only 60 deaths are required for calculation. The PPOR tables in Figure 6 below show a sizeable number of excess deaths between the White reference group and American Indians.

**Figure 6. American Indian/White PPOR Comparison 2006-2008**

<table>
<thead>
<tr>
<th>American Indian</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Health/Prematurity</td>
<td>Maternal Health/Prematurity</td>
</tr>
<tr>
<td>Maternal Care</td>
<td>Newborn Care</td>
</tr>
<tr>
<td>3.2</td>
<td>3.2</td>
</tr>
</tbody>
</table>

Overall IMR= 12.2  Overall IMR= 5.3  Overall Excess: 6.9

In comparison to the Black table, the American Indian PPOR shows a very even distribution across three categories: Maternal Care, Newborn Care and Infant Health. Therefore, interventions to address American Indian fetal-infant mortality should focus more attention on Maternal Care, Newborn Care and Infant Health than Maternal Health/ Prematurity. These differences in the PPOR tables for African Americans and American Indians highlight the need to develop population-specific strategies to reduce infant mortality in each racial group.

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4 Reference group defined by maternal characteristics: 20 or more years of age; 13 or more years of education; and White, non-Hispanic.

Source: 2008 Live Birth, Fetal Death and Death Cohort Matched Infant Death Files, Vital Records and Health Data Development Section, Michigan Department of Community Health
Section 2: Roles and Responsibilities of Public Health
“The mission of public health is addressed by private organizations and individuals as well as by public agencies. But the governmental public health agency has a unique function: to see to it that vital elements are in place and that the mission is adequately addressed” (Institute of Medicine, 1988, p. 7).

The preeminent guidelines articulating the roles and scope of U.S. public health are the Three Core Functions and the Ten Essential Services of Public Health (see Figure 7). These guidelines were created to achieve several aims:

- clarify the roles, functions, and responsibilities of the public health system;
- ensure consistency within and across states;
- facilitate a coherent and integrated public health system;
- differentiate public health from allied fields such as healthcare and medicine; and
- provide guidelines that federal, state and local public health can utilize to ascertain how well their activities are in accordance with the stated responsibilities of public health within the U.S.

The Three Core Functions—assessment, policy development, and assurance—were developed by the Institute of Medicine in 1988 (IOM, 1988) and later expanded to include the Ten Essential Services (IOM, 2008). Despite these efforts to outline the roles and functions of different levels of the public health system, there are two important limitations of these guidelines that influence the role of Bureau of Family, Maternal and Child Health in addressing racial disparities in infant mortality:

1. the lack of clarity on the day-to-day activities of state public health departments
2. the lack of explicit guidelines on the role of state public health departments in our national strategy to eliminate health disparities.

A major limitation of these guidelines is the lack of clear division and definition of the roles and responsibilities of different levels of government in public health. Roles have generally been described thus:

- **federal government** should take a supportive role in public health
- **state public health departments** should assume a central role, and
- **local and county health departments** should focus on service provision (IOM, 1988).

This, however, lacks the specificity necessary to guide the day-to-day activities of state and local health departments or to inform the public of the government’s roles in public health (IOM, 1999; National Association of County Health Officials, 1989; Riegelman, 2010; U.S. Conference of Local Health Officers, 1989).
While the role of state health departments tends to be less well-defined than federal or local public health, the National Public Health Performance Standards Program (NPHPSP) and others assert that state public health departments should be concerned with:

- Planning and implementation
- State-local relationships
- Performance management and quality improvement
- Public health capacity
- Coordinating and guiding state level activities
- Guiding program decision-making based on data gathered from local and county health departments
- State-level advocacy for public health
- Justifying resource expenditures, and
- Determining gaps in local services and providing resources to fill, or facilitate filling, gaps in local services (CDC, 2010; others).

A second major limitation of the existing U.S. public health guidelines is the lack explicit recommendations or direction regarding health disparities. Both the American and international health communities have expressed concern over continued racial and ethnic health disparities. Though health disparities have received considerable attention in the U.S. public health sphere for more than a decade (Ladenheim & Groman, 2006; U.S. Department of Health & Human Services, 1998), U.S. public health guidelines have yet to reflect the necessity of addressing health disparities. Public health guidelines from the United Kingdom and the Pan-American Health Organization (PAHO), however, explicitly highlight public health’s responsibility to reduce or eliminate health disparities and provide some limited guidance on how public health should seek to achieve these aims (Department of Health, 2001; Ministry of Health & Longterm Care, 2004).

Most governmental public health efforts to reduce and eliminate health disparities in the U.S. have originated at either the federal level or from local and county health departments; few state public health departments have actively sought to address health disparities (Ladenheim & Groman, 2006). It is worth noting that MDCH and its Health Disparities Reduction and Minority Health Section have been national leaders in outlining a strategy to guide their efforts to reduce health disparities in the state of Michigan (e.g., MDCH Roadmap, 2010). Despite these efforts, the lack of role differentiation between state and local health departments, limited resources and staff capacity, the absence of guidance in the public health guidelines, and the lack of clarity on the strategies that are appropriate for the state’s position within the public health system remain challenges for MDCH and other state health departments’ efforts to address health disparities.
Section 3: Existing Training Resources and Models
## Selected Trainers and Training Models

<table>
<thead>
<tr>
<th>Training</th>
<th>Agency</th>
<th>Theoretical Basis</th>
<th>Format</th>
<th>Objectives</th>
<th>Intended Outcomes</th>
</tr>
</thead>
</table>
| Undoing Racism                   | People’s Institute for Survival and Beyond (founded 1980) | Theory and methodology from community organizing and activism | Two-day anti-racism training                | • Attempts to address Black-White racism through multiculturalism and social change  
• Provides diverse communities and organizations with a theoretical framework through which institutional and structural racism can be discussed | • Increased participant understanding of institutional and structural racism  
• Identify strategies to address institutional and structural racism |
| Vigorous Interventions Into Ongoing Natural Settings (VISIONS) | ---                                         | Multiculturalism, equity, conflict resolution techniques | Four-day, small group presentation and discussion workshop | • Addresses racism, internalized and societal oppression, and disparities  
• Focus on how oppression occurs | • Increased participant ability to pinpoint specific potential areas of individual and structural change |
| Health Equity and Social Justice | Ingham County Health Department              | Health and social equity, personal reflection, awareness of power structures/imbalances | Presentations and facilitated group discussions and activities | • Introduce participants to a way of thinking that helps to view health problems as consequences of health inequalities rather than individual health behaviors | • Identification of problematic policies and practices that support institutional racism  
• Generate an action plan to facilitate change from within the agency |
| Racial Equity Impact Assessment  | Applied Research Center (1981) [http://www.arc.org/](http://www.arc.org/) | Enables users to estimate the impact of a proposed action or decision on a particular racial/ethnic group | Toolkit                                    | • Determination of impact is made by identifying and engaging stakeholders, identifying and documenting racial inequalities, clarifying purpose of action, identifying adverse impacts, identifying alternatives, identifying success measures, and identifying methods for sustainability | • Create an impact assessment and formulate recommendations for policy revision |
### Video and Documentary Resources and Materials

<table>
<thead>
<tr>
<th>Resource</th>
<th>Organization</th>
<th>Format</th>
<th>Objectives</th>
<th>Intended Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnatural Causes (2008)</td>
<td>California Newsreel</td>
<td>Three-hour series of six</td>
<td>• Highlights the fundamental economic and political causes of disease</td>
<td>• Series producers hope to shift the discussion of illness from individual health behaviors to “upstream” determinants.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>episodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race, the Power of an Illusion (2003)</td>
<td>California Newsreel</td>
<td>Three-film series</td>
<td>• Illustrates the social construction of race and how the intersection of race and politics has shaped both wealth and health in America today</td>
<td>• Increased viewer understanding of the influence of race, as a social construction, on wealth and health</td>
</tr>
<tr>
<td>California Newsreel materials (1968)</td>
<td>---</td>
<td>Documentary film production and distribution</td>
<td>• Focus is on films that promote diversity, anti-racism, and promote African and Black history, culture, and well-being</td>
<td>• Identification of problematic policies and practices that support institutional racism • Generate an action plan to facilitate change from within the agency</td>
</tr>
<tr>
<td>The Deadly Deception (1993)</td>
<td>WGBH Boston and NDR International for NOVA</td>
<td>60 minute documentary film</td>
<td>• This program investigates the Tuskegee Study of Untreated Syphilis in the Negro Male, a medical experiment conducted in Alabama from 1932-1972, in which Afro-American men were led to believe they were receiving free treatment for syphilis, but were given medicines worthless against the disease by government physicians.</td>
<td>• Exposes viewers to testimony of survivors, physicians who led the study, experts in the medical field, and civil rights leaders provides a variety of perspectives (e.g., medical, legal, criminal justice) from which one can judge the experiment.</td>
</tr>
</tbody>
</table>
Section 4: Proposed PRIME Intervention Components
The PRIME project intervention is built on a few basic assumptions:

Training Approach

- The cognitive development of individuals is necessary but insufficient for addressing racial health disparities
- Personal growth can follow skill development
- Education and training is a means to an end; not an end in and of itself
- Education and training components need to help staff improve their confidence and performance in areas that are directly relevant to their day-to-day job roles and tasks

Data on Racial Disparities

- Documenting disparities is necessary but insufficient for addressing disparities
- Good data can not only be used to evaluate the effectiveness of interventions and policies but data also can help guide where and how to intervene to reduce disparities
- Determinants of health disparities are complex and rooted in historical, political and cultural factors
- Black-White health disparities have been widely documented but poorly understood
- American Indian-White health disparities have been underreported, understudied, poorly documented and poorly understood

**Intervention Process**

1. **Baseline Organizational Assessment:**
   a. Conduct a 360-assessment with staff and engage staff in a self-assessment process
   b. Identifies individual, group and organizational areas for growth
   c. Provides a pretest for the intervention

2. **Conduct an Initial Training:**
   a. Provides feedback on findings to leadership and staff
   b. Provides basic conceptualization of the problem
   c. Provides common language and tools to facilitate communication

3. **Identify and Address Group Needs**
   a. Collaborate with leadership and staff to prioritize group and individual needs
   b. Identify activities and resources that can address needs by choosing from a menu of options
   c. Create a timeline for completing training
   d. Reassess staff after an agreed upon timeline and repeat process until key areas are addressed

4. **Optional Resources**
   a. Encourage staff to take advantage of optional resources as individuals
   b. Incentivize staff to organize small learning groups
   c. Incentivize staff to create their own tools to facilitate incorporating SDOH or systematic approaches to eliminating health disparities
   d. Provide support for individuals and groups to seek assistance and support from other staff, particularly HDRMHS
Intervention Timeline

<table>
<thead>
<tr>
<th>Step #1: Baseline Organizational Assessment</th>
<th>Step #2: Initial Training Workshop</th>
<th>Step #3: Review Feedback and Prioritize Needs Create Group-Specific Plan Complete Appropriate Curriculum Units</th>
</tr>
</thead>
</table>

Optional staff and group resources that staff and small groups may use and create

These areas will be used to guide our discussion of the key areas of focus and intervention components for the PRIME intervention.

**Intervention Focus Areas of PRIME**

- **State-Level Policy** – Educating and being a resource to state-level policy-makers and stakeholders; collaboration with other state-level governmental and non-governmental agencies to improve health and address social determinants of health

- **Locals Health Departments** – Relationships with and support of local health department/Local Learning Collaborative efforts

- **MDCH/ BFMC** – departmental and bureau policies, practices and norms

- **Data Systems** – Data collection, storage, analysis, and dissemination methods that may help to inform and evaluate BFMC programs, efforts and activities

- **Programs** – Programs and activities led or administered by BFMC staff

**Intervention Components**

We have organized the key potential areas of focus for PRIME into four key areas:

- **Conceptual** – the explicit or implicit theories that people use to explain health outcomes, why health disparities exist and what should be done about health issues or health disparities in Michigan

- **Practical** – the application of experience, knowledge and skills to addressing a particular issue, job role or professional task that staff must address in their typical, day-to-day work
Technical – the specific skills, resources and information staff marshal to systematically justify and address racial disparities in infant mortality

Organizational – the social, cultural, institutional and contextual aspects of MDCH, BFMCH and the divisions of BFMCH that facilitate and hinder the ability of staff to create, implement and evaluate the most effective strategy to address racial disparities in infant mortality in Michigan

Conceptual

“People approach new data or new theories and attempt to place them into existing schema. When information “fits” into existing schema, it is experienced as obvious and even helpful... However, people are likely to reject the new information – rather than the existing schema – if there is not a fit.” (Fullilove, et al., 2006)

Racial disparities are not new, nor are racial disparities in infant mortality. Thus, many staff have read materials, participated in trainings and had other experiences that shape how they think about several key issues:

- determinants of infant mortality
- determinants of racial disparities in infant mortality
- what should be done to address infant mortality
- what should be done to address racial disparities in infant mortality
- what MDCH, BFMCH and their specific division can and should do to address infant mortality and racial disparities in infant mortality.

We highlighted conceptual factors in PRIME because training and education about terms and concepts (i.e., racism) do not necessarily translate to understanding and application to BFMCH staff roles and responsibilities. It is critical to make sure all staff have a basic understanding of key definitions and terms as well as how those concepts apply to the unique roles that roles MDCH, BFMCH and divisions of BFMCH are charged with playing in the public health system’s effort to eliminate racial disparities in infant mortality. Thus, it is critical that all BFMCH staff adopt a common conceptualization of race, racism and the relevance of each for their work. This common conceptualization will guide the Bureau and the work done in BFMCH.

Conceptualizing Race and Racism

- Racial disparities, by definition, are health outcomes that vary by race.
- What tends to be less clear is how we should define race and racism in ways that are useful for addressing racial disparities.
- Race denotes a common social and political experience and history for people who define themselves in these terms or those whose physical appearance maps onto a particular racial group
- Racism is useful as an analytic tool but difficult to describe or communicate
- Racism is most useful as a framework when the focus remains on the system, not individuals
- Racism is useful as a lens through which to understand health outcomes that vary by race
- Focuses on outcomes rather than intentions, highlighting covert, not merely overt, operations of racism
• Racism is a dynamic, rational response aligned with the normative culture (Adams & Balfour, 2004; Grant-Thomas & Powell, 2006; Osorio, 2005)

<table>
<thead>
<tr>
<th>Key Area</th>
<th>Goal</th>
<th>Potential Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conceptual</td>
<td>• Define key terminology in a user-friendly way (e.g., social determinants of health, fundamental determinants, life span, disparities, root causes, racism)</td>
<td>• Individual vs. population health approaches (Kumanyika &amp; Morrisnk, 2006)</td>
</tr>
<tr>
<td></td>
<td>• Operationalize key terminology</td>
<td>• How should you define race and ethnicity (LaVeist, 1996; Smedley &amp; Smedley, 2005)</td>
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<tr>
<td></td>
<td>• Clarify how these factors apply to Black-White disparities and American Indian-White disparities</td>
<td>• Racism as a determinant of health (Williams, 2005)</td>
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<tr>
<td></td>
<td>• Distinguish between theories of the problem (i.e., determinants of health) and theories of the intervention (i.e., where and how to intervene) (McLeroy et al., 1993)</td>
<td>• How should we consider determinants of population-level disparities (Warnecke, et al. 2008)</td>
</tr>
<tr>
<td></td>
<td>• Clarify the roles MDCH, BFMCH and divisions of BFMCH are charged with playing in the public health system and which roles they are not</td>
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</table>

Key Conceptual Questions:

1. How should we define racism in our work?
2. How much should we focus on changing how staff define racism personally vs. changing how they use racism as a term in their work?
3. How should we incorporate a life course perspective in the work of BFMCH and each of its divisions?
4. How should we think about what it means to be Black or American Indian in our efforts to address infant mortality?
5. What are the common components of Black-White and American Indian-White disparities and what the unique elements of each? How can these elements be addressed in our work?
6. Why is it important for staff to understand and identify social determinants of health?
7. How should staff think about the relative importance of key determinants of racial disparities in infant mortality (see Figure 8)?
Practical

Our public health workforce, particularly those in the BFMCH, is often provided many opportunities for training and continuing education. The best of these trainings are not only thought-provoking and interesting but help staff be more effective in their day-to-day jobs, increasing the efficiency and quality of their work. Trainings addressing racism, racial disparities, social determinants of health and the like have tended to lack the ability to help staff do their jobs more effectively as a direct result of the training. The PRIME approach is to build from the experience and tasks of BFMCH staff and create practical tools, resources and educational opportunities for staff that immediately help staff understand concepts and develop skills that make them more effective and efficient employees. While these experiences and instruments will not be ‘magic’, they will be designed and taught with practical skills and tasks in mind.
<table>
<thead>
<tr>
<th>Key Area</th>
<th>Goal</th>
<th>Potential Components</th>
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</table>
| Practical         | • Create tangible tools to help staff incorporate and apply new knowledge  
                   • Create tools that promote staff accountability and increase staff capacity to attend to SDOH  
                   • Make the application of new knowledge as easy as possible  
                   • Develop and pilot resources and experiences that help staff incorporate SDOH in their day-to-day work  
                   • Increase the capacity of staff and teams to assess and address their training needs in these areas  
                   • Help staff identify needs for data  
                   • Help staff utilize data for planning and evaluation  
                   • Help staff create logic models that incorporate SDOH | • Create conceptual models to guide program planning that incorporate SDOH  
                   • Create logic model templates for BFMCH staff  
                   • Create logic model templates for staff to require of grantees  
                   • Create a strategic planning development tool  
                   • Practice utilizing the Racial Equity Impact Assessment |

Key Practical Questions:

1. What kind of tools could be developed to assist staff?
2. What tools do staff feel that they need? What tools do leadership feel that staff need?
3. What is the expected staff time allocated for implementing PRIME?
4. Who should staff turn to for conceptual or technical assistance?
5. What resources are available to support staff in their work to more effectively address health disparities in infant mortality?
6. What are barriers that may be encountered during our efforts to address racism and health disparities and how will they be overcome?
7. What are the practical definitions, differences, and similarities between health disparities, health inequities, health inequalities and health equity that staff need to know? How can these be standardized?
8. How should “progress” in addressing racism and health inequalities be defined and measured?
9. How can we use limited resources to balance our, potentially conflicting, responsibilities to Black and American Indian populations and the State at large?
10. Who makes decisions about priorities and how are these decisions made?
11. What current MDCH and BFMCH policies and practices address the fundamental, or root, causes of racial disparities in infant mortality?
12. Who will ensure that SDOH are addressed in policies and practices?
13. How can we incorporate community input into our work? Is this something we should collect ourselves or rely on local HDs to provide to us (and how shall we require they collect this?)?
Technical

Figure 10. A Framework for Understanding the Relationship between Race and Health (King & Williams 1995)

<table>
<thead>
<tr>
<th>Key Area</th>
<th>Goal</th>
<th>Potential Components</th>
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</table>
| Technical  | • Create separate but complementary plans to address AA-White and Al-White disparities in infant mortality  
• Improve the quality of data available to inform statewide strategies to address AA-White and Al-White disparities in infant mortality  
• Identify the data needs to inform efforts to address American Indian infant mortality  
• Increase capacity for BFMCH for staff to use data to inform decisions, practices and policies | • Create an American Indian PRAMS survey  
• Create Google Earth map and conceptual framework to help staff understand American Indian SDOH and infant mortality  
• Create Google Earth map and conceptual framework to help staff understand Black SDOH and infant mortality  
• Revise strategic plans and other documents |
Key Technical Questions:

1. Are there particular MDCH policies that cause systematic misidentification of AI cases of infant mortality?
2. How can we capture more of the cases of American Indian infant mortality?
3. How and why should data for AI cases be treated differently than data for AA or White cases?
4. How can the amount of missing data, such as birth weight or gestational age, on birth or death certificates be minimized?
5. What techniques are used to analyze data with small populations or missing information?
6. How can MDCH monitor the social determinants of infant mortality?
7. What preconceptions underlie data that is collected, and how we view data?
8. How do we more effectively use data to link us to resources?
9. How do we create separate but complementary plans to address AA/White and AI/White disparities in infant mortality?
10. How should staff think about the focus and impact of their programs and activities to address AA/White and AI/White disparities in infant mortality? (see figure from RI Dept. of Health)
11. How do we use an Equity Pyramid to identify gaps in programs, services and policies? (see figure from RI Dept. of Health)
12. How can we increase the capacity of BFMCH staff to use data to inform decisions, practices, and policies?
Organizational

<table>
<thead>
<tr>
<th>Key Area</th>
<th>Goal</th>
<th>Potential Components</th>
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</table>
| Organizational  | • Decrease duplication of BFMCH and MDCH programs that affect infant mortality  
                  • More effective utilization of inter-division expertise, resources and data and better quality improvement  
                  • Increase capacity for BFMCH to support local efforts to address racial disparities in infant mortality  
                  • Help staff view addressing disparities as part of quality improvement, organizational growth and the mission and goals of MDCH  
                  • Create/ foster a supportive and encouraging culture may be helpful  
                  • Gain buy-in from all levels of MDCH and BFMCH staff and leadership  
                  • Incentivize staff to incorporate new knowledge in their work  
                  • Incentivize staff to create and share new tools         |

Key Organizational Questions:

1. How can we coordinate this new knowledge with existing efforts to address health disparities?
2. What inter-organizational relationships need to be created/ strengthened in order to better address social determinants of infant mortality?
3. How can we break down the silos within the Bureau and within State government to collaborate more effectively across areas and across discipline, especially given our recognition of the importance of social determinants of health?
4. Do we have a culture that embraces equity and, if so, how do we know that and how is it evident to those within the organization?
5. What specific activities can MDCH do to create a supportive organizational culture that encourages anti-racism and social justice?
6. How will incorporation of SDOH into daily work be encouraged and institutionalized?
7. How can MDCH leadership model incorporation of new knowledge into their daily responsibilities?
8. How can staff support each other and encourage critical reflection and action?
9. Does everyone in the organization understand what his or her role is in understanding and promoting equity?
10. Is addressing disparities explicit in programs, job descriptions, and other documents?
11. What’s the organizational climate in terms of “stress”? Is everyone just getting by doing the bare minimum because they have too many responsibilities as it is, or do they have time to dedicate to focusing on and prioritizing health disparities?
12. How can we plan to facilitate staff embracing PRIME’s efforts?
13. How do we negotiate political threats that have the potential to derail our efforts? How much power do we have to influence our work vs. respond to directives coming from the top?
This matrix is to be used to identify how and where to intervene within MDCH. It is designed to help inform how units prioritize continuing education needs of staff.

<table>
<thead>
<tr>
<th>Focus</th>
<th>State-Level Policies, responsibilities, relationships and activities</th>
<th>Locals Health Departments Relationships with and support of local health department/ Local Learning Collaborative efforts</th>
<th>MDCH/BFMCH Departmental and bureau policies, practices and norms</th>
<th>Data Systems Data collection, storage, analysis, and dissemination methods</th>
<th>Programs Programs and activities led or administered by BFMCH staff</th>
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<tbody>
<tr>
<td><strong>Conceptual</strong></td>
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<tr>
<td>Explicit or implicit theories that people use to explain and address racial disparities in infant mortality in MI</td>
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<tr>
<td><strong>Practical</strong></td>
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<tr>
<td>Application of information and resources to addressing day-to-day work issues, job roles and tasks to address racial disparities in infant mortality in MI</td>
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<tr>
<td><strong>Technical</strong></td>
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<tr>
<td>Specific skills, resources, and information used to systematically justify and address racial disparities in infant mortality in MI</td>
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<tr>
<td><strong>Organizational</strong></td>
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<tr>
<td>Aspects of MDCH, BFMCH and the divisions of BFMCH that influence BFMCH’s ability to address racial disparities in infant mortality in MI</td>
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Selected Priority Areas for Consideration

State-Level Policy

1) Define the role of BFMCH and its divisions in statewide efforts to educate policy makers about determinants of disparities in infant mortality
2) What educational and communication tools can be used to inform policy makers on the health implications of policies that affect health outcomes and particularly racial disparities in infant mortality?
3) Educate policy makers about the implications of policies for Black-White and American Indian-White disparities in infant mortality.

Local Health Departments

4) Define and differentiate the role of the state health department from local health department efforts to address racial disparities in infant mortality
5) Guide and support local health department efforts to address racial disparities in infant mortality.
6) Use data to inform and evaluate local efforts to address racial disparities in infant mortality.
7) Define and quantify “progress” in addressing racism and address racial disparities in infant mortality.
8) Help local health department staff develop culturally sensitive programs that address efforts to address Black-White disparities and American Indian-White disparities in infant mortality.
9) Create logic model templates for staff to require of grantees
10) Create tools for BFMCH staff to provide technical assistance for grantees to incorporate social determinants of health in their programs

MDCH/ BFMCH Organizational

11) Create a strategic planning development tool
12) Revise strategic plans and other documents
13) Increase the capacity of staff and teams to assess and address their training needs
14) Create tools and strategies to increase communication among staff
15) How do we help divisions prioritize training and educational priorities
16) How do we help staff explain why we must prioritize AA and AI in order to effectively reduce disparities in infant mortality.

Data

17) What data should be collected to inform efforts to address Black-White disparities and American Indian-White disparities in infant mortality?
18) How can the amount of missing data, such as birth weight or gestational age, on birth or death certificates be minimized?
19) How can we capture more of the cases of American Indian infant mortality?
20) What are the most effective strategies for monitoring social determinants of infant mortality? How do these data need to vary by race?
21) Identify MDCH and BFMCH policies that contribute to systematic misidentification of American Indian cases of infant mortality?
22) Increase capacity of BFMCH staff to use data to inform decisions, practices, and policies
23) Increase the utilization of data to inform, plan and evaluate BFMCH programs and activities
Programs

24) Help staff consider the following factors in program development, planning and evaluation:
   a) Social determinants of health disparities
   b) How social determinants of health disparities differ between Black infant mortality and American Indian infant mortality
   c) Individual vs. population health approaches
   d) Distinguish between theories of the problem (i.e., determinants of health) and theories of the intervention (i.e., where and how to intervene)
   e) A life course perspective
   f) Effective and realistic roles for community members in state health department efforts and strategies for gathering community perspectives and input

25) Create tools that help staff understand common and unique modifiable components of Black-White and American Indian-White disparities?
   a) Create Google Earth map and conceptual framework to help staff understand American Indian SDOH and infant mortality
   b) Create Google Earth map and conceptual framework to help staff understand Black SDOH and infant mortality
Section 5: Process for Reviewing the Green Paper
The PRIME Green Paper provided a stimulus for considering, discussing and refining the PRIME project’s aims, goals and objectives in an all-day retreat attended by the project’s Steering Team and moderated by a professional facilitator. A draft of the Green Paper was provided to Steering Team members to review in advance. The retreat began with a review of PRIME’s goals, objectives, and accomplishments to date. The group also discussed Steering Team members’ experiences collaborating together on this project and ways to further enhance the group’s functioning and collaboration.

Next, the group participated in a facilitated review of the Green Paper in which the main components were described, questions were raised, and Steering Team members were encouraged to share their feedback and suggestions. Modifications to the document’s structure and formatting were noted and incorporated into a subsequent draft. Discussion points, questions, and suggestions are summarized in Appendices B and C. A significant portion of time was devoted to discussing and debating the practical aspects of how the Intervention Process (pp. 16-17) would and could be implemented within BFMCH. Major issues addressed included how to take advantage of the Bureau’s strengths, practical limitations and challenges within and outside the Bureau, and how to design and implement the process in a way that maximizes its likelihood of engaging and supporting staff and of changing Bureau policies and practices in a sustainable manner.

Finally, the Steering Team divided into small groups of 4-5 members. Each group was provided with the list of questions associated with one of the key potential areas of focus for PRIME—conceptual, practical, technical, or organizational (pp. 17-26)—and the groups were invited to add questions to, revise as needed, and prioritize elements within each focus area. Each group also was asked to consider who should and had the authority to make decisions in answering each question—BFMCH leadership, PRIME Steering Team, one of the PRIME workgroups (intervention, evaluation, AI data, local learning collaborative, new workgroups groups). Each group was then asked to report back to the full group, where further discussion took place on each area of focus. The prioritization and suggested changes to the lists of questions that occurred during this exercise are recorded in Appendix C.
Section 6: PRIME Intervention Next Steps
The PRIME Green Paper has outlined the breadth of issues and questions that we have identified through our collaborative partnership. In the course of this three-year grant, we will not be able to address all of these questions. Thus, we will need to determine how we as a PRIME Project will prioritize key questions, issues and focus areas both to work with BFMCH staff as well as to develop tools for staff and others to use. We also need to collectively determine how we will balance providing assistance and support to each of the divisions within BFMCH and the PRIME intervention timeline. Moving forward we will pursue the following steps in implementing PRIME:

1. Review findings from Organizational Assessment

2. Create Division-Specific Plans
   a. Prioritize program and policy needs and interests
   b. Identify relevant focus areas and intervention components
   c. Identify timeline, resource needs, and consultation supports
   d. Determine what resources/ components exist vs. ones that need to be created within PRIME

3. Create a communication strategy about the project for staff and internal and external stakeholders

4. Use LLC products as a resource for MCH program development/policy

5. Implement, complete and evaluate plan

6. Develop a quality assurance process

7. Determine next steps to be completed in the course of the grant and after
References

Section 1


Section 2

Cited References


Additional References


Assistant Secretary for Health's Task Force to Strengthen Public Health in the United States. (1991). A
plan to strengthen public health in the United States. *Public Health Reports*, 106(Supplement 1), 1-86.


### Section 3


Section 4


**Appendix A**


Appendix A: Definitions of Terms

The definitions below are derived from the *Michigan Health Equity Roadmap* and other sources.

**Discrimination**
Discrimination is unequal treatment on the basis of some socially defined category; it involves behavior aimed at denying members of particular groups equal access to societal rewards and, as such, goes beyond merely thinking unfavorably about particular groups (Blank, Dabady, & Forbes Citro, 2004). There are two aspects of discrimination – differential treatment and differential effects: differential treatment describes behavior, often intentional, to treat someone less favorably based on some socially defined category; differential effects are practices that adversely impacts one group but not another without a sufficiently compelling reason (Blank, Dabady, & Forbes Citro, 2004).

**Health Disparities**
Healthy People 2020 defines a *health disparity* as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.” Signiﬁcant differences in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in a racial or ethnic minority population as compared to the health status of the general population (Minority Health and Health Disparities Research and Education Act, 2000). Health disparities refer to measured health differences between two populations, regardless of the underlying reasons for the differences. (MI Roadmap)

**Health Inequities**
Health inequities refers to differences in health across population groups that are systemic, unnecessary and avoidable, and are therefore considered unfair and unjust (Whitehead, 1990). Health inequities have their roots in unequal access or exposure to social determinants of health such as education, healthcare, and healthy living and working conditions. Racial and ethnic minority populations are disproportionately impacted by poor conditions in these areas which, in turn, result in poor health status and health outcomes. (MI Roadmap)

**Health Inequalities**
In the *Michigan Health Equity Roadmap*, the term health inequalities is used distinctly to connote health differences related to unfair and unjust social contexts (i.e., inequities) rather than simple observations of differences in health determinants or health outcomes noted between populations (i.e., disparities) (MI Roadmap)

**Health Equity**
Healthy People 2020 defines *health equity* as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”
“Health equity is the absence of systematic disparities in health and its determinants between groups of people at different levels of social advantage (Minority Health and Health Disparities Research and Education Act, 2000). To attain health equity means to close the gap in health between populations that have different levels of wealth, power, and/or social prestige. For example, low-income persons and racial/ethnic minorities generally have poorer health relative to people who have more economic resources or who are members of more powerful and privileged racial groups. Health equity falls under the umbrella of social justice, which refers to equitable allocation of resources in society. Eliminating health disparities and health inequities between racial and ethnic populations moves us toward our goal of health equity and social justice, and a significant focus of this effort is to address social determinants of health that influence our priority public health outcomes.” (MI Roadmap, p. 15)

Racism
Racism is “an organized system, rooted in an ideology of inferiority that categorizes, ranks, and differentially allocates societal resources to human population groups” (Williams & Rucker, 2000, p. 76). Principles of utilizing racism as a term:

- Racism is useful as an analytic tool but difficult to describe or communicate
- Racism is most useful as a framework when the focus remains on the system, not individuals
- Racism is useful as a lens through which to understand health outcomes
- Racism incorporates the interconnections of social institutions that produce disparate outcomes
- Racism focuses on outcomes rather than intentions, highlighting covert, not merely overt, operations of racism
- Racism is a dynamic, rational response aligned with the normative culture
- Racism summarizes the processes and outcomes that follow a pattern of U.S. cultural beliefs, structural patterns, historical legacies, institutions, organizations and individuals (Griffith, et al., 2007a & b)

*Cultural racism* represents the cumulative effects of living in a society and culture that views racial groups as biologically distinct; hierarchically ranks people of socially defined races; allows these cultural beliefs and definitions to influence institutional policies and practices and the ideologies and behaviors of individuals; passes these beliefs and values on from generation to generation (Jones, 1997; Smedley & Smedley, 2005). “In a race-conscious society, *cultural racism* reflects attitudes, values, and beliefs about races and the importance of race in society. Processes of racialization involve the emergence of cultural notions of racial and ethnic hierarchy, or cultural racism, that become institutionalized in legislation or in institutional policies” (Griffith, et al., 2010, p. 72).

*Institutional racism* is a systematic set of patterns, procedures, practices, and policies that operate within institutions so as to consistently penalize, disadvantage, and exploit individuals who are members of non-White groups (Better, 2002; Rodriguez, 1987). *Institutional racism* is the primary tool or process that promotes cultural racism, and maintains white power and privilege (segregation, discrimination, unequal distribution of resources) (Jones, 1997).

Social Determinants of Health
“Social determinants of health refer to social, economic, and environmental factors that contribute to the overall health of individuals and communities (Commission on Social Determinants of Health, 2008). *Social factors* include, for example, racial and ethnic discrimination; political influence; and social connectedness. *Economic factors* include income, education, employment, and wealth. *Environmental factors* include living and working conditions, transportation, and air and water quality. A focus on
health equity in Michigan calls for more targeted efforts to address these and other social determinants of health in order to optimize health promotion and disease prevention efforts.” (MI Roadmap, p. 15)

“...the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life” (WHO Commission on Social Determinants of Health, 2008, p. 1).
Appendix B: Green Paper Discussion Summary

- **Section 1**: The PPOR labels typically used to characterize the different components of the PPOR may not accurately capture the underlying causes of infant mortality for cases falling within a particular box. PPOR is a statistical algorithm used to group cases based on birth weight and weeks of gestation. Although the labels are useful for identifying differing patterns of infant mortality between groups (e.g., comparing AA, AI, and Whites) and potential approaches to intervention, their limitations must also be recognized.

- **Section 4 (Process)**: The group discussed how to actively engage BFMCH staff in PRIME so that they want to be involved and how different approaches to the intervention model could facilitate or hinder this.

- **Section 4 (Process)**: It was felt the Bureau leadership played a critical role in this. Their endorsement of PRIME would encourage staff to participate. Conveying to staff how important the process is and that its goal is to expose them to new ideas and ways of thinking about issues, such as health disparities, were also identified as potentially beneficial ways of engaging staff.

- **Section 4 (Process)**: The group discussed whether participation in the PRIME intervention components should be voluntary or mandatory. Benefits and drawbacks of both approaches were identified. The concept of “herd immunity” was raised with the idea that if PRIME activities started out as voluntary, the most interested staff would participate and then help others along and encourage the involvement of more and more staff. Some staff may never come onboard, yet changes within BFMCH would still affect their work and the way they functioned in carrying out their respective duties.

- **Section 4 (Process)**: It was suggested that the “initial training workshop” instead be referred to as a learning experience or learning collaborative.

- **Section 4 (Process)**: It was also suggested that the intent of the initial training workshop may be better achieved through an ongoing diologic process for staff. The rationales for this were that: a) the conceptual aspects of health disparities and social determinants of health can be difficult for people to grasp and ongoing exposure and discussion may give staff more opportunity to learn, reflect, and understand these concepts and their relationship to disparities in infant mortality and their job duties; and b) an ongoing process would promote sustainability, given staff turnover, busy schedules, and other barriers.
Section 4 (Process): It would be helpful if the intervention model was designed so that staff and units that are farther along in actively addressing health disparities in their work could continue to move forward, while pulling along those with less understanding and experience in this area.

Section 4 (Components): During the prioritization of questions exercise, some of the small groups initially focused on whether or not particular questions belonged in a category or not, rather than the objectives of the exercise, which were to prioritize questions and determine who had the authority to answer each question.

Section 4 (Components): Although the matrix on pages 26-27 was identified as helpful for brainstorming potential areas of intervention by some, it was viewed as overly complicated by others.

Section 4 (Components): For the majority of questions discussed, the PRIME Steering Team was identified as the group that ought to be making decisions. It was suggested that PRIME workgroups (intervention, evaluation, AI data, local learning collaborative and possibly new workgroups such as a data group and communications group) develop proposals on how to answer questions relevant to their charge and bring these to the Steering Team for review and approval before moving forward with any plans.
Appendix C: Key Questions: Ranked and Revised

NOTE: Bold comments in parentheses describe (and, for revisions, reflect) the nature of suggestions provided during the retreat, compared to original questions on pages 20-26.

Key Conceptual Questions:

1. Why and how should we define racism in our work? [REVISED]
2. Why and how should we think about what it means to be Black or American Indian in our efforts to address infant mortality? [REVISED]
3. Why is it important for staff to understand and identify social determinants of health?
4. What are the common components of Black-White and American Indian-White disparities and what the unique elements of each? How can these elements be addressed in our work?
5. How should we incorporate a life course perspective in the work of BFMCH and each of its divisions?
6. How much should we focus on changing how staff define racism personally vs. changing how they use racism as a term in their work?
7. How should staff think about the relative importance of key determinants of racial disparities in infant mortality (see Figure 8)? [DELETE?]

Key Practical Questions:

1. What are the practical definitions, differences, and similarities between health disparities, health inequities, health inequalities and health equity that staff need to know? How can these be standardized?
2. What kind of tools could be developed to assist staff? What tools do staff feel that they need? What tools do leadership feel that staff need? [COMBINE TWO SEPARATE QUESTIONS?]
3. What are barriers that may be encountered during our efforts to address racism and health disparities and how will they be overcome?
4. Who should staff turn to for conceptual or technical assistance?
5. How should “progress” in addressing racism and health inequalities be defined and measured?
6. What is the expected staff time allocated for implementing PRIME?
7. What resources are available to support staff in their work to more effectively address health disparities in infant mortality?
8. How can we incorporate community input into our work? Is this something we should collect ourselves or rely on local HDs to provide to us (and how shall we require they collect this?)?
9. How can we use limited resources to balance our, potentially conflicting, responsibilities to Black and American Indian populations and the State at large? [MOVE TO ANOTHER SECTION?]
10. Who makes decisions about priorities and how are these decisions made? [MOVE TO ANOTHER SECTION?]
11. What current MDCH and BFMCH policies and practices address the fundamental, or root, causes of racial disparities in infant mortality? [MOVE TO ANOTHER SECTION?]
12. Who will ensure that SDOH are addressed in policies and practices? [MOVE TO ANOTHER SECTION?]
Key Technical Questions:

1. What techniques are used to analyze data with small populations or missing information?
2. How can we capture more of the cases of American Indian infant mortality?
3. How and why should data for AI cases be treated differently than data for AA or White cases?
4. Are there particular MDCH policies that cause systematic misidentification of AI cases of infant mortality?
5. How can MDCH monitor the social determinants of infant mortality?
6. How can the amount of missing data, such as birth weight or gestational age, on birth or death certificates be minimized?
7. What preconceptions underlie data that is collected, and how we view data?
8. How do we more effectively use data to link us to resources?
9. How do we create separate but complementary plans to address AA/White and AI/White disparities in infant mortality?
10. How can we increase the capacity of BFMCH staff to use data to inform decisions, practices, and policies?

Key Organizational Questions [NOT PRIORITIZED]:

1. How can we coordinate this new knowledge with existing efforts to address health disparities?
2. What inter-organizational relationships need to be created/strengthened in order to better address social determinants of infant mortality?
3. What specific activities can MDCH do to create a supportive organizational culture that encourages anti-racism and social justice?
4. How will incorporation of SDOH into daily work be encouraged and institutionalized?
5. How can MDCH leadership model incorporation of new knowledge into their daily responsibilities?
6. How can staff support each other and encourage critical reflection and action? [MOVE TO PRACTICAL?]
7. Does everyone in the organization understand what his or her role is in understanding and promoting equity?
8. Is addressing disparities explicit in programs, job descriptions, and other documents? [MOVE TO PRACTICAL?]
9. What’s the organizational climate in terms of “stress”? Is everyone just getting by doing the bare minimum because they have too many responsibilities as it is, or do they have time to dedicate to focusing on and prioritizing health disparities? [MOVE TO PRACTICAL?]
10. How can we plan to facilitate staff embracing PRIME’s efforts?
11. How can we break down the silos within the Bureau and within State government to collaborate more effectively across areas and across discipline, especially given our recognition of the importance of social determinants of health?
12. Do we have a culture that embraces equity and, if so, how do we know that and how is it evident to those within the organization?
13. How do we negotiate political threats that have the potential to derail our efforts? How much power do we have to influence our work vs. respond to directives coming from the top?