Practices to Reduce Infant Mortality through Equity (PRIME)* Organizational Assessment with Women, Infant and Children (WIC) Division, April/May 2012

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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 Community Health's (MDCH) Bureau of Family, Maternal and Child Health (BFMCH) and its staff to address and eliminate infant mortality disparities in Michigan, specifically focusing on reducing infant mortality rates among African Americans and American Indians.

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

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

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

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

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

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

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

- **Professional development:** WIC staff reported using conferences, internal trainings, webinars and other BFMCH staff to gather information about racial health disparities more than other methods. Management staff reported using resources to learn about racial health disparities

significantly more than non-managers. Between 30-45% of WIC staff indicated they did not think or know if the Bureau allocated resources for staff interpersonal and professional skill development.

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

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

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

OBJECTIVES

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

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

METHODS

Assessment Tool Description

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

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

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

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

In the organizational assessment, racial health disparities is defined as "differences in health outcomes that exist among racial/ethnic groups in the U.S., and that have roots in unequal access or exposure to social determinants of health such as education, healthcare, and healthy living and working conditions."

The assessment is web-based and was developed using Qualtrics software. It contains 100 closed-ended items and is designed to take 20-30 minutes to complete. Participants can skip questions if they choose. All items, except for the demographic questions, have Likert-scale response options ranging from 4 = Strongly Agree to 1 = Strongly Disagree. Some items provide the additional response option of "Don't Know," for when respondents are asked to provide factual information they may not know or have an opinion about and for which the "Don't Know" response option provides useful information for analysis.

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

Data Collection

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

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

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

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

Data Analysis

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

FINDINGS

Participant Demographics

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

Participant race/ethnicity*

Race/ethnicity	n	%
White	31	73.8
Black, African-American	9	21.4
Asian	4	9.5
Pacific Islander	0	0.0
American Indian or Alaska Native	2	4.8
Other	3	7.1
Latino	1	2.4

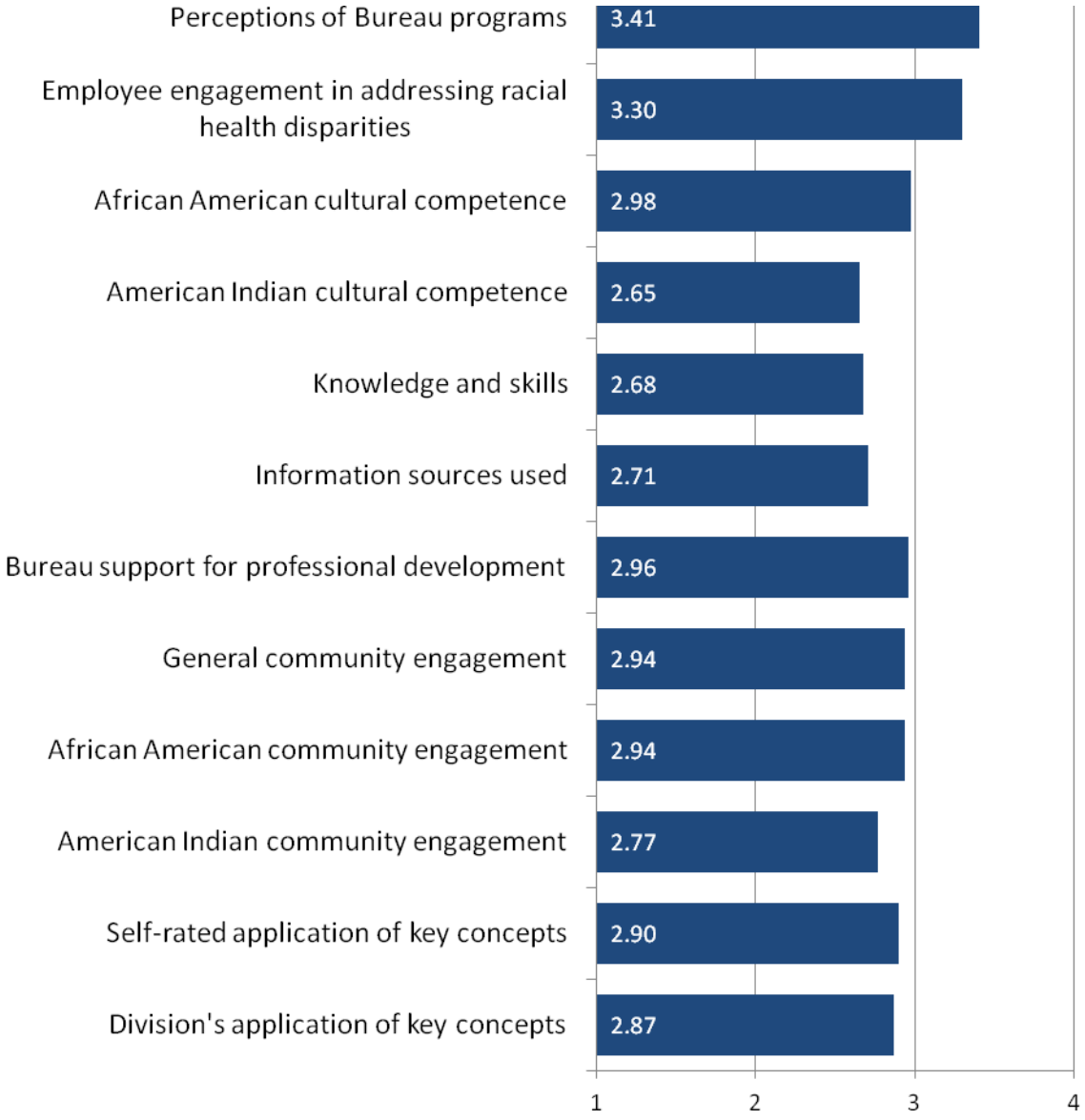
*Column may not total to 100% as some respondents may have chosen more than one category

Participant employment characteristics

Description	n	%
Administration/Management	7	17.1
Administrative Support	6	14.6
Program Coordinator/Specialist	7	17.1
Program Consultant	15	36.6
Vendor Consultant	4	9.8
Other	2	4.9
Full-time	41	97.6
Permanent	35	83.3

Overall Topic Ratings

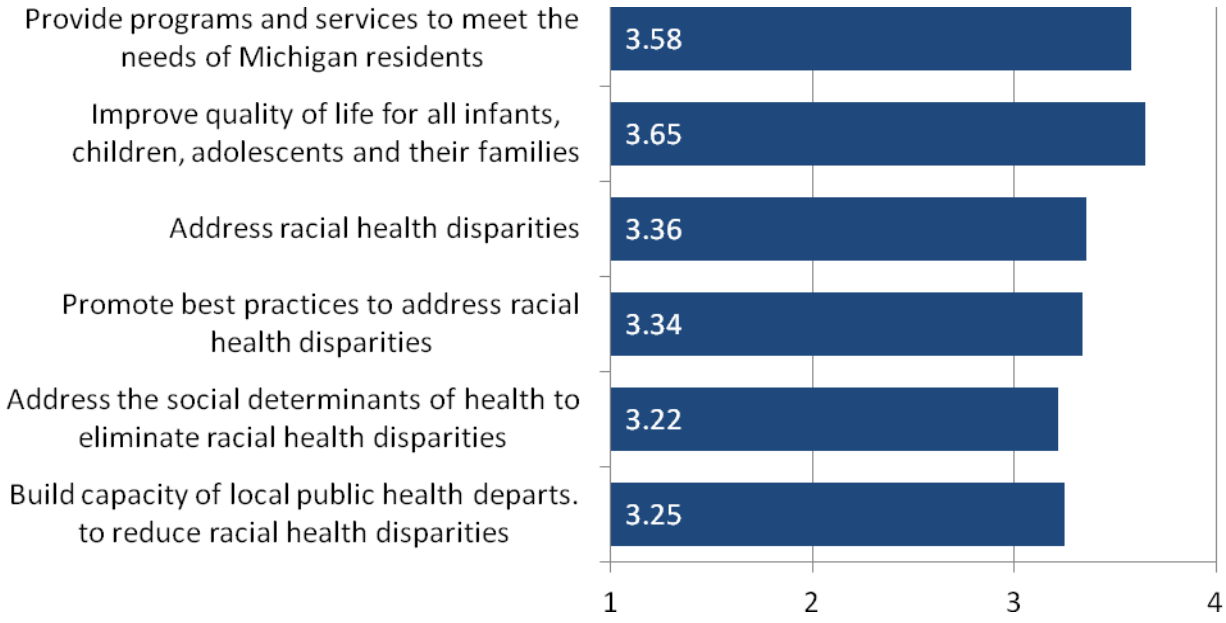
We created a bar chart (below) to depict the average scores for all topic/subtopic areas. Scores could range from 1.0 to 4.0, with higher scores representing higher ratings for a topic/subtopic. Perceptions of Bureau programs and services (3.41) and employee engagement in addressing racial health disparities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



Perceptions of Programs and Services within the Bureau of Family, Maternal and Child Health

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

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



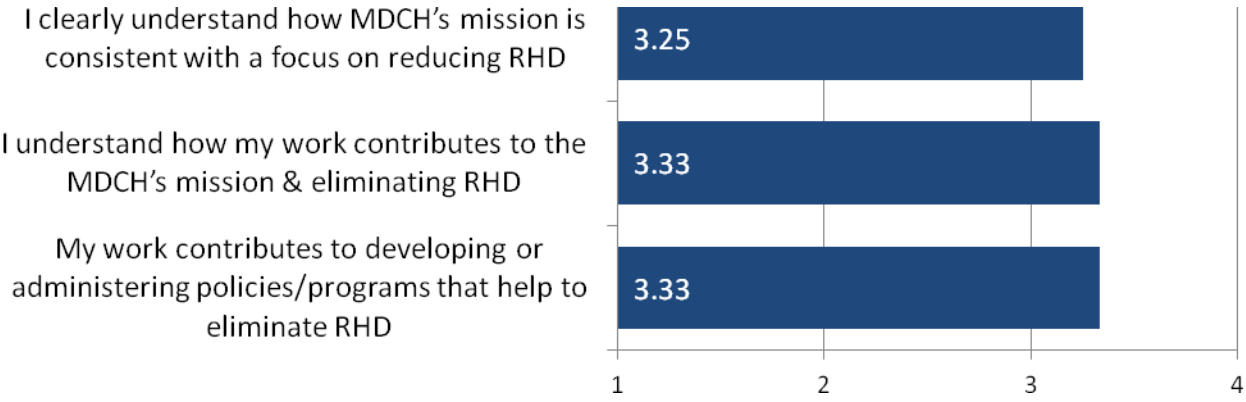
The Bureau's programs and services are designed to:	n	Average^ (SD)	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
Provide programs and services to meet the needs of Michigan residents	40	3.58 (0.501)	57.5%	42.5%	0%	0%	0%
Improve quality of life for all infants, children, adolescents and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

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

Employee Engagement in Addressing Racial Health Disparities

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

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



Item	n	Average ^ (SD)	Strongly Agree	Agree	Disagree	Strongly Disagree
I clearly understand how MDCH's mission is consistent with a focus on reducing racial health disparities	40	3.25 (0.588)	32.5%	60.0%	7.5%	0%
I understand how my work contributes to the MDCH's mission and eliminating racial health disparities	40	3.33 (0.616)	40.0%	52.5%	7.5%	0%
My work contributes to developing or administering policies and programs that help to eliminate racial health disparities	40	3.33 (0.694)	45.0%	42.5%	12.5%	0%

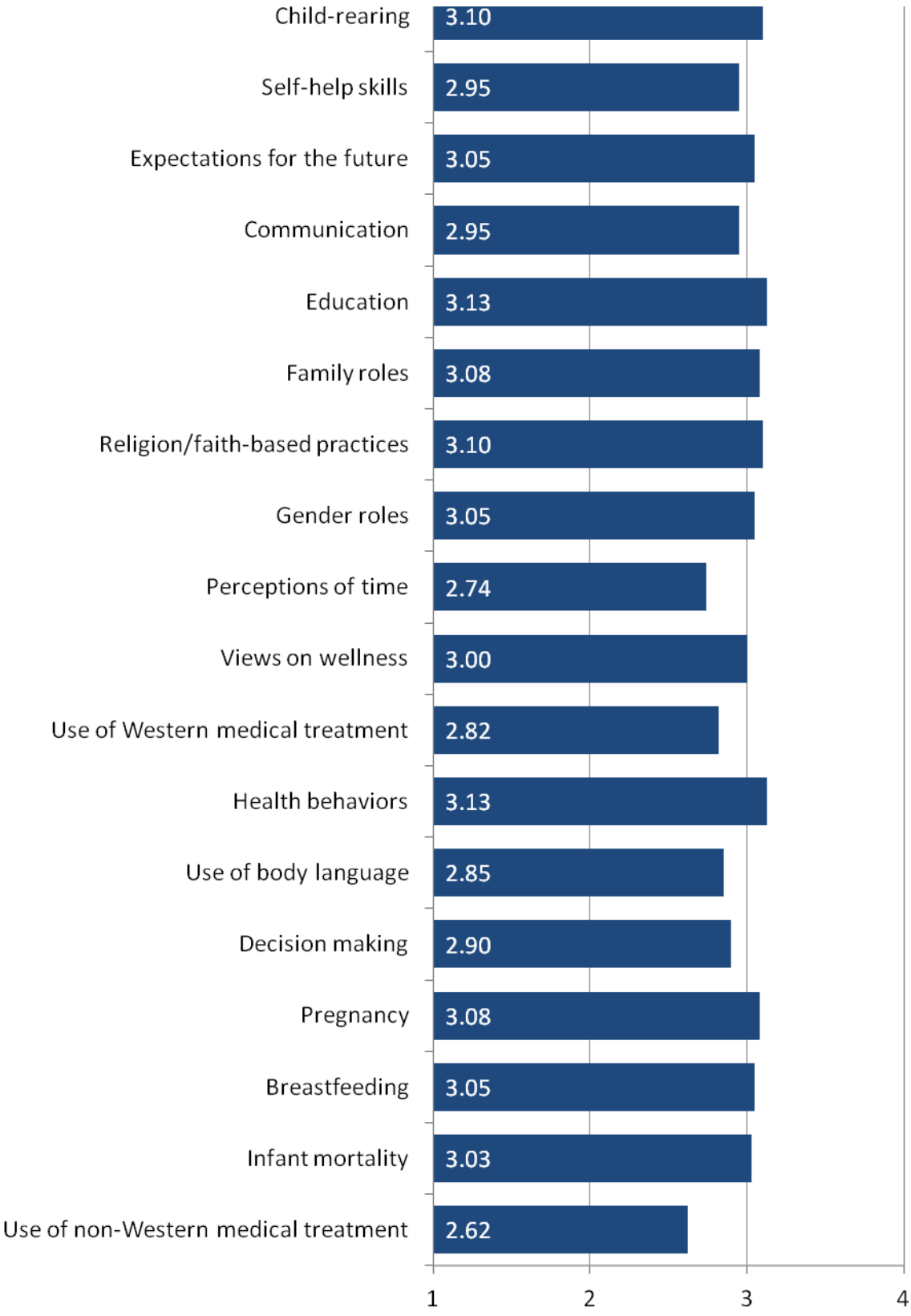
^ 4-1 range, with 4 indicating strongly agree and 1 indicating strongly disagree

Cultural Competence

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

<u>African American Cultural Competence</u>

- The average score for all questions within this subtopic area was 2.98 (SD: 0.47), with a range from 2.00 to 4.00.
- Average scores from administration/management staff did not significantly differ from average scores from non-management staff.
- The majority of WIC staff reported a moderate level of African American cultural competence for all the areas assessed. Using a cutoff of 20% disagree, respondents reported lower understanding of how African American culture affects self-help skills, religion and faith-based practices, perceptions of time, use of Western and non-Western medical treatments, body language, decision making, and infant mortality.
  - Clarifying question: We were surprised at the relatively high disagree rates for use of non-Western medical treatment and infant mortality categories, in particular, as these seem more relevant to the WIC program than some of the other areas with lower scores. How can these results be explained?

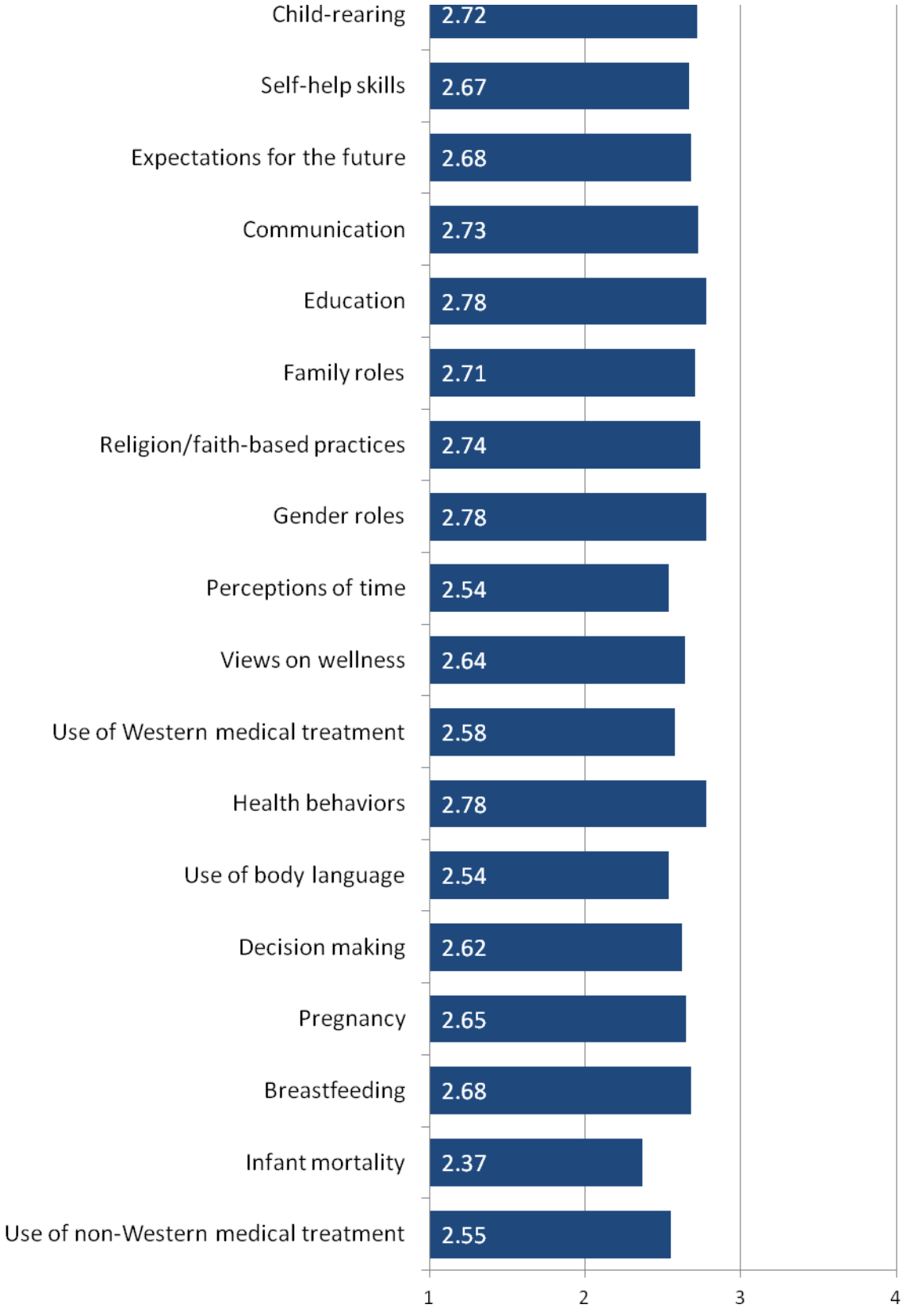

Child-rearing
3.10
Self-help skills
2.95
Expectations for the future
3.05
Communication
2.95
Education
3.13
Family roles
3.08
Religion/faith-based practices
3.10
Gender roles
3.05
Perceptions of time
2.74
Views on wellness
3.00
Use of Western medical treatment
2.82
Health behaviors
3.13
Use of body language
2.85
Decision making
2.90
Pregnancy
3.08
Breastfeeding
3.05
Infant mortality
3.03
Use of non-Western medical treatment
2.62
1
2
3
4

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

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

American Indian Cultural Competence

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


Child-rearing
2.72
Self-help skills
2.67
Expectations for the future
2.68
Communication
2.73
Education
2.78
Family roles
2.71
Religion/faith-based practices
2.74
Gender roles
2.78
Perceptions of time
2.54
Views on wellness
2.64
Use of Western medical treatment
2.58
Health behaviors
2.78
Use of body language
2.54
Decision making
2.62
Pregnancy
2.65
Breastfeeding
2.68
Infant mortality
2.37
Use of non-Western medical treatment
2.55
1
2
3
4

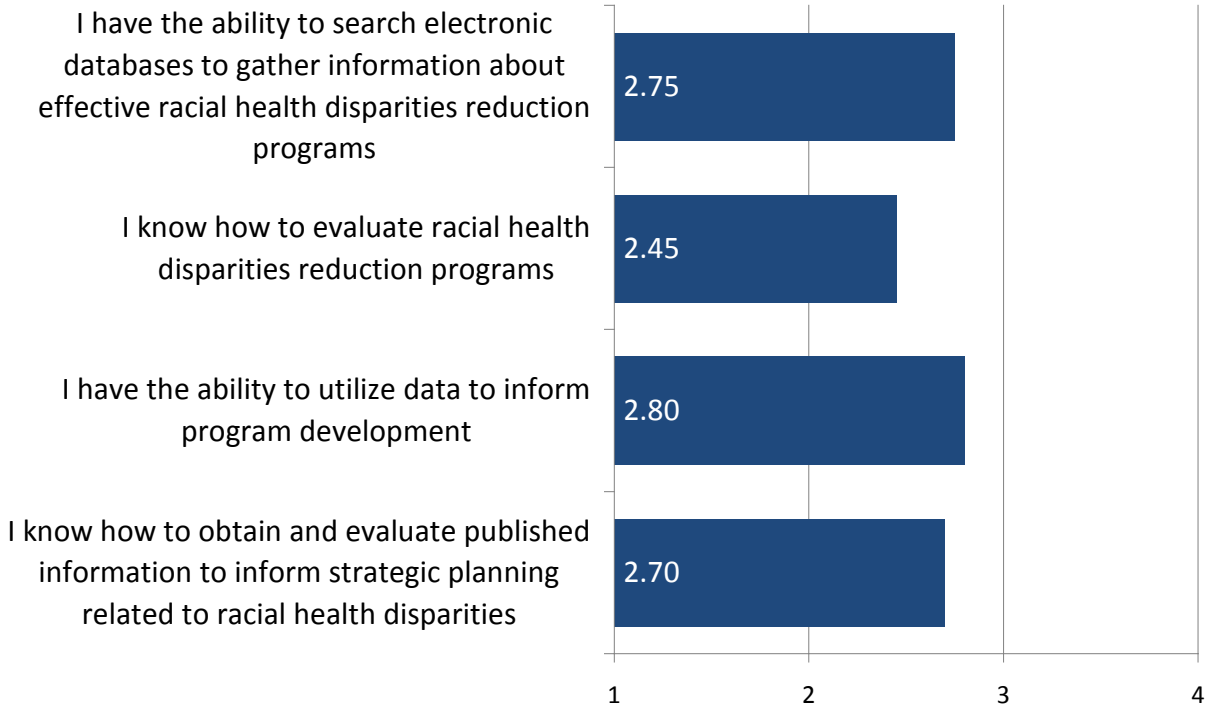
I understand how culture impacts American Indians' lives, such as:	n	Average^ (SD)	Strongly Agree	Agree	Disagree	Strongly Disagree
Child-rearing	40	2.72 (0.599)	5.0%	65.0%	27.5%	2.5%
Self-help skills	39	2.67 (0.701)	7.7%	56.4%	30.8%	5.1%
Expectations for the future	40	2.68 (0.764)	12.5%	47.5%	35.0%	5.0%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

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

Knowledge and Skills

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

- The average score for all questions within this topic area was 2.68 (SD: 0.59), with a range from 1.25 to 3.75.
- This question set received the second lowest average score compared to other topics assessed.
- Average scores from administration/management staff did not significantly differ from average scores from non-management staff.
- While approximately half of the respondents reported that they understood how to use data and other published material to learn about, develop and evaluate programs to address racial health disparities, few indicated a high level of confidence in their ability to do so; a sizable percent (30-50) were not confident in their capacity in this area.
  - Clarifying question: Why did approximately one third of respondents indicate that they were not able to use data and other published resources to learn about, develop and evaluate programs related to reducing racial health disparities? Is this due challenges in accessing data and other published material (and would therefore require a technical solution), challenges that are more conceptual in nature, or job specialization?
- 52% of respondents indicated that they were not able to evaluate existing health disparity reduction programs.
  - Clarifying question: Responses indicate more challenges with program evaluation compared to program development or strategic planning. We need to clarify whether this is because program evaluation is the primary responsibility of only a few staff members or if staff would benefit from additional training in this area.



Item	n	Average ^ (SD)	Strongly Agree	Agree	Disagree	Strongly Disagree
I have the ability to search electronic databases to gather information about effective racial health disparities reduction programs	40	2.70 (0.791)	15.0%	45.0%	35.0%	5.0%
I know how to evaluate racial health disparities reduction programs	40	2.45 (0.597)	2.5%	42.5%	52.5%	2.5%
I have the ability to utilize data to inform program development	40	2.80 (0.758)	15.0%	55.0%	25.0%	5.0%
I know how to obtain and evaluate published information to inform strategic planning related to racial health disparities	40	2.75 (0.742)	15.0%	47.5%	35.0%	2.5%

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

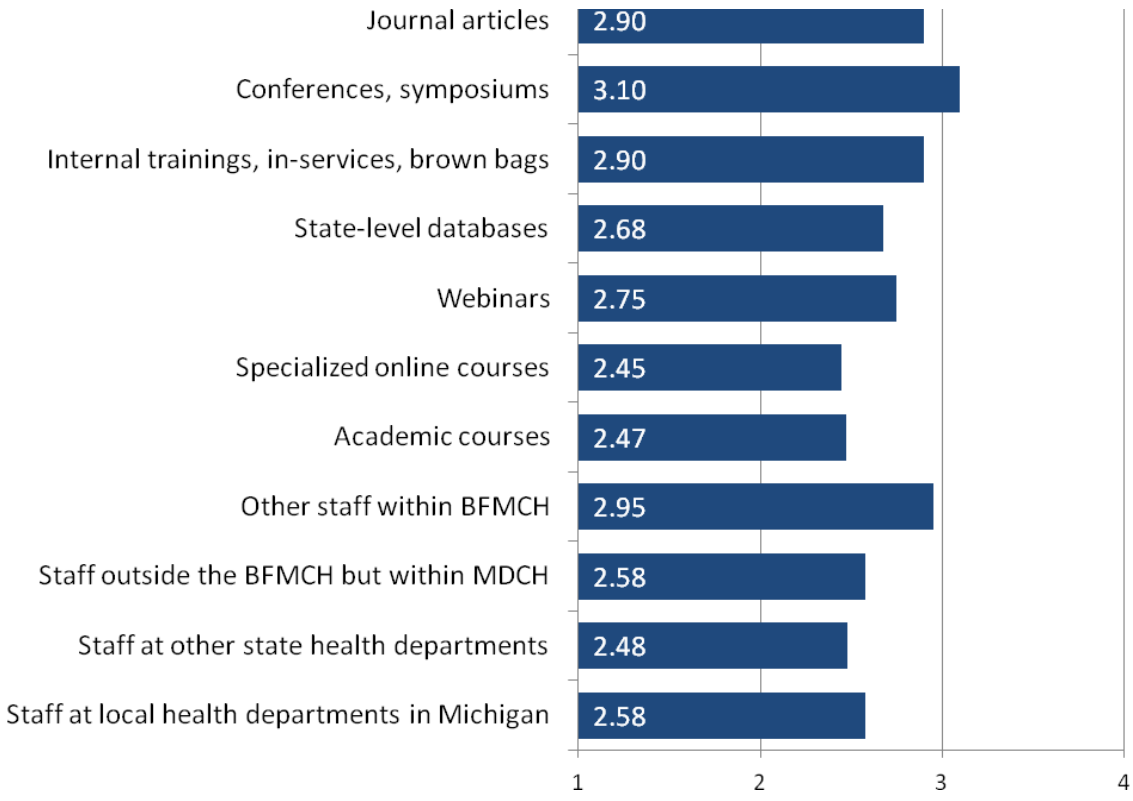
Professional Development

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

Information Sources Used

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

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



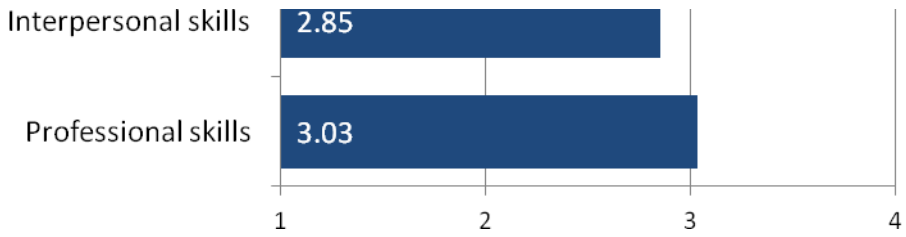
To do my job, I use information about racial health disparities from:	n	Average ^ (SD)	Strongly Agree	Agree	Disagree	Strongly Disagree
Journal articles	40	2.90 (0.778)	22.5%	47.5%	27.5%	2.5%
Conferences, symposiums	40	3.10 (0.672)	27.5%	55.0%	17.5%	0%
Internal trainings, in-services, brown bags	40	2.90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

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

Bureau Support of Professional Development

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

- The average score for all of these questions within this subtopic area was 2.96 (SD: 0.80), with a range from 1.00 to 4.00.
- Average scores from administration/management staff did not significantly differ from average scores from non-management staff.
- Responses for these questions were fairly spread out over the Strongly Agree, Agree, and Disagree response options.
  - Clarifying question: Are resources available, and how can staff awareness of them be increased?



The Bureau allocates resources for staff to enhance their:	n	Average^ (SD)	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
Interpersonal skills	40	2.85 (0.857)	20.0%	37.5%	22.5%	5.0%	15.0%
Professional skills	40	3.03 (0.799)	27.5%	42.5%	20.0%	2.5%	7.5%

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

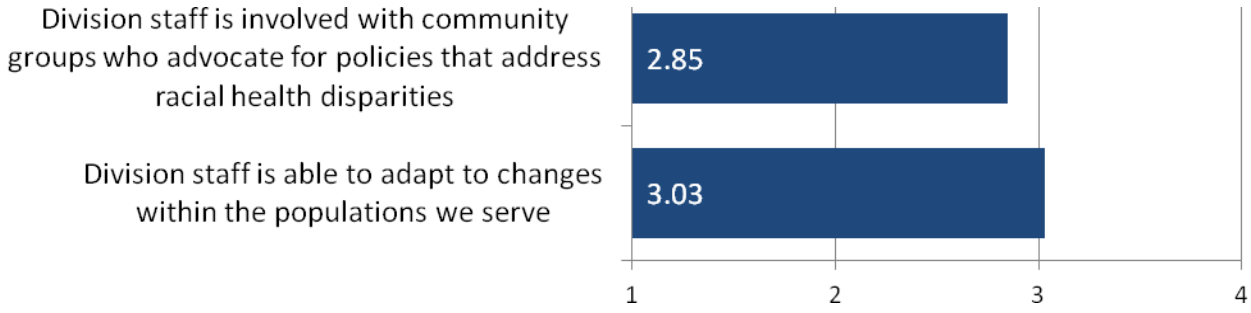
Division's Community Engagement

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

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

<u>Division's General Community Engagement</u>

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

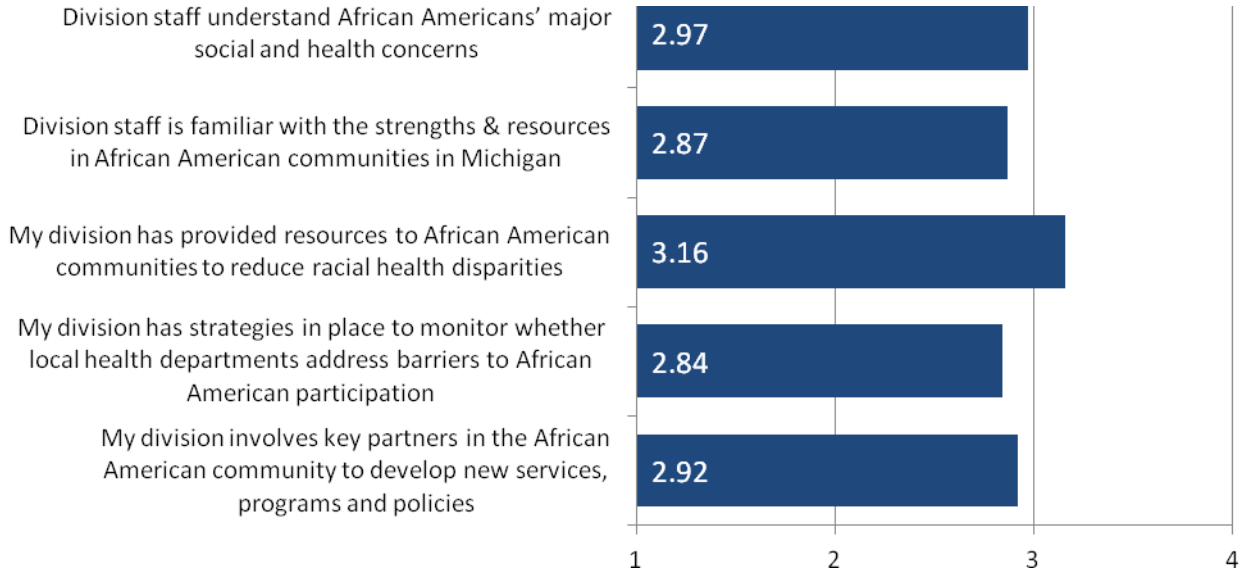


Item	n	Average ^ (SD)	Strongly Agree	Agree	Disagree	Strongly Disagree
Division staff is involved with community groups who advocate for policies that address racial health disparities	39	2.85 (0.670)	10.3%	69.2%	15.4%	5.1%
Division staff is able to adapt to changes within the populations we serve	39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

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

Division's Community Engagement of African Americans

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

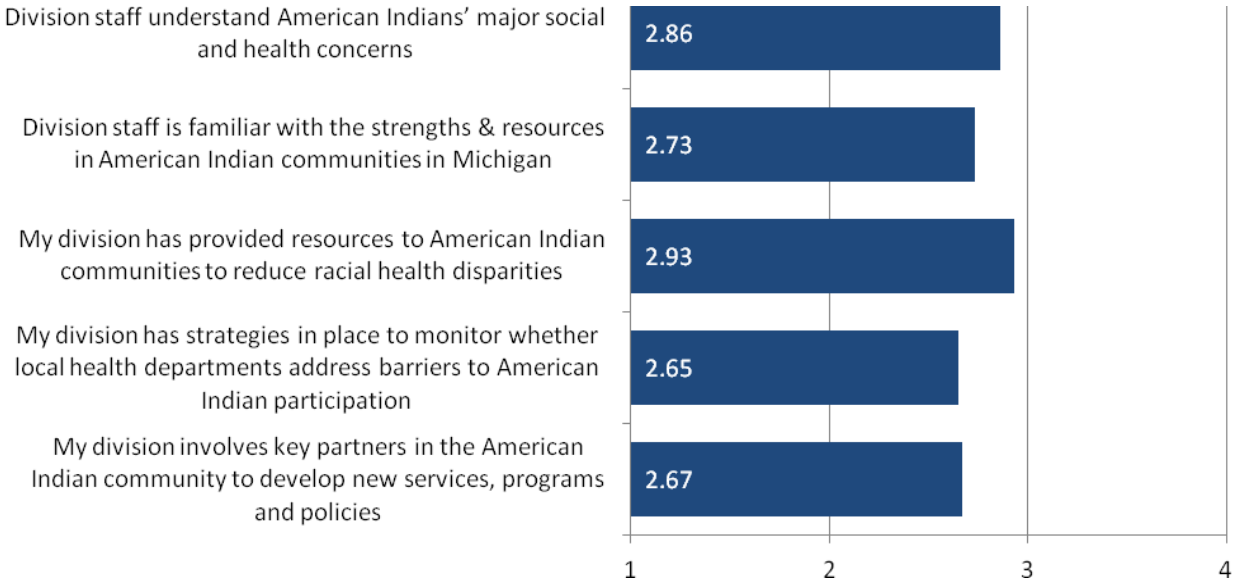


Item	n	Average^ (SD)	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
Division staff understand African Americans' major social and health concerns	40	2.97 (0.547)	7.5%	62.5%	5.0%	2.5%	22.5%
Division staff is familiar with the strengths & resources in African American communities in Michigan	40	2.87 (0.629)	7.5%	52.5%	12.5%	2.5%	25.0%
My division has provided resources to African American communities to reduce racial health disparities	40	3.16 (0.448)	15.0%	62.5%	2.5%	0%	20.0%
My division has strategies in place to monitor whether local health departments address barriers to African American participation	40	2.84 (0.554)	5.0%	42.5%	15.0%	0%	37.5%
My division involves key partners in the African American community to develop new services, programs and policies	40	2.92 (0.572)	7.5%	42.5%	12.5%	0%	37.5%

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

Division's Community Engagement of American Indians

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



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

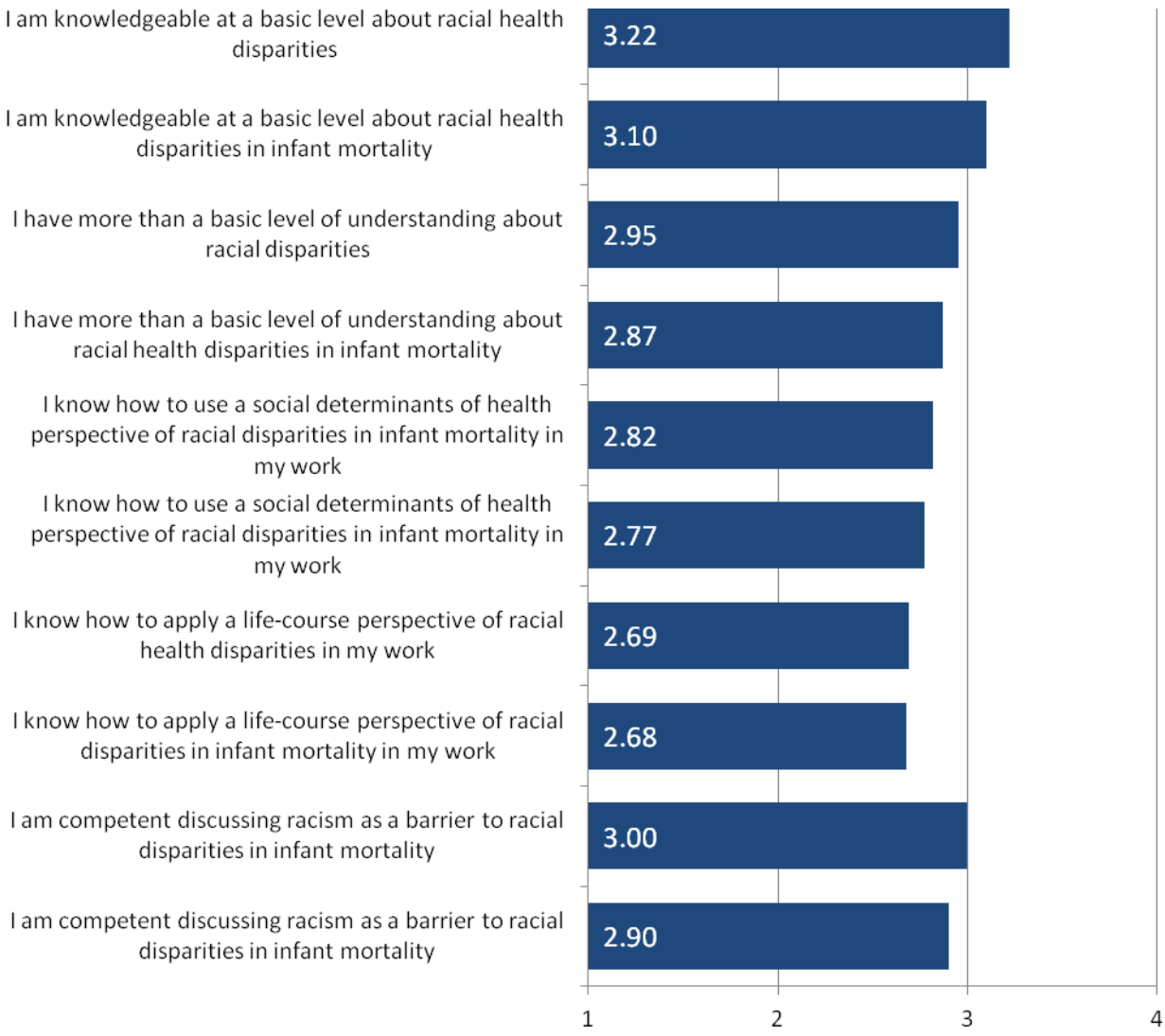
^ 4-1 range, with 4 indicating strongly agree and 1 indicating strongly disagree

Understanding and Application of Key Concepts

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

Self-Rated Understanding and Application of Key Concepts

- The average score for all questions within this subtopic area was 2.90 (SD: 0.61), with a range from 1.44 to 4.00.
- Average scores from administration/management staff did not significantly differ from average scores from non-management staff.
- WIC staff reported a basic understanding of racial health disparities in general and in infant mortality, specifically. A deeper understanding of the problem and potential solutions appears still needed.
- Respondents reported challenges with their ability to apply a social determinants of health approach and a life-course perspective, and to discuss racism as a barrier to racial health disparities and disparities in infant mortality. This is consistent with findings described above that staff are unsure of the role that BFMCH should play in addressing health disparities.



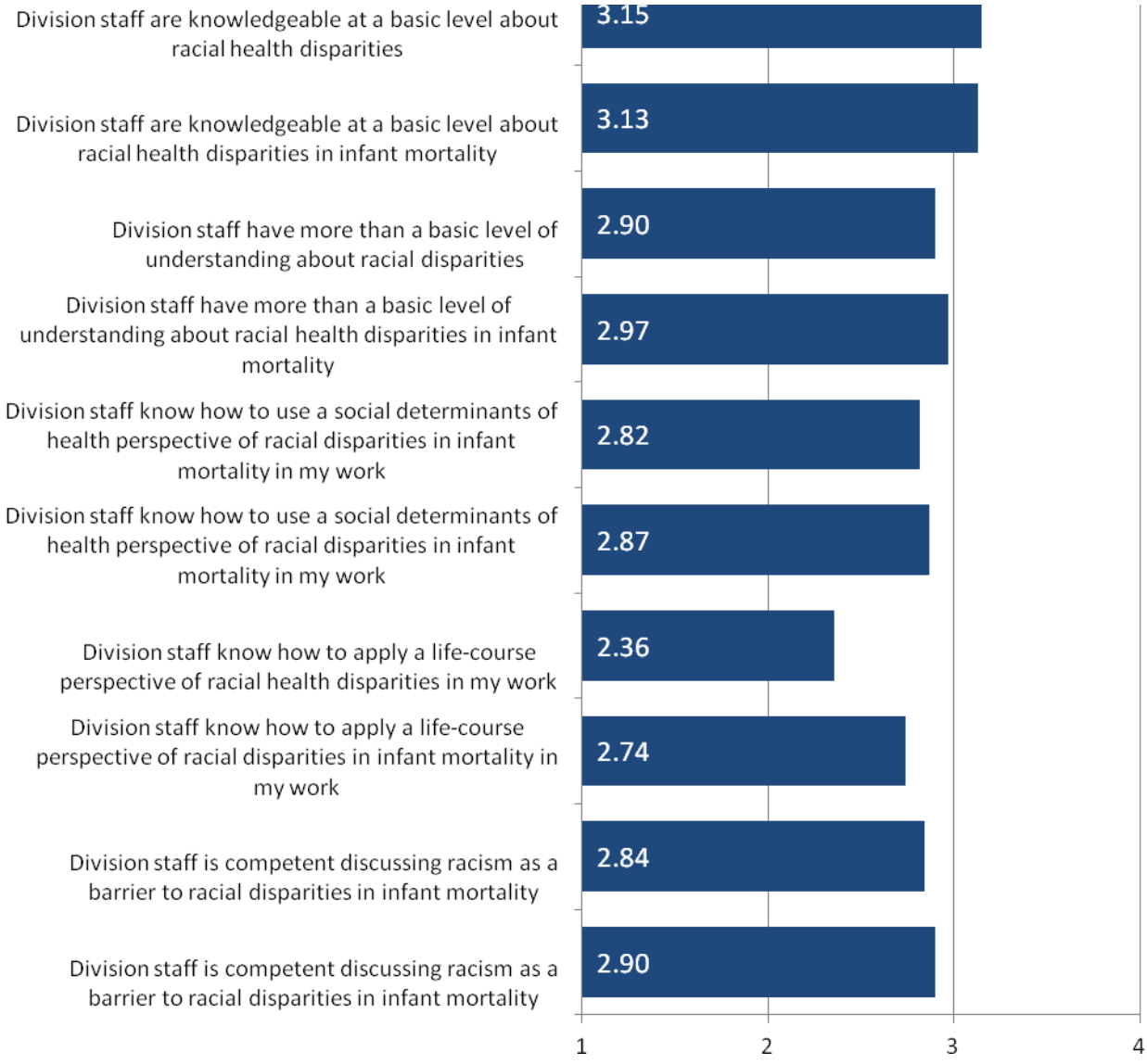
Item	n	Average ^ (SD)	Strongly Agree	Agree	Disagree	Strongly Disagree
I am knowledgeable at a basic level about racial health disparities	40	3.22 (0.530)	27.5%	67.5%	5.0%	0%
I am knowledgeable at a basic level about racial health disparities in infant mortality	40	3.10 (0.672)	25.0%	62.5%	10.0%	2.5%
I have more than a basic level of understanding about racial disparities	40	2.95 (0.749)	25.0%	45.0%	30.0%	0%
I have more than a basic level of understanding about racial health disparities in infant mortality	39	2.87 (0.864)	25.6%	41.0%	28.2%	5.1%
I know how to use a social determinants of health perspective of racial health disparities in my work	39	2.82 (0.683)	12.8%	59.0%	25.6%	2.6%

I know how to use a social determinants of health perspective of racial disparities in infant mortality in my work	39	2.77 (0.706)	10.3%	61.5%	23.1%	5.1%
I know how to apply a life-course perspective of racial health disparities in my work	39	2.69 (0.766)	12.8%	48.7%	33.3%	5.1%
I know how to apply a life-course perspective of racial disparities in infant mortality in my work	40	2.68 (0.797)	12.5%	50.0%	30.0%	7.5%
I am competent discussing racism as a barrier to racial disparities in infant mortality	39	3.00 (0.725)	25.6%	48.7%	25.6%	0%
I am competent discussing racism as a barrier to racial disparities in infant mortality	39	2.90 (0.821)	25.6%	41.0%	30.8%	2.6%

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

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

- The average score for all questions within this subtopic area was 2.87 (SD: 0.40), with a range from 2.00 to 3.70.
- Average scores from administration/management staff did not significantly differ from average scores from non-management staff.
- Respondents overwhelmingly reported that Division staff were knowledgeable at a basic level about racial health disparities in general and disparities in infant mortality specifically. However, when asked if Division staff had more than a basic knowledge of racial health disparities in general and disparities in infant mortality specifically, agreement dropped for both topics.
- When asked if Division staff were able to apply a social determinants of health or life course perspective to their work, 70% of respondents chose the "Strongly Agree" or "Agree" responses, while approximately 30% of respondents chose "Disagree" or "Strongly Disagree". Approximately 80% of respondents agreed that Division staff as a whole were competent in discussing racism as a barrier to racial health disparities, while 20% disagreed.



Item	n	Average ^ (SD)	Strongly Agree	Agree	Disagree	Strongly Disagree
Division staff is knowledgeable at a basic level about racial health disparities	39	3.15 (0.432)	17.9%	79.5%	2.6%	0%
Division staff is knowledgeable at a basic level about racial disparities in infant mortality	38	3.13 (0.475)	18.4%	76.3%	5.3%	0%
Division staff have more than a basic level of understanding about racial health disparities	39	2.90 (0.598)	12.8%	64.1%	23.1%	0%
Division staff have more than a basic level of understanding about racial disparities in infant mortality	39	2.97 (0.668)	20.5%	56.4%	23.1%	0%
Division staff know how to apply a social determinants of health perspective of racial health disparities in their work	39	2.82 (0.601)	7.7%	69.2%	20.5%	2.6%

Division staff know how to apply a social determinants of health perspective of racial disparities in infant mortality in their work	39	2.87 (0.767)	17.9%	56.4%	20.5%	5.1%
Division staff know how to apply a life-course perspective to work of racial health disparities in their work	39	2.36 (0.743)	7.7%	56.4%	28.2%	7.7%
Division staff know how to apply a life-course perspective to work of racial disparities in infant mortality in their work	39	2.74 (0.785)	12.8%	56.4%	23.1%	7.7%
Division staff is competent discussing racism as a barrier to racial health disparities	38	2.84 (0.679)	10.5%	68.4%	15.8%	5.3%
Division staff is competent discussing racism as a barrier to racial disparities in infant mortality	39	2.90 (0.718)	15.4%	64.1%	15.4%	5.1%

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

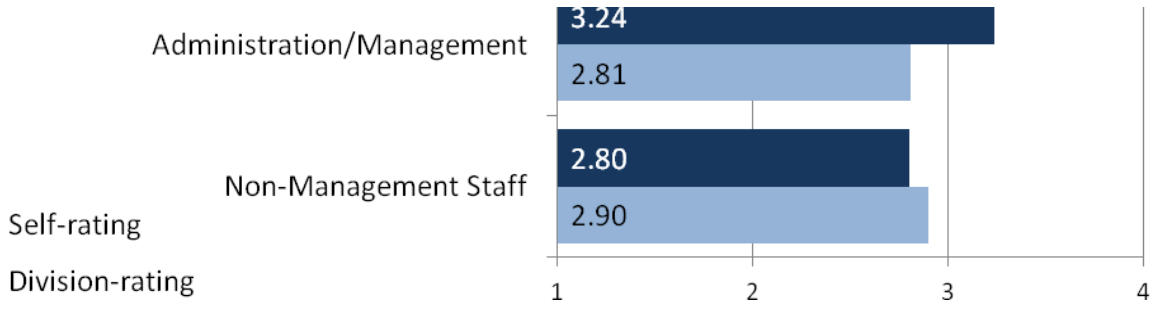
Comparison of Manager versus Non-Manager Ratings for Self and for the Division

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

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

- Managers' self-rating on these key concepts did not significantly differ from non-mangers' self-rating. We also did not detect differences between managers' and non-managers' rating of the Division as a whole.
- There were, however, distinctions when comparing how each group rated themselves versus their rating of the Division. Staff who did not categorize themselves as administration/management rated the Division's collective abilities higher, though not significantly so, than their own capacity. The opposite pattern was found for administration/management. Management staff rated their individual understanding and application of these concepts significantly higher than they rated the collective abilities of the Division staff.

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



IMPLICATIONS FOR NEXT STEPS

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