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

Thomas M. Reischl, PhD
Allison Krusky, MPH

Prevention Research Center of Michigan
University of Michigan School of Public Health

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This project is supported by Grant # P3016224 from the W.K. Kellogg Foundation.
This report provides a summary of evaluation efforts, including descriptions of project activities. The report is organized to first address three evaluation questions from the Kellogg Foundation guidance document. After addressing these evaluation questions, we include summaries of evaluation efforts and project activities as they related to the list of 10 program evaluation activities that we proposed to conduct for this project.

A. Evaluation Questions From Kellogg Guidance

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

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

Some MDCH staff, however, have begun sharing what they have learned about Social Equity and Health Justice with local partners. Staff from Adolescent Health, Family Planning and Maternal Infant Health Program wanted their local providers to benefit from learning how to promote health equity within their communities. Ingham County Health Department staff facilitated the sessions.

- **Adolescent Health** – In January, 2012, a session titled Health Equity & Social Justice was held with 65 supervisors, coordinators and other clinic staff from the Teen Pregnancy Prevention projects.
- **Family Planning** – In February, 2012 a session titled Health Inequity: How it Impacts the Provision of Health Services was held with 15 state and local family planning staff. The session was videotaped and shared with all PRIME Steering Team and Local Learning Collaborative members.
- **MIHP** – In March, 2012 a session titled Health Inequity was held in four locations (Plymouth, Grand Rapids, Gaylord and Marquette) with MI with 185 MIHP coordinators and staff.

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

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

The PRIME staff and steering team members have discussed the potential of using the biennial Pregnancy Risk Assessment Monitoring System (PRAMS) questionnaire to monitor social determinants of health disparities. PRAMS is a surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments. PRAMS collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. The PRAMS questionnaire has two parts. There are core questions that are asked by all states. The core portion of the questionnaire includes questions about the following:

- Attitudes and feelings about the most recent pregnancy.
- Content and source of prenatal care.
- Maternal alcohol and tobacco consumption.
- Physical abuse before and during pregnancy.
- Pregnancy-related morbidity.
- Infant health care.
- Contraceptive use.
- Mother's knowledge of pregnancy-related health issues, such as adverse effects of tobacco and alcohol; benefits of folic acid; and risks of HIV.

The remaining questions on the PRAMS questionnaire are chosen from a pretested list of standard questions developed by CDC or developed by states on their own. As a result, each state's PRAMS questionnaire is unique. The PRAMS questionnaire has potential for assessing social determinants of health because of its potential for accounting for differences in access to health care, barriers to receiving care, hardships and stressors during pregnancy, and financial resources (household income, Medicaid status). Additionally, PRAMS respondents can be linked with state birth records to determine how responses to different questions may be associated with a variety of perinatal health outcomes. In order to better understand perinatal health and social determinants of infant mortality among Native Americans, the PRIME project initiated and began implementing a PRAMS questionnaire for all women who gave birth to a Native American child in Michigan in 2012. The new questions include:

1. During your most recent pregnancy, did you have problems with any of the following basic needs? Check all that apply.
   a) Transportation to and from health care appointments; b) Skipping meals or eating less because there wasn’t enough money for food; c) Safety of your house/apartment; d) Your house/apartment being too crowded; e) Ability to keep basic utility services (heat, water, lights); f) Access to a telephone when needed.
2. Did your doctor, nurse, or other health care worker talk to you about where you could get help with any of these basic needs? (Yes/No)

Additionally, the Native American PRAMS survey includes questions from the CDC’s Behavioral Risk Factor Survey Reactions to Race module to assess women’s experiences with racism.

Michigan Health Equity Data Project
The Health Disparities Reduction and Minority Health Section (HDRMHS) released its first Health Equity Data Tables in May, 2011, and is currently updating the tables and creating factsheets for the Michigan Health Equity Data Project (HEDP). The HEDP measures and monitors health disparities among Michigan’s racial and ethnic minority populations. Among the 18 indicators monitored, 5 are social determinants of health (median household income, children at or below poverty, unemployment, high school dropout rate, and persons not registered to vote). This reflects the view that inequities in SDOH must be monitored as carefully as inequities in other risk factors and health outcomes if we are to achieve health equity in Michigan. Three staff members from HDRMHS sit on the PRIME Steering Team.

**Coordinated Chronic Disease Grant Epidemiology/Surveillance Workgroup**
Funded by a grant from the CDC, the Chronic Disease Division is currently implementing a “Coordinated Chronic Disease Grant”. As part of this grant, an Epidemiology/Surveillance Workgroup is developing a surveillance plan for chronic disease in Michigan. Among indicators included in the plan are 8 SDOH: Percent with adequate fruit and vegetable consumption, Percent who could not see a doctor in the past 12 months due to cost, Percent living in poverty, Percent who are unemployed, Percent with limited access to healthy foods, Percent with limited access to recreational facilities, Percent who reside in primary care shortage areas, and Percent of households with no vehicle available. Additionally, these indicators will be monitored separately by race/ethnicity, gender, age, geography, education, income, insurance status, and ability to speak English.

**Continuous Quality Improvement Survey**
MDCH is currently working on a quality improvement project to standardize the collection and use of race, ethnicity, sex, language, and disability status data. It is hoped that this will better allow MDCH to understand how these factors affect health status and access to care, and how to better target interventions to specific populations. The HDRMHS manager leads the work group and PRIME’s Principal Investigator works on the CQI team.

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

Changes in MDCH policies and practices to strengthen racial equity and inclusivity remains a long-term goal for the PRIME project. At this stage of the project, the PRIME staff and steering team members have been engaged in discussions among themselves and with other MDCH staff about the types of policies and practices that should be addressed.

Several new initiatives within the Bureau of Family, Maternal & Child Health have begun. These include improvements to the Nurse Family Partnership program, a new way of reviewing infant deaths and WIC participation, new staff training and development activities, and new collaborative efforts. Each are described below.

**Nurse Family Partnership & Use of Kitagawa Method**
Reducing infant mortality among African American, American Indian infants and other high risk populations is essential if Michigan is to reduce the overall infant mortality rate and to achieve health equity. To better understand the connection between the effects of institutional racism and health inequities on poor birth outcomes, Division of Family and Community Health staff completed Undoing Racism and Health Equity and Social Justice Workshops in 2011.

It has not been uncommon for the Division of Family and Child Health (DFCH) staff to receive “push back” from local communities when promoting policies to focus increased efforts to decrease infant mortality among racial and ethnic populations. In some instances the community argues that “all” woman should be targeted to reduce poor birth outcomes.

Although home visiting programs serving low-income, first time mothers in Michigan’s highest risk counties and cities is one strategy to reduce infant mortality, in some counties the program was not reaching high risk populations. To maximize efficiency of limited resources, a method was needed to identify high risk populations and to create a caseload target for each county that could be included in contract language.

The MCH epidemiologist was asked to use a scientific method to identify populations at highest risk for infant mortality stratified by race/ethnicity for each of the counties that were participating in this home visitation program. In stratifying by race/ethnicity it is important to remember that despite adjustment for other factors (such as maternal age, education, smoking and pre-natal care) significant racial disparities exist. The Kitagawa formula was used to calculate the excess percent risk of IMR by race/ethnicity for each of the high risk counties. The Kitagawa formula is a method to evaluate the excess risk of an outcome taking into account differences in the distribution of the outcome and the risk rate. This method is suited for smaller populations and is one component of the Perinatal Periods of Risk approach developed by City MatCH. For this study we used data from the 2007 to 2009 Michigan Resident Live Birth/Infant death linked file and Michigan women > 20 years old and > 13 years of education were the reference population.

Compared to state race/ethnicity-specific rates, excess mortality was highest for Black infants (56.5% to 132.8%) in 7 counties, for Hispanic infants (86.6%) and White infants (48.2%) in one county each. The largest racial/ethnic disparity in excess mortality within one county was -84.4% in White and 123.1% in Black infants. The analysis identified high risk populations within each county and caseload targets were determined by the differences in racial/ethnic distribution and IMR between the county and the reference population.

The caseload recommendations were different for each county and reflected the excess risk rate of infant mortality, taking into account the difference in racial/ethnic distribution within each county compared to the standard population. The results were shared with the local health department health officers and epidemiologists. Although some resistance to change has been encountered, DFCH continues to rely on this analysis of infant mortality risk to guide race/ethnicity-specific caseload targets.

**Failure to Thrive Review**

Last year, the Bureau of Family, Maternal & Child Health (BFMCH) Director and the MI Child Death Review Coordinator saw the need to convene stakeholders to determine if increased collaboration
and coordination could decrease infant deaths. There was review of the data to ascertain the number of deceased infants that were enrolled in WIC.

Staff Training and Development
Staff members participated in Undoing Racism and/or Health Equity and Social Justice workshops and have identified the following techniques to address racial and ethnic disparities:

- **Division of Health Wellness and Disease Control**—The Division’s Training and Education Unit has included health equity topics in their HIV Training Curriculum; The Health Disparities Reduction and Minority Health (HDRMHS) Section has developed a Health Equity Toolkit (with video vignettes) to increase community and professional awareness around Health and Racial Equity. The Toolkit has been approved for printing and is scheduled for release in late summer 2012; The MDCH intradepartmental Health Equity Steering Committee (HESC) is co-chaired by the HDRMHS Manager. Many of the HESC members have participated in the Undoing Racism, Ingham County Health Equity & Social Justice and/or NACCHO Roots of Health Inequity on-line learning workshops. The HESC has undertaken the task of re-visioning its work to promote and implement health equity best practices throughout the Department.

- **Early Hearing Detection and Intervention**—The EHDI program “Barriers to Services” survey now requests identification of race to assist in analyzing barriers that may be linked to race; The program is working with hospitals to provide greater accessibility for hearing re-screening, especially in the Wayne County area; Reducing racial disparities is now a goal in the EHDI program MCHB grant work plan; As new brochures/publications are designed or revised for the EHDI program, photos are evaluated to ensure that they represent the diverse populations of the state; Staff have continued to increase their knowledge and share techniques with BFMCH staff about successful programs targeting pregnant African-American and Hispanic women. Staff attended the Michigan Midwives Association Conference where Jennie Joseph, a British Midwife, discussed techniques used for women to have more full term pregnancies and no low-birth weight babies.

- **Fetal Infant Mortality Review (FIMR)**—maternal interviews have incorporated additional questions related to race and how mothers felt they were treated in seeking and receiving care and services during their pregnancy; monthly State FIMR Network meetings are held for all the 14 current sites. An Undoing Racism exercise now starts off every meeting, in an effort to raise team members’ awareness and perceptions around racism and discrimination. Individual local Case Review and Community Action Teams encouraged to also start their and meetings with a similar exercise.

- **Reproductive Health**—has made a commitment to providing a cultural competency/social justice/health equity training opportunity at least once every three years to delegate agencies. A Health Inequity Training was held in February 2012. The Title X program requires that delegates treat clients with dignity and respect, nondiscrimination, and make efforts to serve vulnerable and special populations. These requirements are reviewed regularly on site visits.

- **Women, Infants and Children (WIC)**—Ongoing release of materials in multiple languages, and use of language lines in local clinics.
Collaborative Efforts

- **Health Disparities Reduction and Minority Health Section (HDRMHS)**—continues to fund seven organizations under the Capacity Building Grant Program (CBGP). As a condition of funding, each lead agency must develop or strengthen broad community partnerships. The number of organization partners represented within the Capacity Building Grants is over 100. Each of the CBGP grantees is funded to address some aspect of social determinants of health to reduce racial and ethnic health disparities. In addition to the CBGP, the HDRMHS participates in the Coordinated Chronic Disease Grant Epidemiology and Surveillance Work Group to add a disparities lens to that work; collaborates with Michigan State University Survey Research Office and the MDCH-BRFS program staff to implement a stand-alone Behavioral Risk Factor Survey (BRFS) that oversamples Asian Americans and Hispanic/Latinos in 2012; and chairs a Continuous Quality Improvement project at MDCH to standardize the collection and use of Race, Ethnicity, Sex, Language, and Disability data.

- **Early Hearing Detection and Intervention**—staff has initiated efforts to improve collaboration and provide education on the importance of newborn screening and follow up with the American Indian Health Center and the American Arab-Chaldean Council. EHDI staff are also consulting with the Maternal Infant Health Program (MIHP) to provide appropriate access to support services for mothers who are deaf or hard of hearing.

- **Fetal Infant Mortality Review (FIMR)**—The State Coordinator is part of the Travel Team with the PEDIM grant, Partnerships to Eliminate Disparities in Infant Mortality through Action Learning Collaboratives. Recognizing the disparities in child welfare outcomes, and supported by FIMR findings in the state, a representative of the Department of Human Services has been added to the PEDIM Action Learning Collaborative to better engage Child Protective Services and Child Welfare workers in Michigan in this work.

- **Reproductive Health**—MDCH is working with Brogan and Partners to develop media spots for Plan First! The market for the Plan First! media is statewide with a focus in Southeast Michigan. The target audience is women ages 19-44, which a focus on African American, Latino, and Arab/Chaldean women.

- **WIC**—WIC held a joint Birth Defects Webcast in April, 2012 Genetics; the webcast focused on health considerations of specific racial/ethnic groups adversely affected. Project Fresh piloted the use of the EBT method for Farmers and clients to more easily obtain produce benefits of the program; Genesee County new hospital enrollment into WIC to support early breastfeeding and also decrease gaps in client access to WIC enrollment. Dickinson-Iron County effort to recruit children requiring lead screening into WIC to identify those eligible for WIC, monitor for lead, and mitigate potential harm. In the next quarter: the Bridges - Breastfeeding Promotion in Henry Ford Hospital, Detroit, Detroit Urban League - African American Breastfeeding Kellogg Grant - are efforts that help to mitigate Health Inequity.
B. Summary of Evaluation Activities and Results

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

Steering Team and Workgroups Activities

The Steering Team met on eight occasions between October 2011 and May 2012. The work during this period focused on reviewing the project activities of the first year, the completion of a “Green Paper” on possible curriculum and project directions, planning for project years two and three, updates on ongoing project activities and partnerships, discussions of opportunities to disseminate and share lessons learned from this project, discussion of new training opportunities with WIC program staff, and the development of the project’s web page and wiki page.

The PRIME project has five work groups to plan and implement the primary project activities. The Website Development Workgroup was created in November 2011. The five work groups are:

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

These work groups met separately and reported their progress to the project leaders and the Steering Team. A summary of the Steering Team meetings and the work group meetings including meeting dates, number of attendees, and primary topics discussed are provided on the next page and subsequent pages.
<table>
<thead>
<tr>
<th>Meeting Dates</th>
<th>Number of Participants</th>
<th>Meeting Objectives</th>
</tr>
</thead>
</table>
| October 24, 2011   | 14                     | - Updates on LLC Pre-conference  
- HESJ Workshops  
- DFCH activities and PRIME connection |
| November 18, 2011 (Retreat) | 20                  | - Year-one accomplishments  
- Identification of improvement areas  
- UR and HESJ Training Results  
- Evaluation Results  
- Reorganization of Green Paper  
- Timeline for Years 2 & 3 |
| December 19, 2011 | 11                     | - Share Michigan Infant Mortality Summit updates  
- PRIME Retreat Report  
- Review PRIME Narrative & Evaluative Reports  
- Workgroup updates  
- 2012 Meeting Dates |
| January 23, 2012   | 13                     | - Updates on MI’s Infant Mortality Reduction Plan, Kellogg evaluation meeting and PEDIM ALC meeting  
- Review the draft PRIME task list and gather feedback  
- BFMCH directors to give updates on work in their divisions  
- Announcement – PRIME presentation at the UM MCH Community Training Program  
- Share brief updates & next steps from the workgroups. Highlight items that need the team’s support. |
| February 27, 2012  | 15                     | - Review and discuss the final draft of the Green Paper, APHA abstracts, infant mortality rates and Kids Count data.  
- Share and discuss the PEDIM ALC racism definition.  
- Brief updates from Division Directors on their health equity work.  
- Brief updates from the workgroups; highlight items that need the team’s support. |
| March 26, 2012     | 14                     | - Discuss feedback from Steering Team members on the PRIME focus and goal statements and PRC Website.  
- Discuss ideas for a presentation at the Michigan Premier Public Health Conference and Public Health Reports call for papers.  
- Discuss engaging consultants to assist with conducting Social Determinants of Health training with the WIC Division.  
- Brief updates from Division Directors on their health equity work.  
- Brief updates from the workgroups. |
### STEERING TEAM (22 members)

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<tr>
<th>Meeting Dates</th>
<th>Number of Participants</th>
<th>Meeting Objectives</th>
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| April 9, 2012 | 14                     | • Develop a communication strategy for introducing PRIME activities to the WIC Division.  
                       • Share information on epidemiology abstracts submitted for the Council for State and Territorial Epidemiologists Conference & MI Premier Public Health.  
                       • Discuss the benefits of developing a Wiki Page for PRIME.  
                       • Brief updates from Division Directors on their health equity work.  
                       • Brief updates from the workgroups. |
| May 7, 2012   | 13                     | • Updates on the Partnership to Eliminate Disparities in Infant Mortality (PEDIM) Action Learning Collaborative (ALC) & America Healing meetings.  
                       • View and discuss the Unequal Opportunity Race video & PRIME Wiki Page.  
                       • Brief updates from Division Directors on their health equity work.  
                       • Brief updates from the workgroups. |

### INTERVENTION WORKGROUP (7 members)

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<thead>
<tr>
<th>Meeting Dates</th>
<th>Number of Participants</th>
<th>Meeting Objectives</th>
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| October 26, 2011 | 9                   | • MDCH Needs Assessment  
                       • Green Paper Overview |
| December 5, 2011 | 8                   | • Retreat Discussion  
                       • Next Steps and Schedule Meeting Dates |
| January 9, 2012 | 8                    | • PRIME Task List  
                       • MDCH Organizational Assessment  
                       • Schedule prospective meeting dates |
| February 6, 2012 | 10                  | • Organizational Assessment  
                       • PRIME Task List |
### INTERVENTION WORKGROUP (7 members)

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<th>Meeting Dates</th>
<th>Number of Participants</th>
<th>Meeting Objectives</th>
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<tbody>
<tr>
<td>March 5, 2012</td>
<td>6</td>
<td>- Green Paper</td>
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<td>- PRIME focus and goals statement</td>
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<td>- Michigan Premier Public Health Conference</td>
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<td>- Public Health Reports</td>
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<td>- Organizational Assessment</td>
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<td>- Grant Writing</td>
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<td>- PRC Website/Dissemination Guidelines</td>
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<td>- Curriculum Development/Consultants</td>
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<td>- PRIME Task list</td>
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<tr>
<td>April 2, 2012</td>
<td>5</td>
<td>- Organizational Assessment</td>
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<td></td>
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<td>- SDOH Training</td>
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<td>- Consultant Work Statements</td>
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<td>- PRIME Task list</td>
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<td></td>
<td>- Rhode Island – Grant Application Checklist</td>
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<td>May 14, 2012</td>
<td>10</td>
<td>- Organizational Assessment Update</td>
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<td>- NA Consultants Update</td>
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<td>- HESJ/Workshops &amp; Site Visit</td>
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<td>- Rhode Island Grant Application Check List</td>
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<td>- Task List</td>
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<td></td>
<td>- Communication/Approach with WIC Staff</td>
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<td>- Next Steps</td>
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### NATIVE AMERICAN AD-HOC DATA WORKGROUP (5 members)

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<tr>
<td>October 12, 2011</td>
<td>4</td>
<td>- Review survey questions</td>
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<td>- Develop communication strategy to include tribal health centers</td>
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<td></td>
<td></td>
<td>- Add race questions</td>
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<tr>
<td>October 25, 2011</td>
<td>4</td>
<td>- Review survey questions and PRAMS MI Phone Script</td>
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<td></td>
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<td>- Develop communication strategy to include tribal health centers</td>
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<td></td>
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<td>- Additional race questions</td>
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<td>November 30, 2011</td>
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<td>- Promotion of NA PRAMS</td>
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<td>- Review of Survey Questions</td>
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<td>December 15, 2011</td>
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<td>- Race-related and safe-sleep questions for survey</td>
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<td>- Draft for mid-January</td>
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### NATIVE AMERICAN AD-HOC DATA WORKGROUP (5 members)

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<tr>
<td>January 6, 2012</td>
<td>4</td>
<td>• PRAMS Survey dissemination strategy&lt;br&gt;• BRFSS Race Questions</td>
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<tr>
<td>January 12, 2012</td>
<td>5</td>
<td>• Birth certificate data link to PRAMS Survey&lt;br&gt;• Letters and consent form</td>
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<td>January 20, 2012</td>
<td>4</td>
<td>• How to extract NA births&lt;br&gt;• Mail and phone responses</td>
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<td>February 15, 2012</td>
<td>4</td>
<td>• Timeline&lt;br&gt;• Survey to have ITCM logo and letterhead&lt;br&gt;• Data sharing agreement</td>
</tr>
<tr>
<td>February 24, 2012</td>
<td>5</td>
<td>• Cover design&lt;br&gt;• Data agreement&lt;br&gt;• Letters</td>
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<tr>
<td>March 16, 2012</td>
<td>4</td>
<td>• Memorandum of Understanding&lt;br&gt;• Informed Consent</td>
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### EVALUATION WORKGROUP (6 members)

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<tr>
<td>October 4, 2011</td>
<td>6</td>
<td>• Review draft of process evaluation online survey</td>
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<tr>
<td>October 10, 2011</td>
<td>6</td>
<td>• Review draft of process evaluation online survey</td>
</tr>
<tr>
<td>October 26, 2011</td>
<td>6</td>
<td>• Steering team survey&lt;br&gt;• ICHD – Health Equity Social Justice Pre/Post Test Results&lt;br&gt;• Undoing Racism Focus Group Results</td>
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<tr>
<td>April 16, 2012</td>
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<td>• Discuss Kellogg Evaluation&lt;br&gt;• Examine possible measures of MDCH Culture Change&lt;br&gt;• Evaluation goals for 2012</td>
</tr>
<tr>
<td>May 14, 2012</td>
<td>6</td>
<td>• SDOH Training&lt;br&gt;• Organizational Assessment&lt;br&gt;• Kellogg Report</td>
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<td>Meeting Dates</td>
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<td>Meeting Objectives</td>
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| December 2, 2011 | 10 | • Updates on the MI Premier Public Health Conference, Infant Mortality Summit, PEDIM Action Learning Collaborative, and PRIME Retreat  
• Discuss ideas for dissemination  
• Discuss PRIME Local Learning Collaborative Contracts  
• Highlight remaining PRIME meeting schedule |
| January 27, 2012 | 12 | • Updates on MDCH & PRIME activities  
• Member Updates: What was one or two of your best successes and what elements made them successful?  
• Discuss ideas for dissemination  
• Discuss PRIME Local Learning Collaborative Contracts |
| May 25, 2012 | 10 | • Introductions  
• Review Meeting Minutes from 3/23/12  
• Update on MDCH & PRIME activities  
• PRIME Website Update  
• PRIME LLC Contracts/Updates  
• PEDIM ALC Meeting – Local Historical Overview  
• National Kidney Foundation & Berrien County Health Department – Health Equity Overviews  
• Discuss resources necessary for health equity work |
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| November 29, 2011   | 5                      | ● Review PRIME goals and objectives  
● Describe existing dissemination activities  
● Review Hannalori Bates Frick website option document  
● Discuss possible content and dissemination methods |
| December 14, 2011   | 4                      | ● Share dissemination strategy draft  
● Review LLC booklet content  
● Discuss website options  
● Internal updates |
| April 12, 2012      | 3                      | ● General Layout of Website/Look and Feel  
● Requirements  
● Timeline |
| 5/16; 5/22; 5/31    | 4                      | ● Calls with Michigan Public Health Institute to determine timeline, requirements, & website specifics.  
● MDCH Approval Process  
● Review Draft Website Design |
Intervention Development

The PRIME Intervention Workgroup focused on three main projects. These projects included the finalization of the PRIME Green Paper, development and distribution of an Organizational Assessment, and planning for a Social Determinants of Health training. Copies of the Green Paper and the Organizational Assessment are in the Appendix.

Green Paper on Practice Model Development
Steering Team members provided feedback on the Green Paper during the Steering Team Retreat in November 2011. The Green Paper outlined several critical questions that would need to be addressed in order to move forward in the intervention process. Steering team members were asked to prioritize questions based on their importance in addressing them and they identified who or which group would be responsible for addressing the questions. The Intervention Workgroup revised the Green Paper after the Steering Team Retreat, and the Green Paper was finalized and approved in March 2012. The Green Paper was shared with the MDCH Director, Public Health Administration, and all staff in the Bureau of Family & Maternal Child Health. In addition, the paper has been shared with other departments outside of BFMCH when giving presentations about PRIME. Lastly, the paper was discussed during meetings with the PRIME Steering Team and Local Learning Collaborative members.

Organizational Assessment
The Intervention Workgroup partnered with University of Michigan Health System Program for Multicultural Health to develop and administer an Organizational Assessment to MDCH staff. The responses to this organizational assessment will be used to help PRIME identify the types of changes, resources, training, and technical assistance needed for Bureau staff to more effectively address racial disparities in infant mortality in its work.

MDCH staff was asked to share their perspective on BFMCH programs and services (e.g., The Bureau’s program and services are designed to address racial health disparities: Strongly agree, agree, disagree, strongly disagree), employee engagement (e.g., I understand how my work contributes to the MDCH’s mission and eliminating racial health disparities: Strongly agree, agree, disagree, strongly disagree), cultural competency (e.g., I understand how culture impacts African Americans’ lives, such as: child rearing), knowledge and skills (e.g., I know how to evaluate racial health disparities reduction programs; and I have more than a basic level of understanding about racial disparities), professional development (e.g., To do my job, I use information about racial health disparities from: journal articles), community engagement (e.g., Division staff understand African Americans’ major social and health concerns), division awareness (e.g., Division staff have more than a basic level of understanding about racial disparities in infant mortality) and demographics (i.e., Race, Ethnicity, division, job classification). The cultural competency questions were asked for both African Americans/Blacks and Native Americans.

The Organizational Assessment was administered online to MDCH staff in April 2012. Data collection ended in May 2012. Members from the Intervention Workgroup have partnered with the Evaluation Workgroup to evaluate the responses. The Evaluation Workgroup is exploring the idea of
using the Organizational Assessment results to measure “cultural shift” within MDCH. Results from the Organizational Assessment will be available in a future report.

Training Development
The Evaluation Workgroup evaluated the results from the PRIME Steering Team online survey. The results from this process evaluation were presented to Steering Team members at the PRIME retreat and helped to guide the retreat discussion. In addition, the Evaluation Workgroup presented and discussed the results from the Health Equity Social Justice Pre/Post Test and Undoing Racism Pre/Post Test and Focus Group at the PRIME retreat. There were no additional trainings held during this reporting period.

The PRIME project was in the early phase of collaborating with two consultants from the University of North Carolina, Chapel Hill. Both consultants have extensive experience in social determinants of health and race relations. The Evaluation Team will collaborate with the consultants to develop evaluation methods for the Social Determinants of Health trainings in development. Finally the consultants will collaborate with the Intertribal Council of Michigan to develop a curriculum that will be used to teach public health professionals about Native American culture and implementing culturally sensitive public health programs.

Data Collection
The PRIME project has been involved in the development of data methods and efforts; most notably within the Native Ad-Hoc Data Workgroup. Other MDCH departments and sections, which have participated in PRIME activities, have begun to make changes to their data collection efforts.

Native American PRAMS. The PRIME project has been working to address a lack of data for the Native American community. The Native American Data Workgroup has worked extensively to identifying data needs and improve data collection methodology. A partnership between MDCH, the Inter-Tribal Council of Michigan, Great Lakes Intertribal Epidemiology Center, and Michigan State University formed to design a survey to include only mothers of Native infants.

PRAMS surveys mothers selected from the state birth records. MDCH used an approach suggested by the Inter-Tribal Council of MI to identify Native American births by using the race of the mother or father to select mothers for the survey. This approach increased the number of women expected to be surveyed by approximately 1300, which means the sample size may be large enough to calculate tribe-specific estimates, if the tribe is interested. Mothers of all Native infants born in 2012 will receive an invitation to participate in the survey beginning this month and continuing through June 2013. Cultural sensitivity training will be provided to staff that make calls to mothers. Other noteworthy details regarding the unique aspects of our process include developing data use agreements that were negotiated with and signed by each tribe. Two data use agreements were created: 1) between MDCH and Native American tribes (to be customized for each tribe) on how the data will be used and findings provided; and 2) One between MDCH and ITC regarding provision of the actual data files. Finally, a communication strategy was developed to inform tribal staff and other local health providers about the survey to promote an increased response rate.

The PRIME-funded Native American PRAMS survey was modified in two ways:
1) Three original questions about Social Determinants of Health were added to the survey:

- During your most recent pregnancy, did you have problems with any of the following basic needs? Check all that apply.

  - Transportation to and from health care appointments
  - Skipping meals or eating less because there wasn’t enough money for food
  - Safety of your house/apartment
  - Your house/apartment being too crowded
  - Ability to keep basic utility services (heat, water, lights)
  - Access to a telephone when needed

- Did your doctor, nurse, or other health care worker talk to you about where you could get help with any of these basic needs? (Yes/No)

- Was the nurse, health care worker, or social worker from a tribal home visiting program or other program specifically for Native Americans? (Yes/No)

2) The survey includes questions from the CDC’s Behavioral Risk Factor Survey Reactions to Race module to assess women’s experiences with racism.

A final activity related to Native American data is that an MDCH epidemiologist on the committee has worked to help develop methods for extracting Native American births from state records.

**Other Data Collection Efforts.** Data collection efforts have been reported from MDCH staff members who have been affiliated with PRIME trainings. This work was summarized above on page 4:

- The Health Disparities Reduction and Minority Health Section released its first Health Equity Data Tables in May 2011, and is currently updating the tables and creating factsheets for the Michigan Health Equity Data Project (HEDP). The HEDP measures and monitors health disparities among Michigan’s racial and ethnic minority populations.
- The Chronic Disease Division is currently implementing a “Coordinated Chronic Disease Grant”. As part of this grant, an Epidemiology/Surveillance Workgroup is developing a surveillance plan for chronic disease in Michigan.
- MDCH is currently working on a quality improvement project to standardize the collection and use of race, ethnicity, sex, language, and disability status data.

**Capacity Building**

**Consultants**

The PRIME project has contracted with 5 consultants during this reporting period. Three Native American Consultants were contracted through the Inter-tribal Council of Michigan to assist with developing components of the PRIME intervention to best address the unique needs of the Native American population. The consultants will assist in creating curricula and toolkit components that
will increase the BFMCH’s capacity to address social determinants of health disparities in the Native American community.

In addition, PRIME contracted with two professors from the University of North Carolina, Chapel Hill in March 2012. The professors have knowledge and experience in applying a health equity model that incorporates a social determinants of health approach in reducing the racial disparities in infant mortality. In May 2012, the consultants met with PRIME Steering Team members, WIC, and other MDCH staff to begin to identify the training needs of staff and outline the curricula and training components for the Social Determinants of Health trainings planned for the fall of this year.

Internships
The PRIME project provided internships to three graduate students. One master level student from John’s Hopkins assisted with developing poster and booklet for the Local Learning Collaborative (LLC), and has worked with the Perinatal regionalization project. A copy of the LLC booklet is included in the appendix. One intern from the University of Michigan School of Public Health has gained experience in state-level public health by attending workgroup and departmental meetings related to PRIME, along with meetings with local health departments and local organizations. This intern’s primary responsibility has been the development of a PRIME website to disseminate information online about the PRIME Project and Local Learning Collaborative. Additionally, this intern has participated in the planning of interventions such as the Social Determinants of Health Curriculum, and has gained experience in the program planning process necessary for a grant-funded project. Finally, a third intern continues to work with the University of Michigan staff to develop the Google Earth Map that outlines some effects of social determinants of health for Native Americans in Michigan. Also, a medical student from Wayne State University is helping to draft an implementation plan for a statewide perinatal system.

Dissemination of Results and Presentations
The Intervention Workgroup submitted several abstracts to disseminate results of the PRIME project activities. In February 2012, PRIME submitted three abstracts to the American Public Health Association. The first abstract titled, “Evaluating Undoing Racism and Health Equity Training with a State Health Department,” focused on the pre/post test and focus group results from last year’s Undoing Racism and Health Equity Social Justice trainings. Two other abstracts PRIME submitted include, “PRIME: A state health department effort to build organizational capacity to reduce health disparities,” and “Historical and spatial relations as fundamental determinants of American Indian infant mortality in Michigan”.

PRIME co-principal investigators presented information on the PRIME project at the Making an Impact: Maternal & Child Health Equity conference in March 2012. The presentation discussed the goals of the PRIME project, described the unique elements of PRIME, demonstrated how state and local health departments can partner to address health disparities, and explained unique determinants of Black and Native American infant mortality.

In April 2012, PRIME members submitted an abstract titled, “The Effect of Previous Health Disparities/Equity Training on Undoing Racism Pre- and Post-Tests with a State Health Department,”

In early May 2012, the PRIME group submitted an abstract to Public Health Reports. The abstract was submitted for a Public Health Reports supplement on applying social determinants of health to public health practice. The abstract, “PRIME Practices to Address Social Determinants of Racial Disparities in Infant Mortality,” described PRIME’s goals, proposed activities and rationale behind PRIME’s approach to organizational capacity building. The abstract, however, was not selected for the final publication.

**PRIME Website.** The Website Development Workgroup has focused on the creation and development of a PRIME website. Group members have drafted content and dissemination methods. The Website Development Workgroup contracted with the Michigan Public Health Institute to create the PRIME website in May 2012. Website Development Workgroup members continue to draft and revise website materials. PRIME Steering Team members will review website content once available.

**Lessons Learned from Local Learning Collaborative**

The Local Learning Collaborative (LLC) discussed dissemination methods for the information they presented at the Michigan Premier Public Health Conference in 2011, along with information gained through the Infant Mortality Summit, and Partnership to Eliminate Disparities in Infant Mortality (PEDIM) Action Learning Collaborative. The LLC is also developing methods to disseminate “lessons learned” among LLC members to other organizations. The following responses were received from six organizations, which include: Berrien County Health Department, Detroit Healthy Start, Dispute Resolution Center, Ingham County Health Department, Saginaw County Health Department, and Genesee County REACH:

**Berrien County**

- Engaging BCHD staff and community members in a dialogue about the root causes of health inequalities (supported by the Social Justice/Health Equity grant through Ingham County) has helped staff and community members to see true reasons why disparities exist and encourages work towards sustainable solutions.
- Community Photovoice has empowered community members through participatory-based action research, has allowed the community to see how their environment affects their health, and has been a useful discussion tool for presentations and groups across the country.

**Detroit Healthy Start**

- In partnership with Wayne County Great Start, DHS developed ‘A Healthy Baby Begins With You’ speaker’s bureau, which included a community education power point, training for presenters, and a manual to raise awareness about infant mortality, racial disparities, roots of disparities, and everyone’s roles in addressing the problems.

**Dispute Resolution Center**
Best practices include partnerships with other organizations and grantors to maximize resources and capabilities of the grantees to meet requirements of grants.

DRC members have learned to adapt each model to each novel situation to address diversity issues in one’s community.

**Genesee County REACH**

- Anti-racism awareness and education across multiple sectors, including, *Undoing Racism Workshops* that have changed individual’s perspectives and enhanced knowledge of racism to motivate actions to reduce health disparities.
- Addressing the connections between racism and infant mortality from a *historical and cultural perspective* through the Genesee County intervention is designed to challenge racial stereotypes and change the thinking, feelings, and behaviors of participants, including reducing internalized racism. The intervention also encourages participants to combat racial victimization through coping mechanisms such as positive racial identification, self-affirmation and empowerment, and community support.
- The *Pregnancy Risk Assessment Tool (PRAT)*, an original, enhanced perinatal assessment tool created for the Genesee County community that facilitates standardized, evidence based, perinatal assessment of high-risk women across institutions.
- *Windshield Tours*, which are bus tours through neighborhoods where high-risk clients reside, improve understanding of the social conditions of women and families to providers, administrators, and policymakers. These tours have resulted in clinic adaptations to better accommodate clients and has prompted successful advocacy for structural changes.
- *Community Health Advocates* are part of a health outreach team for pregnant and childbearing women and their families. These CHA’s facilitate access to clinical care and community resources, direct outreach services, and have resulted in improved birth outcomes in Genesee County.
- Sustained community engagement and mobilization has increased participation of ‘non-traditional’ partners, such as African American men.

**Ingham County**

- Adoptions of a *health equity lens* for daily practices through four-day, dialogue-based workshops, which are mandatory for all employees. *Dialogue* is an important tool for navigating the difficult issues of racism, class oppression, and gender discrimination, which need to be addressed explicitly to change practices.

**Saginaw County**

- Through providing *community forums and health equity trainings*, Saginaw County has unified service professions to improve health in the county.
- The most successful of these gatherings was with the convening of Great Beginnings Healthy Start Program past and present participants to discuss, in focus groups, their experiences in the health care setting regarding racism and then sharing their responses with medical providers.
2. The project coordinator and the leadership team will read state policy documents and review administrative practices to understand the association between state policies and maternal/child health care outcomes. Evidence of program implementation for these activities will be counts of MDCH employees involved in policy reviews, the number of policy documents reviewed and discussed, and a final report on the reviews.

The Steering Team has had discussions about the ability to review MDCH policies and reports to provide recommendations on how to reduce the racial disparities in infant mortality. The project will not be able to conduct a comprehensive review of MDCH policies and reports within the time that remains in the project. The project has identified some reports and will outline policies that are impacted as a result of staff’s engagement in the project. Some of the policies involve the use of data to inform policy and decision making and particularly for the Native American population. Additional policy involves the Bureau’s approach to focus community efforts to identify disparities among infant mortality rates and tailor initiatives to address these disparities. Some of these efforts are described above on pp. 4-7.

In addition to tracking these efforts to review and change policies and practices, the staff and steering team has been discussing and effort to create a template to give to staff that they can use to think about the policy decisions they make for various programs.

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

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

The PRIME project is involved with MDCH Epidemiologists in the development of methodology for data collection and data analysis. PRIME continues to collaborate with multiple local health departments and community-based organizations through its Local Learning Collaborative.

**MDCH Epidemiologists**

An MCH epidemiologist, Rebecca Coughlin, affiliated with the PRIME project was asked to identify populations at highest risk for infant mortality stratified by race/ethnicity for each of the counties that were participating in an MDCH home visitation program. In stratifying by race/ethnicity it is important to remember that despite adjustment for other factors (such as maternal age, education, smoking and pre-natal care) significant racial disparities exist. This work was summarized earlier on page 5.

As mentioned previously, the PRIME Local Learning Collaborative (LLC) was established in March 2011 in an effort to share local lessons learned that undo racism and improve infant health. Representatives from Local Health Departments, Healthy Start Projects and other community organizations that have worked in their local community to address racism, health equity and disparities make up the LLC. The intent of the LLC is to disseminate their experiences with other
stakeholders throughout Michigan and seek their involvement in shaping the practices and policies derived from the project.

**PRIME Native American Ad-hoc Data Group**
The yearly Michigan Pregnancy Risk Assessment Monitoring System (PRAMS) does not include enough Native infants to provide information that is helpful for understanding maternal and infant health among American Indians in Michigan. As a result, a partnership with MDCH, the Inter-Tribal Council of Michigan, Great Lakes Intertribal Epidemiology Center, and Michigan State University formed to design a survey to include only mothers of Native infants. The project will interviewing women to find out what can be done to create better opportunities for good health among Native Americans in Michigan. Mothers of all Native infants born in 2012 will receive an invitation to participate in the survey beginning this month and continuing through June 2013.

MDCH used an approach suggested by the Inter-Tribal Council of MI to select Native American births by using the race of the mother or father to identify mothers for the survey. The approach yielded an additional 1300 women to be surveyed. Other noteworthy details regarding the unique aspects of our process include developing data use agreements that were negotiated with and signed by each tribe. Cultural sensitivity training will be provided to staff that make calls to mothers. Also, there is potential for tribal-specific data which is a benefit that is not usually afforded to the Native American community. Finally, a communication strategy was developed to inform, tribal staff and other local health providers about the survey to promote an increased response rate.

**Local Health Departments and Community-Based Organizations**
The LLC prepared a pre-conference session at the 2011 Michigan Premier Public Health Conference. There were about 35 people in attendance. The session began with introducing the Unnatural Causes Health Equity Quiz with the attendees. Dr. Derek Griffith from UM School of Public Health provided an overview of PRIME. About 20 minutes of Unnatural Causes, “When the Bough Breaks” was shown and then members played the CityMatCH Life course game. Prior to the panel presentations, there was some discussion about the video and game. The session ended with panel presentations from Genesee County Health Department, Inter-Tribal Council of MI, Dispute Resolution Center and Strong Beginnings Healthy Start about their local best practices to reduce infant mortality.

Thirty-one participants in the pre-conference session completed evaluations. The aggregated evaluation results suggested high ratings of the session:

1. How satisfied were you with the overall PRIME pre-conference presentation? **4.61 out of 5**
2. The clip from “When the Bough Breaks” from Unnatural Causes was helpful to understand how racism can affect health outcomes. **4.63 out of 5**
3. The Local Learning Collaborative (LLC) panel was helpful to understand local activities related to the improvement of infant health and the elimination of racism. **4.23 out of 5**
4. The life-course game was a helpful illustration of the life-course framework and the interconnectedness of socioeconomic factors, biology and the environment. **4.37 out of 5**
5. How satisfied were you with the pre-conference presenters? **4.55 out of 5**
6. After this session you have a better understanding of how racism can impact infant health disparities in Michigan? **4.3 out of 5**

A booklet highlighting the health equity work in each of the LLC communities was produced and shared at the conference and at Michigan’s Infant Mortality Summit. The booklet includes information about each program’s objectives, intended health outcomes and best practices. Additionally, PRIME was included in the poster session at the conference.

The BFMCH Director continues to serve as the co-chair of Michigan’s Partnership to Eliminate Disparities in Infant Mortality (PEDIM) Action Learning Collaborative (ALC), one of five projects nationally. The Project Coordinator and several PRIME Steering Team and Local Learning Collaborative (LLC) members also participate on the ALC.

The PRIME Project Coordinator will continue to participate on the Inter-Tribal Council of Michigan’s Statewide Consortium. The Consortium provides guidance for a five-year Centers for Disease Control and Prevention (CDC) Racial and Ethnic Approaches to Community Health (REACH) Core initiative to reduce infant mortality among Michigan’s Native Americans.
4. Other evidence will be documents describing strategies for addressing racial disparities in infant mortality & other health problems.

The PRIME project has noted changes within MDCH within divisions which participated in PRIME trainings. The Division of Family and Community Health created a life-course indicators workgroup before PRIME was established. This life-course indicators workgroup is charged with the development of performance metrics based on the life course stages encompassed by MCH. After becoming involved with PRIME, this workgroup has focused on identifying Social Determinants of Health and methods to address them. A framework utilizing a matrix composed of life stage as defined by the units within the division (i.e. reproductive health, perinatal health, etc.) and domains that included not only health outcomes, social determinants, and the environment, but also systems and infrastructure (e.g., access to care, health information networks, etc.). The purpose of identifying life course indicators was not simply to monitor health outcomes, but also to measure system capacity and identify areas of improvement to ensure that services are available, coordinated, culturally competent and effective.

Also, DFCH requested that a MCH epidemiologist identify populations at highest risk for infant mortality stratified by race/ethnicity for each of the counties that were participating in this home visitation program. The Kitagawa formula was used to calculate the excess risk percent of IMR by race/ethnicity for each of the high risk counties. The Kitagawa formula is a method to evaluate the excess risk of an outcome taking into account differences in the distribution of the outcome and the risk rate. The analysis identified high risk populations within each county and caseload targets were determined by the differences in the race/ethnicity distribution and IMR between the county and the reference population. The caseload recommendations were different for each county and reflected the excess risk rate of infant mortality, taking into account the difference in race/ethnicity within each county compared to the standard population.

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

The PRIME project spent this project period preparing for the launch of training within the Women’s, Infant, and Children Division at MDCH. There was no staff training held during this reporting period.

However, the PRIME project intervention group has spent time working on the development of additional MDCH staff training. The PRIME project was in the early phase of collaborating with consultants from the University of North Carolina, Chapel Hill. As mentioned previously, the consultants have extensive experience in social determinants of health and race relations. We plan on continuing to partner with both consultants, and will report on project developments in future reports. The consultants are also working with the Intertribal Council of Michigan on developing culturally sensitive training curriculum for addressing the public health needs of Native Americans.
6. A survey of key stakeholders will be conducted to assess their perceptions of the success & effectiveness of the program work. The feedback will be used to shape the project.

As part of evaluating the process of engaging key stakeholders for the PRIME project, we developed an online survey for assessing the primary project partners’ views about the development and implementation of the PRIME project. All members of the PRIME Steering Team were invited to complete the online survey before a day-long retreat at the start of the second project year. The results of the survey helped focus a discussion about how the PRIME project can be improved during the retreat. A copy of the report on this survey is included with this report.

The PRIME Steering Team online survey asked questions about the PRIME goals and commitments, communications and decision-making, ratings for the PRIME leaders, time invested on PRIME, capacity building from PRIME involvement, and PRIME project achievements. The PRIME Steering Team online survey had a 74% response rate, and was a good representation from each working group. On average, most survey participants agreed that PRIME had clear goals, a high level of commitment, overall good communication and decision making. About half the respondents reported that they worked on PRIME activities 2-3 times a month or more. The average rating of time invested was the “right amount” of time.

When asked about PRIME Steering Team Goals and Commitments, all respondents agreed or strongly agreed that there is a high level of commitment among the PRIME project staff and key stakeholder, they had a clear understanding of the PRIME project goals AND had a clear understanding of how PRIME is trying to accomplish its goals. Most respondents agreed or strongly agreed that the steering team has established reasonable goals, that the abilities, skills, and expertise of PRIME project staff and stakeholder are used to promote the project’s success, that the organizations involved in the PRIME project invest the right amount of time in collaborative efforts, that their ideas about the goals of PRIME are similar to others’ ideas about the project goals AND that they understood their own roles and responsibilities on the prime project.

When asked about PRIME Steering Team Communications and Decision Making, all respondents agreed or strongly agreed that:

- Discussions at PRIME meetings are sensitive to social and cultural issues.
- PRIME project staff and partners communicate honestly and openly.
- Team members were informed about the PRIME project as often as they should be.
- Decision making processes are fair.
- Team members’ opinions are listened to and considered by other PRIME project staff and partners.
- There is clear communication among the PRIME project work groups and steering team.
- There is a clear process for making decisions among PRIME partners.

Survey participants also evaluated the Steering Team Leadership, composition and oversight. All respondents agreed or strongly agreed that the PRIME project leaders have good skills for working with other people and organizations, effectively communicate the vision and mission of the project, and effectively implement steering team decisions. Most respondents agreed or strongly agreed
that the PRIME steering team includes sufficient diversity of organizations and that they are satisfied with the PRIME steering team’s oversight of the project.

When asked about the Steering Team members building capacity due to their participation in the PRIME project all respondents agreed or strongly agreed that they have learned about different health initiatives and opportunities in Michigan because of their involvement in the PRIME project. Most respondents agreed or strongly agreed that they have gained new knowledge and skills because of their involvement in the PRIME project AND that they have developed new relationships with project partners, and that their organization is better able to secure financial resources because of their involvement in the PRIME project, but there were a relatively greater number of respondents who indicated they disagreed or strongly disagreed with this.

Steering Team members were also asked to evaluate PRIME’s Project Achievement, all respondents agreed or strongly agreed that the PRIME project initiated a state/local partnership to help build the capacity of MDCH to effectively incorporate successful local strategies in MCH programs, policies and procedures that reduce disparities in infant mortality. Most respondents agreed or strongly agreed that the PRIME project established an effective Steering Team to help build the capacity of MDCH to reduce disparities in infant mortality, that the PRIME project conducted a comprehensive review of models and curriculum components for inclusion in the training curriculum/intervention model, that the PRIME project effectively focused project activities to identify goals and actions steps to reduce African American and Native American disparities in infant mortality, that the PRIME project effectively reviewed the organizational structure and functions of the Bureau of Family, Maternal and Child Health (BFMCH) to identify capacities and needs related to reducing disparities in infant mortality, but there were a relatively greater number of respondents who indicated they disagreed with this, that the PRIME project built the knowledge and competencies of MDCH staff to incorporate strategies to eliminate racism and health inequities in program planning to reduce disparities in infant mortality, but there were a relatively greater number of respondents who indicated they disagreed or strongly disagreed with this.

7. **The outcome evaluation methods will include the widespread use of the tool kit & curriculum within MDCH & local health departments. Counting of units that request use will be the indicator.**

We plan to assess the use of all PRIME project products by other state and local health departments, but the PRIME Tool Kit and Curriculum have not yet been developed. We anticipate that these projects will be ready for distribution by the end of the third project year.

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

During the reporting period, there were no staff training activities to evaluate. We did meet with consultants from the University of North Carolina and described our methods for assessing change
in knowledge at training events. We agreed to work together to prepare knowledge tests that will be used to evaluate upcoming training workshops.

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

We will continue to discuss issues associated with using PRAMS for monitoring social determinants as well as other methods in the project’s second year. As mentioned earlier in this report, MDCH is currently drafting a PRAMS Native American specific survey. Questions on racism and social determinants of health are being added to the survey.

During Michigan’s 2011 Infant Mortality Summit, there was a focus on social determinants and contributing factors for infant mortality. The action plan that is being derived from the summit will include an emphasis on social determinants across all activities in the work plan.

Finally, a Life course Workgroup (within the Division of Family and Community Health) is engaged in prioritizing which social determinants of health to monitor in their efforts to reduce disparities in health outcomes. Currently, the workgroup is reviewing the health equity data set developed by the Health Disparities Reduction and Minority Health section and the information included in the Health Equity and Social Justice workshop on root causes of health inequities to determine the social determinants to measure.

Systematic efforts to include social determinants in statewide reports of health disparities have not yet started. A great deal of planning and development of new assessments has begun and are summarized on pages 3-4.

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

The annual assessment of MDCH staff effort was initiated with the survey of Women, Infants & Children (WIC) Organizational Assessment – see report on pp. 15-16. A copy of the Organizational Assessment Tool is included in the Appendix.
APPENDICES

Analysis of Steering Team Process Evaluation Surveys

PRIME Organization Assessment

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

PRIME (Practices to Reduce Infant Mortality through Equity) Local Learning Collaborative Booklet
Analysis of Steering Team Process Evaluation Surveys

Allison Krusky, MPH
Thomas M. Reischl, PhD
November 14 2011

1. What organization do you work for?

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2. What have been your roles in the PRIME project so far? (Please check all that apply for you)

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</tr>
</tbody>
</table>

Note: Percents do not total 100; participants selected one or more roles.

3. What is your gender?

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Male</td>
<td>2</td>
<td>14.3</td>
<td>14.3</td>
<td>14.3</td>
</tr>
<tr>
<td>Female</td>
<td>12</td>
<td>85.7</td>
<td>85.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Hispanic, Latino or Spanish origin</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>14</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

This project is supported by Grant # P3016224 from the W.K. Kellogg Foundation.
5. Are you of Arab or Chaldean origin?

<table>
<thead>
<tr>
<th>Arab or Chaldean origin</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>14</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

6. What is your race? *(Check all that apply)*

<table>
<thead>
<tr>
<th>Race</th>
<th>Frequency</th>
<th>Percent</th>
<th>Percent¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>7</td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>3</td>
<td></td>
<td>21.4%</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td></td>
<td>7.1%</td>
</tr>
<tr>
<td>Pacific Islander (e.g. Hawaiian, Samoan)</td>
<td>0</td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>American Indian or Alaska Native*</td>
<td>2</td>
<td></td>
<td>14.3%</td>
</tr>
<tr>
<td>Other²</td>
<td>1</td>
<td></td>
<td>7.1%</td>
</tr>
</tbody>
</table>

Note: 1. Percents do not total 100; participants selected one or more racial/ethnic groups. 2. Two tribes were represented. 3. Multi-racial

Please indicate your level of agreement by circling one answer for each statement.

<table>
<thead>
<tr>
<th>Goals and Commitment</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The level of commitment among the PRIME project staff and key stakeholders is high.</td>
<td>13</td>
<td>3</td>
<td>4</td>
<td>3.54</td>
<td>.519</td>
</tr>
<tr>
<td>I have a clear understanding of the goals of the PRIME project.</td>
<td>14</td>
<td>3</td>
<td>4</td>
<td>3.43</td>
<td>.514</td>
</tr>
<tr>
<td>The relevant abilities, skills and expertise of all PRIME project staff and key stakeholders are used to promote the PRIME success at meeting its goals.</td>
<td>14</td>
<td>2</td>
<td>4</td>
<td>3.29</td>
<td>.726</td>
</tr>
<tr>
<td>I have a clear understanding of how PRIME is trying to accomplish its goals.</td>
<td>12</td>
<td>3</td>
<td>4</td>
<td>3.17</td>
<td>.389</td>
</tr>
<tr>
<td>The PRIME steering team has established reasonable goals.</td>
<td>13</td>
<td>2</td>
<td>4</td>
<td>3.08</td>
<td>.494</td>
</tr>
<tr>
<td>The organizations that belong to the PRIME project invest the right amount of time in our collaborative efforts.</td>
<td>12</td>
<td>2</td>
<td>4</td>
<td>2.92</td>
<td>.515</td>
</tr>
<tr>
<td>My ideas about what PRIME wants to accomplish with this collaboration seem to be the same as the ideas of others.</td>
<td>12</td>
<td>2</td>
<td>4</td>
<td>2.92</td>
<td>.669</td>
</tr>
<tr>
<td>I have a clear understanding of my own role and responsibilities on the PRIME project.</td>
<td>14</td>
<td>1</td>
<td>4</td>
<td>2.86</td>
<td>.864</td>
</tr>
</tbody>
</table>

Note: Scale (1=Strongly Disagree, 2= Disagree, 3= Agree, 4= Strongly Agree)
Please indicate your level of agreement by circling one answer for each statement.

### Descriptive Statistics

<table>
<thead>
<tr>
<th>Communications and Decision Making</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIME project staff and project partners discussions are sensitive to social and cultural issues.</td>
<td>12</td>
<td>3</td>
<td>4</td>
<td>3.67</td>
<td>.492</td>
</tr>
<tr>
<td>My opinion is listened to and considered by other PRIME project staff and project partners.</td>
<td>12</td>
<td>2</td>
<td>4</td>
<td>3.50</td>
<td>.674</td>
</tr>
<tr>
<td>During meetings, PRIME project staff and project partners communicate honestly and openly.</td>
<td>11</td>
<td>3</td>
<td>4</td>
<td>3.45</td>
<td>.522</td>
</tr>
<tr>
<td>I am informed as often as I should be about what goes on in the PRIME Project.</td>
<td>13</td>
<td>3</td>
<td>4</td>
<td>3.38</td>
<td>.506</td>
</tr>
<tr>
<td>The process through which the PRIME project staff and project partners make decisions is fair.</td>
<td>12</td>
<td>3</td>
<td>4</td>
<td>3.25</td>
<td>.452</td>
</tr>
<tr>
<td>There is clear communication among the PRIME project work groups and steering team.</td>
<td>12</td>
<td>2</td>
<td>4</td>
<td>3.25</td>
<td>.754</td>
</tr>
<tr>
<td>There is a clear process for making decisions among PRIME partners in the PRIME project.</td>
<td>11</td>
<td>2</td>
<td>4</td>
<td>2.91</td>
<td>.701</td>
</tr>
</tbody>
</table>

Note: Scale (1=Strongly Disagree, 2= Disagree, 3= Agree, 4= Strongly Agree)

Please indicate your level of agreement by circling one answer for each statement.

### Time Invested

<table>
<thead>
<tr>
<th>How often do you work on PRIME project activities (e.g., team meetings, project activities)?</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>2</td>
<td>6</td>
<td>4.62</td>
<td>1.193</td>
<td></td>
</tr>
</tbody>
</table>

Note: Scale (1= Once a year or less, 2=Several times a year, 3=Once a month, 4=2-3 times a month, 5=1-2 times a week, 6=3 times a week or more)

### Time Invested

<table>
<thead>
<tr>
<th>How would you rate your level of involvement on the PRIME project?</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>1</td>
<td>3</td>
<td>2.08</td>
<td>.669</td>
<td></td>
</tr>
</tbody>
</table>

Note: Scale (1= Less than I prefer, 2=Right amount, 3=More than I prefer)

Please indicate your level of agreement by circling one answer for each statement.

### Ratings of the PRIME Leadership

<table>
<thead>
<tr>
<th>PRIME project leadership effectively communicate the vision and mission of the project.</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>3</td>
<td>4</td>
<td>3.42</td>
<td>.515</td>
<td></td>
</tr>
<tr>
<td>PRIME project leadership effectively implement steering team policies and decisions.</td>
<td>11</td>
<td>3</td>
<td>4</td>
<td>3.36</td>
<td>.505</td>
</tr>
<tr>
<td>PRIME project leadership have good skills for working with other people and organizations.</td>
<td>11</td>
<td>3</td>
<td>4</td>
<td>3.64</td>
<td>.505</td>
</tr>
</tbody>
</table>

Note: Scale (1=Strongly Disagree, 2= Disagree, 3= Agree, 4= Strongly Agree)
### PRIME Steering Team

<table>
<thead>
<tr>
<th>Description</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The PRIME steering team includes sufficient diversity of organizations.</td>
<td>12</td>
<td>2</td>
<td>4</td>
<td>3.18</td>
<td>.718</td>
</tr>
<tr>
<td>I am satisfied with the PRIME steering team’s oversight of the PRIME project.</td>
<td>12</td>
<td>2</td>
<td>4</td>
<td>3.17</td>
<td>.577</td>
</tr>
</tbody>
</table>

Note: Scale (1=Strongly Disagree, 2= Disagree, 3= Agree, 4= Strongly Agree)

### Capacity Building

<table>
<thead>
<tr>
<th>Description</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due to my involvement on the PRIME project, I have developed new relationships with project partners.</td>
<td>12</td>
<td>2</td>
<td>4</td>
<td>3.17</td>
<td>.718</td>
</tr>
<tr>
<td>I have learned about different health initiatives and opportunities in Michigan because of my involvement in the PRIME project.</td>
<td>12</td>
<td>3</td>
<td>4</td>
<td>3.42</td>
<td>.515</td>
</tr>
<tr>
<td>I have gained new knowledge and/or skills because of my involvement in the PRIME project.</td>
<td>12</td>
<td>2</td>
<td>4</td>
<td>3.58</td>
<td>.669</td>
</tr>
<tr>
<td>Due to my involvement in the PRIME project, my organization is better able to secure financial resources.</td>
<td>10</td>
<td>1</td>
<td>4</td>
<td>2.90</td>
<td>.876</td>
</tr>
</tbody>
</table>

Note: Scale (1=Strongly Disagree, 2= Disagree, 3= Agree, 4= Strongly Agree)

### New Relationships

<table>
<thead>
<tr>
<th>Organization</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Michigan</td>
<td>4</td>
</tr>
<tr>
<td>Health Department</td>
<td>2</td>
</tr>
<tr>
<td>MDCH</td>
<td>3</td>
</tr>
<tr>
<td>Local Health Department Collaborative</td>
<td>1</td>
</tr>
<tr>
<td>Intertribal Council</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: 1. Health department representatives, Ingham County trainers for social equity, 2. Division of MCH, Health Disparities, Epidemiology, 3. New people that work on the project and have a better/diverse understanding of the issue; State of Michigan and the several offices/programs that participate in this project.

Please indicate your level of agreement by circling one answer for each statement.

### Achievements

<table>
<thead>
<tr>
<th>Description</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct a comprehensive review of models and curriculum components for inclusion in the training curriculum/intervention model developed for the project.</td>
<td>11</td>
<td>2</td>
<td>4</td>
<td>3.27</td>
<td>.647</td>
</tr>
<tr>
<td>Initiate a state/local partnership to help build the capacity of MDCH to effectively incorporate successful local strategies in MCH programs, policies and procedures that reduce disparities in infant mortality.</td>
<td>10</td>
<td>3</td>
<td>4</td>
<td>3.20</td>
<td>.422</td>
</tr>
<tr>
<td>Establish an effective Steering Team to help build the capacity of MDCH to reduce disparities in infant mortality.</td>
<td>12</td>
<td>2</td>
<td>4</td>
<td>3.08</td>
<td>.515</td>
</tr>
<tr>
<td>Effectively focus project activities to identify goals and actions steps to reduce African American and Native American disparities in infant mortality.</td>
<td>12</td>
<td>2</td>
<td>4</td>
<td>2.83</td>
<td>.718</td>
</tr>
<tr>
<td>Build the knowledge and competencies of MDCH staff to incorporate strategies to eliminate racism and health inequities in program planning to reduce disparities in infant mortality.</td>
<td>12</td>
<td>1</td>
<td>3</td>
<td>2.75</td>
<td>.622</td>
</tr>
<tr>
<td>Effectively review the organization structure and functions of the Bureau of Family, Maternal and Child Health (BFMCH) to identify capacities and needs related to reducing disparities in infant mortality.</td>
<td>11</td>
<td>1</td>
<td>4</td>
<td>2.73</td>
<td>.786</td>
</tr>
</tbody>
</table>

Note: Scale (1= Strongly Disagree, 2= Disagree, 3= Agree, 4= Strongly Agree)
PRIME Organization Assessment

Q1.1 INTRODUCTION You are being asked to complete this survey as part of the Practices to Reduce Infant Mortality through Equity (PRIME) project. The goal of PRIME is to create a comprehensive strategy that can help BFMCH reduce racial disparities in infant mortality in Michigan. PRIME focuses on African Americans and American Indians because infant mortality rates in Michigan for these groups are significantly higher than the rate for whites and other racial/ethnic groups. In this survey, racial health disparities refers to 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.

Your responses to this survey will help us identify the types of changes, resources, training and technical assistance needed for Bureau staff to more effectively address racial disparities in infant mortality in its work. You will be asked to share your perspective on BFMCH programs and services, employee engagement, cultural competency, knowledge and skills, program development, professional development, and your demographics. This survey will take approximately 30 minutes to complete. If needed, you may start, then return to the survey at a later time by using the link you received by email. Your responses are automatically saved.

CONFIDENTIALITY All surveys will be confidential. Only University of Michigan staff will have access to your individual responses. Results will be reported in an aggregate format only. We will not report information in a way that makes an individual identifiable (for example, we would not report something like “one Pacific Islander man indicated....,” when there’s only one Pacific Islander man in the division).

Q2.1 In this section, we ask that you provide us with some basic information about yourself that will help us group responses according to division, job type, and race/ethnicity for analysis. Please answer all questions to the best of your ability, even if you do not consider them relevant to your work.

Q2.2 What division are you in? (Check one answer)
- Women, Infants & Children (WIC) (1)
- Division of Family and Community Health (2)
- Children's Special Health Care Services (3)
- Division of Health Wellness and Disease Control (4)
Q2.3 What is your classification? (Check one answer)
- Administration/Management (1)
- Program Coordinator/Specialist (2)
- Program Consultant (3)
- Administrative Support (4)
- Vendor Consultant (5)
- Other: (6) ____________________

Q2.4 Are you full-time or part-time? (Check one answer)
- Full Time (1)
- Part Time (2)

Q2.5 Is this position permanent or temporary? (Check one answer)
- Permanent (1)
- Temporary (2)

Q2.6 Are you a person of Hispanic, Latino or Spanish origin? (Check one answer)
- Yes (1)
- No (2)

Q2.7 What is your race (Check all that apply)
- White (1)
- Black, African American (2)
- Asian (3)
- Pacific Islander (e.g. Hawaiian, Samoan) (4)
- American Indian or Alaska Native Name of enroll (5)
- Other Race Group: (6) ____________________

Q3.1 In this section, we ask for your perspectives on the Bureau’s program and services by considering BFMCH as a whole, including all three divisions. Please answer all questions to the best of your ability, even if you do not consider them relevant to your work.
Q3.2 Indicate your level of agreement with each of the following statements. The Bureau’s programs and services are designed to:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree (8)</th>
<th>Agree (9)</th>
<th>Disagree (10)</th>
<th>Strongly Disagree (11)</th>
<th>Do Not Know (12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>address racial health disparities. (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>provide programs and services to meet the needs of Michigan residents. (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>promote best practices to address racial health disparities (3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>improve quality of life for all infants, children, adolescents and their families. (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>address the social</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determinants of health (social, environmental, economic conditions) to eliminate racial health disparities. (5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q4.2 Indicate your level of agreement with each of the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree (1)</th>
<th>Agree (2)</th>
<th>Disagree (3)</th>
<th>Strongly Disagree (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I clearly understand how MDCH’s mission is consistent with a focus on reducing racial health disparities. (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand how my work contributes to the MDCH’s mission and eliminating racial health disparities. (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My work contributes to developing or administering policies and programs that help to eliminate racial health disparities. (3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q5.1 In the following two sections, we ask that you share your familiarity with African American and American Indian cultures. We are seeking your understanding of these cultures to help us determine the collective capacity of Bureau staff to consider and address cultural differences. Please answer all questions to the best of your ability, even if you do not consider them relevant to your work.
Q5.2 Indicate your level of agreement with each of the following statements. I understand how culture impacts African Americans’ lives, such as:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>child rearing.</td>
<td>(1)</td>
</tr>
<tr>
<td>self-help skills.</td>
<td>(2)</td>
</tr>
<tr>
<td>expectations for the future.</td>
<td>(3)</td>
</tr>
<tr>
<td>communication.</td>
<td>(4)</td>
</tr>
<tr>
<td>education.</td>
<td>(5)</td>
</tr>
<tr>
<td>family roles.</td>
<td>(6)</td>
</tr>
<tr>
<td>religion/faith-based practices.</td>
<td>(7)</td>
</tr>
<tr>
<td>gender roles.</td>
<td>(8)</td>
</tr>
<tr>
<td>perceptions of time.</td>
<td>(9)</td>
</tr>
<tr>
<td>views on wellness.</td>
<td>(10)</td>
</tr>
<tr>
<td>use of Western medical treatment.</td>
<td>(11)</td>
</tr>
<tr>
<td>health behaviors.</td>
<td>(12)</td>
</tr>
<tr>
<td>use of body language.</td>
<td>(13)</td>
</tr>
<tr>
<td>decision making.</td>
<td>(14)</td>
</tr>
<tr>
<td>pregnancy.</td>
<td>(15)</td>
</tr>
<tr>
<td>breastfeeding.</td>
<td>(16)</td>
</tr>
<tr>
<td>infant mortality.</td>
<td>(17)</td>
</tr>
<tr>
<td>use of non-Western medical treatment.</td>
<td>(18)</td>
</tr>
</tbody>
</table>
Q5.3 Indicate your level of agreement with each of the following statements. I understand how culture impacts American Indians’ lives, such as:

<table>
<thead>
<tr>
<th>Statements</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>child rearing.</td>
<td>(1)</td>
</tr>
<tr>
<td>self-help skills.</td>
<td>(2)</td>
</tr>
<tr>
<td>expectations for the future</td>
<td>(3)</td>
</tr>
<tr>
<td>communication.</td>
<td>(4)</td>
</tr>
<tr>
<td>education.</td>
<td>(5)</td>
</tr>
<tr>
<td>family roles.</td>
<td>(6)</td>
</tr>
<tr>
<td>religion/faith-based practices</td>
<td>(7)</td>
</tr>
<tr>
<td>gender roles.</td>
<td>(8)</td>
</tr>
<tr>
<td>perceptions of time.</td>
<td>(9)</td>
</tr>
<tr>
<td>views on wellness.</td>
<td>(10)</td>
</tr>
<tr>
<td>use of Western medical treatment.</td>
<td>(11)</td>
</tr>
<tr>
<td>health behaviors.</td>
<td>(12)</td>
</tr>
<tr>
<td>use of body language.</td>
<td>(13)</td>
</tr>
<tr>
<td>decision making.</td>
<td>(14)</td>
</tr>
<tr>
<td>pregnancy.</td>
<td>(15)</td>
</tr>
<tr>
<td>breastfeeding.</td>
<td>(16)</td>
</tr>
<tr>
<td>infant mortality.</td>
<td>(17)</td>
</tr>
<tr>
<td>use of non-Western medical treatment.</td>
<td>(18)</td>
</tr>
</tbody>
</table>
Q6.1 In the next two sections, we ask that you evaluate your knowledge and skills on several topics. Your responses will help us understand overall knowledge and skill levels among Bureau staff. Please answer all questions to the best of your ability, even if you do not consider them relevant to your work.

Q6.2 Indicate your level of agreement with each of the following statements.

<table>
<thead>
<tr>
<th>Level of Agreement</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I have the ability to search electronic databases to gather information about effective racial health disparities reduction programs.</td>
</tr>
<tr>
<td>2</td>
<td>I know how to evaluate racial health disparities reduction programs.</td>
</tr>
<tr>
<td>3</td>
<td>I have the ability to utilize data to inform program development.</td>
</tr>
<tr>
<td>4</td>
<td>I know how to obtain and evaluate published information to inform strategic planning related to racial health disparities.</td>
</tr>
</tbody>
</table>
Q6.4 Indicate your level of agreement with each of the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agreement Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am knowledgeable at a basic level about racial health disparities.</td>
<td>1</td>
</tr>
<tr>
<td>I am knowledgeable at a basic level about racial health disparities in infant mortality.</td>
<td>2</td>
</tr>
<tr>
<td>I have more than a basic level of understanding about racial disparities.</td>
<td>3</td>
</tr>
<tr>
<td>I have more than a basic level of understanding about racial health disparities in infant mortality.</td>
<td>4</td>
</tr>
<tr>
<td>I know how to use a social determinants of health perspective of racial health disparities in my work.</td>
<td>5</td>
</tr>
<tr>
<td>I know how to use a social determinants of health perspective of racial disparities in infant mortality in my work.</td>
<td>6</td>
</tr>
<tr>
<td>I know how to apply a life-course perspective of racial health disparities in my work.</td>
<td>7</td>
</tr>
<tr>
<td>I know how to apply a life-course perspective of racial disparities in infant mortality in my work.</td>
<td>8</td>
</tr>
<tr>
<td>I am competent discussing racism as a barrier to racial health disparities.</td>
<td>9</td>
</tr>
<tr>
<td>I am competent discussing racism as a barrier to racial disparities in infant mortality.</td>
<td>10</td>
</tr>
</tbody>
</table>

Q7.1 In this section, we ask that you indicate where and how you acquire new knowledge to fulfill your work obligations and roles. Please answer all questions to the best of your ability, even if you do not consider them relevant to your work.
Q7.2 Indicate your level of agreement with each of the following statements. To do my job, I use information about racial health disparities from:

<table>
<thead>
<tr>
<th>Source of Information</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Journal articles</td>
<td>1</td>
</tr>
<tr>
<td>Conferences, symposiums</td>
<td>2</td>
</tr>
<tr>
<td>Internal trainings, in-services, brown bags</td>
<td>3</td>
</tr>
<tr>
<td>State-level databases</td>
<td>4</td>
</tr>
<tr>
<td>Webinars</td>
<td>5</td>
</tr>
<tr>
<td>Specialized online courses</td>
<td>6</td>
</tr>
<tr>
<td>Academic courses</td>
<td>7</td>
</tr>
<tr>
<td>Other staff within BFMCH</td>
<td>8</td>
</tr>
<tr>
<td>Staff outside the BFMCH but within MDCH</td>
<td>9</td>
</tr>
<tr>
<td>Staff at other state health departments</td>
<td>10</td>
</tr>
<tr>
<td>Staff at local health departments in Michigan</td>
<td>11</td>
</tr>
</tbody>
</table>

Q7.3 Indicate your level of agreement with each of the following statements. The Bureau allocates resources for staff to enhance their:

<table>
<thead>
<tr>
<th>Skill</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal skills</td>
<td>1</td>
</tr>
<tr>
<td>Professional skills</td>
<td>2</td>
</tr>
</tbody>
</table>
Q8.1 In the following three sections, we ask that you provide your perspectives on your Division's community engagement of African American and American Indian groups in general. Your responses will help us to better understand community engagement within the Division staff. Please answer all questions to the best of your ability, even if you do not consider them relevant to your work.

Q8.2 Indicate your level of agreement with each of the following statements regarding community engagement of African Americans.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division staff understand African Americans' major social and health concerns. (1)</td>
<td></td>
</tr>
<tr>
<td>Division staff is familiar with the strengths &amp; resources in African American communities in Michigan. (3)</td>
<td></td>
</tr>
<tr>
<td>My division has provided resources to African American communities to reduce racial health disparities. (7)</td>
<td></td>
</tr>
<tr>
<td>My division has strategies in place to monitor whether local health departments address barriers to African American participation (e.g. it is possible to provide money for child care and transportation to residents attending community meetings, etc.). (9)</td>
<td></td>
</tr>
<tr>
<td>My division involves key partners in the African American community to develop new services, programs and policies. (11)</td>
<td></td>
</tr>
</tbody>
</table>
Q8.3 Indicate your level of agreement with each of the following statements regarding community engagement of American Indians.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agreement Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division staff understand American Indians' major social and health concerns.</td>
<td>2</td>
</tr>
<tr>
<td>Division staff is familiar with the strengths &amp; resources in American Indian communities in Michigan.</td>
<td>4</td>
</tr>
<tr>
<td>My division has provided resources to American Indian communities to reduce racial health disparities.</td>
<td>8</td>
</tr>
<tr>
<td>My division has strategies in place to monitor whether local health departments address barriers to American Indian participation (e.g. it is possible to provide money for child care and transportation to residents attending community meetings, etc.).</td>
<td>10</td>
</tr>
<tr>
<td>My division involves key partners in the Native American community to develop new services, programs, and policies.</td>
<td>12</td>
</tr>
</tbody>
</table>

Q8.4 Indicate your level of agreement with each of the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agreement Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division staff is involved with community groups who advocate for policies that address racial health disparities.</td>
<td>5</td>
</tr>
<tr>
<td>Division staff is able to adapt to changes within the populations we serve.</td>
<td>6</td>
</tr>
</tbody>
</table>

Q9.1 In this section, we ask that you share your perception of knowledge and skills of the Division staff, as a whole. Notice that these questions are the same as those previously asked about yourself. Please answer all questions to the best of your ability, even if you do not consider them relevant to your work.
Q9.2 Indicate your level of agreement with each of the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division staff is knowledgeable at a basic level about racial health disparities.</td>
<td>(1)</td>
</tr>
<tr>
<td>Division staff is knowledgeable at a basic level about racial disparities in infant mortality.</td>
<td>(2)</td>
</tr>
<tr>
<td>Division staff have more than a basic level of understanding about racial health disparities.</td>
<td>(3)</td>
</tr>
<tr>
<td>Division staff have more than a basic level of understanding about racial disparities in infant mortality.</td>
<td>(4)</td>
</tr>
<tr>
<td>Division staff know how to apply a social determinants of health perspective of racial health disparities in their work.</td>
<td>(5)</td>
</tr>
<tr>
<td>Division staff know how to apply a social determinants of health perspective of racial disparities in infant mortality in their work.</td>
<td>(6)</td>
</tr>
<tr>
<td>Division staff know how to apply a life-course perspective to work of racial health disparities in their work.</td>
<td>(7)</td>
</tr>
<tr>
<td>Division staff know how to apply a life-course perspective to work of racial disparities in infant mortality in their work.</td>
<td>(8)</td>
</tr>
<tr>
<td>Division staff is competent discussing racism as a barrier to racial health disparities.</td>
<td>(9)</td>
</tr>
<tr>
<td>Division staff is competent discussing racism as a barrier to racial disparities in infant mortality.</td>
<td>(10)</td>
</tr>
</tbody>
</table>

Q10.1 You have completed the PRIME Organization Assessment survey. Thank you for your time.
Practices to Reduce Infant Mortality through Equity (PRIME)*
Green Paper

Derek M. Griffith, PhD, Kau‘i Baumhofer, MA, MPH, Julie Ober Allen, MPH, Alethia Carr, RD, MBA, Brenda Jegede, MPH, MSW


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

---

\(^1\) 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.
• Establish a sustainable quality assurance process for these efforts within the BFMCH
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).

---

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 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 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.

---

**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>
</table>
| Maternal Health/Prematurity | • Very low birth weight-related deaths generally caused by prematurity or poor maternal health  
• Deaths with birth weights from 500 to 1499 grams | • Preconception health  
• Unintended pregnancy  
• Smoking  
• Drug abuse  
• Specialized perinatal care |
| Maternal Care         | • High birth weight-related deaths  
• Fetal deaths from 24 to 40 weeks gestation  
• Influenced by such factors as prenatal and obstetric care | • Early continuous prenatal care  
• Referral of high risk pregnancies  
• Good medical management of diabetes, seizures, post maturity or other medical problems |
| Newborn Care          | • Neonatal deaths  
• Infant deaths from birth to four weeks  
• Influenced by perinatal care | • Advanced neonatal care  
• Treatment of congenital anomalies |
| Infant Health         | • Post-neonatal deaths  
• Deaths from four weeks to one year | • Infant Safe Sleep activities such as sleep position education or breast-feeding promotion  
• Access to medical homes and injury prevention |
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: 7.0</td>
<td>Maternal Health/Prematurity: 2.1</td>
</tr>
<tr>
<td>Maternal Care: 1.9</td>
<td>Maternal Care: 1.3</td>
</tr>
<tr>
<td>Newborn Care: 2.0</td>
<td>Newborn Care: 1.0</td>
</tr>
<tr>
<td>Infant Health: 3.3</td>
<td>Infant Health: 0.9</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: 2.3</td>
<td>Maternal Health/Prematurity: 2.1</td>
</tr>
<tr>
<td>Maternal Care: 3.2</td>
<td>Maternal Care: 1.3</td>
</tr>
<tr>
<td>Newborn Care: 3.2</td>
<td>Newborn Care: 1.0</td>
</tr>
<tr>
<td>Infant Health: 3.6</td>
<td>Infant Health: 0.9</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.

---

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
- **state public health departments** should assume a central role,
- **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 of 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/imbances | 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 episodes</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>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>
<tbody>
<tr>
<td>6 month</td>
<td>1 year</td>
<td></td>
</tr>
</tbody>
</table>
Components

| 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/ BFMCH** – departmental and bureau policies, practices and norms
- **Data Systems** – Data collection, storage, analysis, and dissemination methods that may help to inform and evaluate BFMCH programs, efforts and activities
- **Programs** – Programs and activities led or administered by BFMCH 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>
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<td>---</td>
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<tr>
<td></td>
<td>Operationalize key terminology</td>
<td></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></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>
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</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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<tr>
<td></td>
<td>How should you define race and ethnicity (LaVeist, 1996; Smedley &amp; Smedley, 2005)</td>
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</tr>
<tr>
<td></td>
<td>Racism as a determinant of health (Williams, 2005)</td>
<td></td>
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<tr>
<td></td>
<td>How should we consider determinants of population-level disparities (Warnecke, et al. 2008)</td>
<td></td>
</tr>
</tbody>
</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.

Figure 9. Whitehead (2007) model of addressing health disparities

<table>
<thead>
<tr>
<th>Key Area</th>
<th>Goal</th>
<th>Potential Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed problem of health inequality</td>
<td>Perceived causes of problem</td>
<td>Policy goals to address causes</td>
</tr>
</tbody>
</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

### 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 can we use limited resources to balance our, potentially conflicting, responsibilities to Black and American Indian populations and the State at large?
9. Who makes decisions about priorities and how are these decisions made?
10. What current MDCH and BFMCH policies and practices address the fundamental, or root, causes of racial disparities in infant mortality?
11. Who will ensure that SDOH are addressed in policies and practices?
12. 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?)?

- 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
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>
</tr>
</thead>
</table>
| Technical | • Create separate but complementary plans to address AA-White and AI-White disparities in infant mortality  
             • Improve the quality of data available to inform statewide strategies to address AA-White and AI-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?
### 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</th>
<th>Locals Health Departments</th>
<th>MDCH/BFMCH</th>
<th>Data Systems</th>
<th>Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State-level policies, responsibilities, relationships and activities</td>
<td>Relationships with and support of local health department/ Local Learning Collaborative efforts</td>
<td>Departmental and bureau policies, practices and norms</td>
<td>Data collection, storage, analysis, and dissemination methods</td>
<td>Programs and activities led or administered by BFMCH staff</td>
</tr>
<tr>
<td><strong>Conceptual</strong></td>
<td></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>
<tr>
<td>Specific skills, resources, and information used to systematically justify and address racial disparities in infant mortality in MI</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Organizational</strong></td>
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</tr>
<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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</tbody>
</table>

**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 devoting 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


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 dialogic 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 are 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? [MOVE TO PRACTICAL?]
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?
Bureau of Family, Maternal and Child Health (BFMCH)

PRIME (Practices to Reduce Infant Mortality through Equity)

Local Learning Collaborative

- ACCESS
- Berrien County Health Department
- Detroit Healthy Start Project
- Dispute Resolution Center
- Genesee County Health Department
- Grand Rapids African American Health Initiative
- Grand Rapids “Strong Beginnings” Healthy Start
- Ingham County Health Department
- InterTribal Council of Michigan/Native American Healthy Start
- Jackson County Health Department
- Kalamazoo Healthy Babies Healthy Start
- Kent County Health Department
- Michigan Minority Health Coalition
- National Kidney Foundation
- Oakland County Health Division
- Saginaw County “Great Beginnings” Healthy Start
- Washtenaw County Health Department
- Wayne County Health Department
PRIME (Practices to Reduce Infant Mortality through Equity)

Michigan Department of Community Health
Bureau of Family, Maternal and Child Health
Local Learning Collaborative

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Michigan Department of Community Health

PRIME (Practices to Reduce Infant Mortality through Equity)

Project Vision & Goals:

The vision of this project is to identify and implement the change in public health practice needed within the maternal and child health (MCH) area of state government to support the reduction of Michigan’s African American and American Indian infant mortality rates, thereby reducing the state disparities in infant mortality.

The project goals are to identify and eliminate institutionalized discriminatory policies and practices in MDCH MCH and to focus more of MCH funding, policy and practice on monitoring and addressing social determinants of racial disparities in infant mortality. If successful, this project will not only lead the statewide 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. The tool-kit will include strategies and tools to promote continuous quality improvement, collaboration and accountability, and public sharing of measurable outcomes that reflect racial and health equity.

Project Objectives:

1. To promote the understanding of practices that support institutional racism and develop an approach that challenges but encourages staff to develop systematic individual and corporate strategies to incorporate social determinants of health in the public health work. Work will occur to identify, tailor and implement an appropriate training and consultation model/curriculum/tool that promotes understanding of practices that support racism as a social determinant of health and contributes to disparities in infant mortality.

2. To effectively engage local stakeholders in MCH policy decision making, and utilize proven practices and lessons learned as state strategies. This objective intends to spread the available local level knowledge base about undoing racism that exists within Michigan as an effort to improve infant outcomes. Additionally, this will provide the opportunity for MDCH to better understand how to effectively engage stakeholders in policy making decisions.

3. To include a quality assurance process for the described goals that is sustained through a revision of the state infrastructure model. Including increased monitoring of social determinants of health provided in a statewide health disparity report and public sharing of measurable outcomes that reflect equity and health equity.
Logic Model:

This project is based on a logic model that acknowledges six contextual conditions. These conditions include a history of programs that have not significantly reduced the black/white disparity in infant mortality; the black/white racial disparity in infant mortality is not well understood; high racial segregation for African Americans in Michigan regardless of income may contribute to disparity; the state budget for MDCH and the MCH bureau has been decreasing; the state economic challenges exacerbate other social determinants of health; and a large percentage of MDCH staff are eligible for retirement suggesting this is a good time for strategic planning.

Project Assumptions:

First, MDCH needs a new strategy to guide efforts for infant mortality reduction; past efforts have not been successful. The strategy should not only consider the contemporary factors that contribute to the disparity, but examine why the disparity exists at all in Michigan by race in its historical context. Also, the strategy should recognize that the causes of individual cases of infant mortality are not the same as the causes of racial disparities in infant mortality. Finally, there is a need to examine both populations at risk and vulnerable populations because they are not synonymous.
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<thead>
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<th>NAME</th>
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<th>ORGANIZATION</th>
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</tr>
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<tbody>
<tr>
<td>Alethia Carr</td>
<td>517/335-8922</td>
<td>Intervention/Local Collaborative</td>
<td>MDCH – BFMCH</td>
<td><a href="mailto:carra@michigan.gov">carra@michigan.gov</a></td>
</tr>
<tr>
<td>Carol Ogan</td>
<td>517/335-8946</td>
<td>Local Collaborative</td>
<td>MDCH – BFMCH</td>
<td><a href="mailto:oganc@michigan.gov">oganc@michigan.gov</a></td>
</tr>
<tr>
<td>Lonnie Barnett</td>
<td>517/241-2963</td>
<td></td>
<td>MDCH – CSHCS</td>
<td><a href="mailto:stifflerk@michigan.gov">stifflerk@michigan.gov</a></td>
</tr>
<tr>
<td></td>
<td>517/241-7186</td>
<td></td>
<td></td>
<td><a href="mailto:kachl@michigan.gov">kachl@michigan.gov</a></td>
</tr>
<tr>
<td>Brenda Fink</td>
<td>517/335-8863</td>
<td>Evaluation</td>
<td>MDCH – DFCH</td>
<td><a href="mailto:finkb@michigan.gov">finkb@michigan.gov</a></td>
</tr>
<tr>
<td>Diane Hennesey, Sec’y</td>
<td>517/335-8486</td>
<td></td>
<td></td>
<td><a href="mailto:henneseyd@michigan.gov">henneseyd@michigan.gov</a></td>
</tr>
<tr>
<td>Paulette Dobynes-Dunbar</td>
<td>517/335-8903</td>
<td>Evaluation</td>
<td>MDCH – DFCH</td>
<td><a href="mailto:durbarp@michigan.gov">durbarp@michigan.gov</a></td>
</tr>
<tr>
<td>Judy Stiles, Temp. Sec’y</td>
<td>517/335-8499</td>
<td></td>
<td></td>
<td><a href="mailto:Markhamd1@michigan.gov">Markhamd1@michigan.gov</a></td>
</tr>
<tr>
<td>Cheryl Celestin</td>
<td>517/241-1918</td>
<td>Intervention</td>
<td>MDCH – DFCH</td>
<td><a href="mailto:celestinc@michigan.gov">celestinc@michigan.gov</a></td>
</tr>
<tr>
<td>Brenda Jegede, Proj. Coor.</td>
<td>517/335-9483</td>
<td>Evaluation/Intervention</td>
<td>MDCH – DFCH</td>
<td><a href="mailto:jegedeb@michigan.gov">jegedeb@michigan.gov</a></td>
</tr>
<tr>
<td>Sheryl Weir</td>
<td>313/456-4377</td>
<td></td>
<td>MDCH – DHWDC –</td>
<td><a href="mailto:weirs@michigan.gov">weirs@michigan.gov</a></td>
</tr>
<tr>
<td>Geraldine Motley</td>
<td>313/456-4377</td>
<td></td>
<td>Health Disparities</td>
<td><a href="mailto:motleyg@michigan.gov">motleyg@michigan.gov</a></td>
</tr>
<tr>
<td>Holly Nickel</td>
<td>517/373-8627</td>
<td>Intervention</td>
<td>MDCH – DHWDC –</td>
<td><a href="mailto:nickelh@michigan.gov">nickelh@michigan.gov</a></td>
</tr>
<tr>
<td>TDB</td>
<td>517/335-9166</td>
<td>Evaluation</td>
<td>MDCH – Epi –</td>
<td><a href="mailto:ganzevoort@michigan.gov">ganzevoort@michigan.gov</a></td>
</tr>
<tr>
<td>Virginia Ganzevoort, Sec’y</td>
<td>517/335-1577</td>
<td></td>
<td>Epi – Genomics</td>
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<tr>
<td>Marina Kleinhapel</td>
<td>517/373-1574</td>
<td>Evaluation</td>
<td>MDCH – Epi –</td>
<td><a href="mailto:kleinhapelm@michigan.gov">kleinhapelm@michigan.gov</a></td>
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<td>Jean Chabut</td>
<td>517/335-8925</td>
<td></td>
<td>MDCH – PHA</td>
<td><a href="mailto:chabutj@michigan.gov">chabutj@michigan.gov</a></td>
</tr>
<tr>
<td>Betsy Pash</td>
<td>517/335-8701</td>
<td></td>
<td>MDCH – PHA</td>
<td><a href="mailto:pashe@michigan.gov">pashe@michigan.gov</a></td>
</tr>
<tr>
<td>Stella Christian, Sec’y</td>
<td>517/335-9709</td>
<td></td>
<td></td>
<td><a href="mailto:christians@michigan.gov">christians@michigan.gov</a></td>
</tr>
<tr>
<td>Stan Bien</td>
<td>517/335-8448</td>
<td></td>
<td>MDCH – WIC</td>
<td><a href="mailto:biens@michigan.gov">biens@michigan.gov</a></td>
</tr>
<tr>
<td>Sheryl Darling, Act. Secy</td>
<td>517/335-8848</td>
<td></td>
<td></td>
<td><a href="mailto:darlings@michigan.gov">darlings@michigan.gov</a></td>
</tr>
<tr>
<td>Renee Canady</td>
<td>517/887-4466</td>
<td>Intervention/Local Collaborative</td>
<td>Ingham County</td>
<td><a href="mailto:rcanady@ingham.org">rcanady@ingham.org</a></td>
</tr>
<tr>
<td>Alice Ailles, Sec’y</td>
<td></td>
<td></td>
<td>Health Department</td>
<td><a href="mailto:aailles@ingham.org">aailles@ingham.org</a></td>
</tr>
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<tr>
<td>Elizabeth Kushman</td>
<td>906/440-5660</td>
<td>Local Collaborative</td>
<td><a href="mailto:ekushman@charter.net">ekushman@charter.net</a></td>
<td></td>
</tr>
<tr>
<td>Lisa Abramson</td>
<td>906/632-6896 x 133</td>
<td>Inter-Tribal Council of MI</td>
<td><a href="mailto:labramson@itcmi.org">labramson@itcmi.org</a></td>
<td></td>
</tr>
<tr>
<td>Debbie Peterson</td>
<td>989/755-4907</td>
<td>Inter-Tribal Council of MI</td>
<td><a href="mailto:dpeterson@sagchip.org">dpeterson@sagchip.org</a></td>
<td></td>
</tr>
<tr>
<td>Ellen Clement</td>
<td>734/714-2260 (o)</td>
<td>Local Collaborative</td>
<td><a href="mailto:eclement@cornerhealth.org">eclement@cornerhealth.org</a></td>
<td></td>
</tr>
<tr>
<td>Regina Myree, Asst.</td>
<td>734/358-1803 (c)</td>
<td>The Corner Health Center</td>
<td><a href="mailto:rmyree@cornerhealth.org">rmyree@cornerhealth.org</a></td>
<td></td>
</tr>
<tr>
<td>Tom Reischl</td>
<td>734/763-5568</td>
<td>Evaluation</td>
<td><a href="mailto:reischl@umich.edu">reischl@umich.edu</a></td>
<td></td>
</tr>
<tr>
<td>Derek Griffith</td>
<td>734/936-1318</td>
<td>Evaluation/Intervention</td>
<td><a href="mailto:derekmg@umich.edu">derekmg@umich.edu</a></td>
<td></td>
</tr>
<tr>
<td>Julie Allen</td>
<td>734/647-0542</td>
<td>Evaluation/Intervention</td>
<td><a href="mailto:joallen@umich.edu">joallen@umich.edu</a></td>
<td></td>
</tr>
<tr>
<td>Angela Stevenson</td>
<td>734/727-7032</td>
<td>Local Collaborative</td>
<td><a href="mailto:astevens@co.wayne.mi.us">astevens@co.wayne.mi.us</a></td>
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<td>Manal Said, MSW</td>
<td>ACCESS</td>
<td><a href="mailto:msaid@accesscommunity.org">msaid@accesscommunity.org</a></td>
<td>313/216-2200</td>
<td>6450 Maple St.</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Dearborn, MI 48126</td>
</tr>
<tr>
<td>Gillian Conrad</td>
<td>Berrien County Health Department</td>
<td><a href="mailto:gconrad@bchdmi.org">gconrad@bchdmi.org</a></td>
<td>269/926-7121</td>
<td>769 Pipestone, P.O. Box 706</td>
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<td>x5249</td>
<td>Benton Harbor, MI 49023</td>
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<tr>
<td>Carolyn Rowland</td>
<td>Detroit Healthy Start Project &amp; Detroit</td>
<td><a href="mailto:rowlandc@detroitmi.gov">rowlandc@detroitmi.gov</a></td>
<td>313/876-4161</td>
<td>Detroit Dept of Health &amp; Wellness Program</td>
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<td>Department of Health &amp; Wellness</td>
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<td>1151 Taylor, Bldg. 6</td>
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<td>Detroit, MI 48202</td>
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<tr>
<td>Hannalori Bates Frick</td>
<td>Dispute Resolution Center</td>
<td><a href="mailto:bateshs@slu.edu">bateshs@slu.edu</a></td>
<td>248/320-3578</td>
<td>110 North Fourth Avenue, Suite 100</td>
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<td>Ann Arbor, MI 48104</td>
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<tr>
<td>Marcia Franks</td>
<td>Genesee County Health Dept.</td>
<td><a href="mailto:Mfranks@gchd.us">Mfranks@gchd.us</a></td>
<td>810/257-3202</td>
<td>McCree Courts &amp; Human Services Bldg.</td>
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<tr>
<td>cc: Mark Valacak</td>
<td></td>
<td><a href="mailto:mvalacak@gchd.us">mvalacak@gchd.us</a></td>
<td>810/257-3588</td>
<td>630 S. Saginaw St.</td>
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<td>Marcia Franks</td>
<td>Genesee County Healthy Start Project</td>
<td><a href="mailto:mfranks@gchd.us">mfranks@gchd.us</a></td>
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<td>Peggy Vander Muelen</td>
<td>Grand Rapids “Strong Beginnings” Healthy</td>
<td><a href="mailto:peggy.vandermeulen@spectrumhealth.org">peggy.vandermeulen@spectrumhealth.org</a></td>
<td>616/331-5838</td>
<td>Cook-DeVoss Ctr for Health Sciences</td>
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<td>301 Michigan. NE, Suite 400</td>
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<tr>
<td>Shannon Wilson, MPH</td>
<td>Grand Rapids African American Health</td>
<td><a href="mailto:shannon.wilson@graahi.org">shannon.wilson@graahi.org</a></td>
<td>616/331-5831</td>
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<td>Doak Bloss</td>
<td>Ingham County Health Dept.</td>
<td><a href="mailto:dbloss@ingham.org">dbloss@ingham.org</a></td>
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<tr>
<td>Lisa Chambers</td>
<td></td>
<td><a href="mailto:lchambers@ingham.org">lchambers@ingham.org</a></td>
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<tr>
<td>Julie Dingerson</td>
<td></td>
<td><a href="mailto:jdingerson@ingham.org">jdingerson@ingham.org</a></td>
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<tr>
<td>cc: Dean Sienko</td>
<td><a href="mailto:dsienko@ingham.org">dsienko@ingham.org</a></td>
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<tr>
<td>Renee Canady</td>
<td><a href="mailto:rcanady@ingham.org">rcanady@ingham.org</a></td>
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<tr>
<td>Amy Schultz</td>
<td>Jackson County Health Department</td>
<td><a href="mailto:Amy.Schultz@allegiancehealth.org">Amy.Schultz@allegiancehealth.org</a></td>
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<tr>
<td>Linda Vail Buzas, Health Officer</td>
<td>Kalamazoo County Health Dept</td>
<td><a href="mailto:lvbuza@kalcounty.com">lvbuza@kalcounty.com</a></td>
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<tr>
<td>Josh Jacobs</td>
<td></td>
<td><a href="mailto:jejaco@kalcounty.com">jejaco@kalcounty.com</a></td>
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<tr>
<td>Marc Meulman</td>
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<td><a href="mailto:mtmeul@kalcounty.com">mtmeul@kalcounty.com</a></td>
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<td>Carman Sweezy</td>
<td>Kalamazoo Healthy Babies Healthy Start</td>
<td><a href="mailto:lcswee@kalcounty.com">lcswee@kalcounty.com</a></td>
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<td>Kalamazoo Health &amp; Community Services</td>
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<td>Nazareth, MI 49074-0042</td>
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<tr>
<td>Teresa Branson</td>
<td>Kent County Health Dept.</td>
<td><a href="mailto:Teresa.branson@kentcounty.mi.gov">Teresa.branson@kentcounty.mi.gov</a></td>
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<tr>
<td>Karyn Pelon</td>
<td></td>
<td><a href="mailto:Karyn.Pelon@kentcountymi.gov">Karyn.Pelon@kentcountymi.gov</a></td>
<td>616/632-7067</td>
<td></td>
</tr>
<tr>
<td>JoAnn Hoganson</td>
<td></td>
<td><a href="mailto:Joann.Hoganson@kentcountymi.gov">Joann.Hoganson@kentcountymi.gov</a></td>
<td>616/632-7083</td>
<td></td>
</tr>
<tr>
<td>cc: Cathy Raevsky</td>
<td></td>
<td><a href="mailto:cathy.raevsky@kentcountymi.gov">cathy.raevsky@kentcountymi.gov</a></td>
<td></td>
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<tr>
<td>Dr. Othelia Pryor</td>
<td>MI Minority Health Coalition</td>
<td><a href="mailto:opryor@michiganmhc.com">opryor@michiganmhc.com</a></td>
<td>517/337-0705</td>
<td>PO Box 4654, East Lansing, MI 48826</td>
</tr>
<tr>
<td>Kristie King-Lewis, MSW</td>
<td>National Kidney Foundation</td>
<td><a href="mailto:Kking@nkfm.org">Kking@nkfm.org</a></td>
<td>800/482-1455</td>
<td>1169 Oak Valley Dr., Ann Arbor, MI 48108</td>
</tr>
<tr>
<td>Elizabeth Kushman, Lisa Abramson</td>
<td>Native American Healthy Start Project</td>
<td><a href="mailto:ekushman@charter.net">ekushman@charter.net</a></td>
<td>906/440-5660</td>
<td>Inter Tribal Council of MI</td>
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<td></td>
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<td><a href="mailto:labramson@itcni.org">labramson@itcni.org</a></td>
<td>906/632-6896</td>
<td>2956 Ashmun St., Suite A, Sault Ste. Marie, MI 49783</td>
</tr>
<tr>
<td>Lynn McDaniels, MSN, APRN-BC</td>
<td>Oakland County Health Division</td>
<td><a href="mailto:mcdanielsl@oakgov.com">mcdanielsl@oakgov.com</a></td>
<td>248/424-7059</td>
<td>27725 Greenfield Rd., Southfield, MI 48076</td>
</tr>
<tr>
<td>Dawn Shanafelt</td>
<td>Saginaw County “Great Beginnings” Healthy Start</td>
<td><a href="mailto:dshanafelt@saginawcounty.com">dshanafelt@saginawcounty.com</a></td>
<td>989/758-3853</td>
<td>Saginaw Co. Dept. of P.H. 1600 N. Michigan Saginaw, MI 48601</td>
</tr>
<tr>
<td>cc: John McKellar</td>
<td></td>
<td><a href="mailto:jmckellar@saginawcounty.com">jmckellar@saginawcounty.com</a></td>
<td>989/758-3818</td>
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</tr>
<tr>
<td>Monique Reeves, MD, MPH</td>
<td>Washtenaw County Health Department</td>
<td><a href="mailto:reevesm@ewsashtenaw.org">reevesm@ewsashtenaw.org</a></td>
<td>734/544-3058</td>
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<tr>
<td>Vinny Taneja</td>
<td>Wayne County Health Dept.</td>
<td><a href="mailto:vtaneja@co.wayne.mi.us">vtaneja@co.wayne.mi.us</a></td>
<td>734/727-7045</td>
<td>33030 Van Born Rd. Wayne, MI 48184</td>
</tr>
<tr>
<td>Alethia Carr, Dir.</td>
<td>MI Dept of Community Health</td>
<td><a href="mailto:carra@michigan.gov">carra@michigan.gov</a></td>
<td>517/335-8922</td>
<td>Capitol View Building-6th Floor 201 Townsend Street Lansing, MI 48913</td>
</tr>
<tr>
<td>Brenda Jegede, PRIME Coor</td>
<td>MI Dept. of Community Health</td>
<td><a href="mailto:jegedeb@michigan.gov">jegedeb@michigan.gov</a></td>
<td>517/335-9483</td>
<td>Washington Sq. Bldg-3rd Floor 109 W. Michigan Avenue Lansing, MI 48913</td>
</tr>
<tr>
<td>Carol Ogan</td>
<td>MI Dept. of Community Health</td>
<td><a href="mailto:oganc@michigan.gov">oganc@michigan.gov</a></td>
<td>517/335-8946</td>
<td>Capitol View Building-6th Floor 201 Townsend Street Lansing, MI 48913</td>
</tr>
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</table>
## ACCESS

Contact Person: Manal Said  
msaid@accesscommunity.org  
313-216-2232

Website: [www.accesscommunity.org](http://www.accesscommunity.org)

| Why/How Started | • Health equity work in ACCESS began when Manal collaborated with the Health Disparities and Minority Health Section. In this collaboration, ACCESS participated in the Health Disparity Summit and the road mapping that the section put out, bringing together a variety of partners: Health Alliance Plan, Wayne County Health Department, and universities to use their strength to pull together a proposal to look at the health disparities issues and determinants of health.  
• Also, the Arab community is not recognized as a specific race or ethnicity under the Office of Management and Budget so there is no standard of data collected across the state on this community which creates a social injustice and health inequity for this population. |
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<tbody>
<tr>
<td>Length of Involvement in Work</td>
<td>• 3 years</td>
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<tr>
<td>Initiative Goal</td>
<td>• Reduce health disparities and achieve health equity and social justice in minority communities with a special focus on the Arab American community.</td>
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<tr>
<td>Target Population</td>
<td>• Southeast Michigan minority communities with a special focus on Arab Americans.</td>
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<tr>
<td>Initiative Objectives</td>
<td>• Identify the social determinants of health that are specifically affecting the health disparities in the Arab American community.</td>
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<tr>
<td>Specific activities, methods, tools implemented</td>
<td>• Health Disparities Reduction capacity building leadership team which is a multisector stakeholder team that meets to share information, resources, and programs. This team will be hosting a Community Wellness Event to help reduce disparities by providing free services for community members as well as staff that include: flu shots, educational</td>
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</table>
| Please highlight efforts in infant mortality reduction and elimination of institutionalized racism | presentations, and health screenings.  
| --- | --- |
| • Conducting a comprehensive community needs assessment focusing on Arab and Caldean Americans in southeast Michigan.  
• Conducting research in cancer outcomes for the Arab community.  
• Education presentations for professionals in learning about cultural competency for the Arab American community to improve health care services to improve health outcomes.  
• Educating the community on how to utilize available ACCESS resources.  
• Advocating to promote policy changes that will positively affect the Arab American community.  
• Collaborating with other state institutions like MDCH and PRIME. |
| Organizational Partnerships | • Michigan Department of Community Health  
• Health Alliance Plan  
• Wayne State University  
• Michigan State University  
• University of Michigan  
• Michigan Primary Care Association  
• National Arab American Medical Association  
• Michigan Public Health Institute  
• National Health Policy Training Alliance  
• Wayne County Health Department  
• American Cancer Society |
| Intended Health Outcomes | • Improve health outcomes and quality of life for Arab Americans. |
| Recommended Resources | • “Undoing Racism” workshop  
• National Health Policy Training Alliance  
• Office of Minority Health |
| Dissemination of Findings                                                                 | • Health Disparities Summit  
• ACCESS communications department puts out a weekly electronic newsletter that shows what this agency and other partners are doing.  
• Biennial National Health Conference on Health Issues in Arab American Communities |
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<tr>
<td>Resulting Policy/Practice Changes</td>
<td>• None at this time.</td>
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</table>
| Funding Sources and Amount (separate local, state, federal)                              | • Michigan Department of Community Health: HDRMH & PRIME  
• Kellogg Foundation                                                               |
| Challenges to Future Work                                                                | • Funding  
• Lack of data for Arab American community under the Office of Management and Budget |
| Lessons Learned                                                                         | • Cultural competency is essential in this work which requires keeping an open mind. |
| Next Steps                                                                              | • Collaborate with PRIME project.  
• Trying to implement a Maternal Infant Health Program within ACCESS. |
Berrien County Health Department

Contact Person: Theresa Green
tgreen@bchdmi.org
269-927-5607
Website: www.bchdmi.org

| Why/How Started | Berrien County, similar to other jurisdictions in Michigan, continues to have significant health disparities based on race, economic status, and education. Disparities exist in overall health status, specific chronic diseases, infant mortality, and access to preventative care. The Health Department is always working toward fulfilling its mission of preventing disease, prolonging life, protecting the health of the community, and promoting an optimal quality of life for the citizens of Berrien County. Achieving health equity and reducing disparities in the communities we serve is high on the list of Health Department priorities.

- After attending the Michigan Premier Public Health conference of 2007 presentation given by Dr. Atewale Troutman on social equity, and then watching Unnatural Causes, the health department made a conscious effort to do something to improve health equity in Berrien County.

| Length of Involvement in Work | The Health Department began to focus its efforts on working towards health equity in 2008. We began internally by training all BCHD staff through two 45 minute sessions on health equity including clips from Unnatural Causes. In addition, the Board of Health received four 30 minute sessions with video clips, local data and discussion questions to bring them up to par on social determinant of health and health equity. The county commissioners, community leaders and local hospital system were all given similar sessions.

- Since so much work was already being done on health equity, when grant opportunities came up, we naturally applied for them. We were successful in winning an MDCH Capacity Building Planning Grand for Health Disparities, and then a subsequent Implementation Grant. We also were successful and receiving a REACH US grant through Genesee County which focused primarily on health disparity in infant mortality based on race. |
| Initiative Goal | • Each initiative has individual goals. The Berrien County Health Department went through a strategic planning process at the end of 2010 and set as a long-term departmental goal to: Increase equity in health outcomes for all Berrien County residents. Through the Capacity Building Grant (CBG) we set up a county-wide coalition called the Health Equity Alliance, or HEAL, and they have as a goal to build a healthier Berrien County through medical, as well as non-medical strategies aimed to reduce social stratification and inequalities in health.  

• The HEAL support the REACH initiative with has as its goal to: address disparity in the rates of infant mortality between white and African American populations in Berrien County by providing training to healthcare providers to increase their understanding of social determinates of health with specific emphasis on social factors leading to infant mortality. We hope to reach 30 OB/GYN or Pediatric providers, an additional 50 providers from other health care fields and staff from at least 8 offices or clinics throughout Berrien County. |
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<tr>
<td>Target Population</td>
<td>• Issues of social inequity and health disparity effect all populations in our county, therefore our target population is the population of Berrien. However, since disparity adversely affects African Americans in the 49022 zip code (City of Benton Harbor and Benton Township) who have the highest rates of infant mortality and worst health statuses of the populations in Berrien County, this target should receive the greatest benefit from our intervention.</td>
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| Initiative Objectives | Some of the objectives in the disparity reduction work we have been doing include:  

• Complete a curriculum package tailored to providers with local information on infant mortality and social determinants of health in African Americans.  

• Measurably increase awareness and understanding providers have of social determinants of health and infant mortality from provider training/lectures.  

• Increase knowledge of social determinants of health through Health Equity Alliance meetings and members  

• Improve data collection (Behavioral Risk Factor Survey) to include questions about race and social context.  

• Qualitatively and quantitatively evaluate Berrien County to assess health inequity using survey tools and Photovoice. |
### Specific activities, methods, tools implemented

**Please highlight efforts in infant mortality reduction and elimination of institutionalized racism**

- Creation of Health Equity Alliance: this taskforce group is made up of at least 11 area organizations and more than 25 individuals who understand and advocate for health equity.
- Successful Provider education on infant mortality including a lecture from Dr. James Collins (nationally acclaimed researcher on infant health disparity and neonatologist).
- CME Provider lunch at Lakeland Healthcare resulting in increased awareness and understanding of disparities in infant mortality and the social determinants of health.
- All Berrien County Health Department employees, leaders and Board of Health members have been educated to understand the social determinants of health and are working towards undoing racism in their daily work.
- The county Behavior Risk Factor Survey now contains questions about racism and social context.
- Over twenty presentations have been given to students, policy makers, community leaders and social advocates regarding the social determinants of health and health equity.
- A model curriculum has been developed to help others present the Unnatural Causes material in shorter, incremental pieces.

### Organizational Partnerships

- Partners involved in health equity work include:
  - Berrien County Health Department
  - MI Civil Rights Commission
  - Consortium for Community Development
  - City of Benton Harbor
  - Lakeland HealthCare
  - Whirlpool Corporation
  - Communities of Health
  - Southwest Michigan Planning Commission
  - Healthy Berrien Consortium
  - Hospice at Home
  - Board of Health
  - Conservation Fund
  - American Cancer Society
  - Individual Community Activists

### Intended Health Outcomes

- Through the work we are doing, we have a two fold intention: first, to bring awareness to the community about the disparities that do exist; and second to influence community leaders to make positive policy changes to reduce these disparities.

### Recommended Resources

- “Unnatural Causes” DVD and Curriculum, California News Reel, 2008. [www.unnaturalcauses.org](http://www.unnaturalcauses.org)
| **Dissemination of Findings** | • Our message has been widely broadcast in the community through many press releases, newspaper articles and community presentations. Some notable achievements include the Provider Dinner Lecture about Infant Mortality featuring an informative lecture by the renowned neonatologist Dr. James Collins. There have been CME Provider Luncheons and presentations at Lakeland Regional HealthCare that greatly impacted the medical professionals in attendance. Additionally, our message and mission have been communicated to many groups throughout Southwest Michigan during presentations, but is also reiterated and revisited in a monthly news column in the local paper. |
| **Resulting Policy/Practice Changes** | • Health Department staff training on the social determinants of health have educated and inspired employees to all work towards the goal of health equity.  
• The Capacity Building Grant is also working towards not only awareness of health disparities, but also to positive policy change in the community that will effectively reduce disparities. |
| **Funding Sources and Amount (separate local, state, federal)** | • Capacity Building Grant Planning – Phase I ($30,000)  
• Capacity Building Grant Implementation – Phase II ($30,000)  
• REACH Grant – Genesee County ($36,000) |
| **Challenges to Future Work** | • We continue to struggle with the overwhelming nature of the problem of health disparity. If we believe health disparity is a “bigger problem” then use of resources, than the solution must be also being bigger. When the underlying causes of health disparity are identified as racism, or chronic stress, or lack of jobs – then the solution become impossible. How does one end racism with small grants and limited time? This is certainly a challenge. There is so much to do that it is challenging to limit the focus to achievable goals that will also make a difference. |
| **Lessons Learned** | • This is difficult work that takes time and also diverse community involvement |
| **Next Steps** | • The work that we have started will be continued with our Health Equity Alliance, the Capacity Building Grant work, and other Health Department initiatives. |
Detroit Healthy Start Project

Contact Person: Carolynn Rowland

Rowland@detroitmi.gov

313-876-4161

<table>
<thead>
<tr>
<th>Why/How Started</th>
<th>● Detroit Healthy Start is charged with reducing perinatal health disparities, thus the project has become involved in any local effort to racial disparities in infant mortality. We have been a part of 4 local collaborative efforts: IVAN, Great Start, Place Matters, and the Regional Infant Mortality Task Force.</th>
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<tr>
<td>Length of Involvement in Work</td>
<td>● The effort to specifically address African American infant mortality began in 2005 with the Detroit/Wayne County Infant Vitality Network (IVAN).</td>
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<tr>
<td>Initiative Goal</td>
<td>● Raise general awareness about the high rates of infant mortality, identify and implement actions to address racial disparities as a community collective.</td>
</tr>
<tr>
<td>Target Population</td>
<td>● General community, men and women of childbearing age, providers, policy makers.</td>
</tr>
</tbody>
</table>
| Initiative Objectives | ● IVAN – raise awareness, assure women have access to comprehensive, quality care including pre/interconception care.
● Great Start – raise awareness, help all members of the community to understand what they can do to help.
● Place Matters – address social determinants of health
● Regional Infant Mortality Task Force – improve access to services and coordination of care |
| Specific activities, methods, tools implemented | ● IVAN & Great Start – developed community/provider education presentations on infant mortality, provider tool kits, and resource guides. Racial disparities including the social/economic/political factors contributing specifically addressed in the education presentations.
● Supplied most, if not all, of the data for the Place Matters “White Paper.” The White Paper is intended as a community call to action.
● Detroit Regional Infant Mortality Task Force is including provider education focused on racism and disparities in its newly funded “Sew Up the Safety Net” initiative. |
| Organizational Partnerships | • Great Start, Wayne County Health Department  
|                           | • Detroit Regional Infant Mortality Task Force |
| Intended Health Outcomes   | • Improved women’s health.  
|                           | • Decrease in unplanned pregnancies.  
|                           | • Improved birth outcomes. |
| Recommended Resources      | • March of Dimes  
|                           | • Unnatural Causes  
|                           | • CityMatch |
| Dissemination of Findings  | • Results/feedback from the community education work have been shared with the Great Start Collaborative. |
| Resulting Policy/Practice Changes | • No evidence any systemic changes have been made. |
| Funding Sources and Amount (separate local, state, federal) | • HS – HRSA grant  
|                           | • IVAN – MDCH grant  
|                           | • Great Start – March of Dimes grant. |
| Challenges to Future Work  | • The challenge this agency faces is attitudes and beliefs about racism. People of color live with effects daily and white people don’t think it is a problem. Even if the larger society gives lip service, they do not think it is their problem. |
| Lessons Learned            | • Racism remains a very touchy subject. Many folks of color do not want to hear about their problems and bad outcomes because it gets tired and personal. Many white people do not want to hear that their good outcomes are a result not only of privilege, but come at a cost to others. |
| Next Steps                 | • Will continue work with Great Start, Place Matters, Detroit Regional Infant Mortality Task Force to educate, inform, and improve services and systems. |
The Dispute Resolution Center

Contact Person: Belinda Dulin, Executive Director

734-222-3745

Website:

[www.thedisputeresolutioncenter.org](http://www.thedisputeresolutioncenter.org)

Diversity Project/Survey of Mediation Centers:

[http://www.thedisputeresolutioncenter.org/the-drc-diversity-project.html](http://www.thedisputeresolutioncenter.org/the-drc-diversity-project.html)

Capacity Building Grant Press Release:


<table>
<thead>
<tr>
<th>Why/How Started</th>
<th>● To address the lack of diverse and disenfranchised communities participating in the mediation process, as mediators and disputants.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Involvement in Work</td>
<td>● Involvement has been a high priority since November 2007.</td>
</tr>
<tr>
<td>Initiative Goal</td>
<td>● To provide services sensitive to the diversity of clients and teach skills to mediators and the wider community to manage conflicts involving cultural identity.</td>
</tr>
<tr>
<td>Target Population</td>
<td>● African-American, Arab-American, Latino-American, and Asian-American</td>
</tr>
</tbody>
</table>
| Initiative Objectives | ● To expand the mediator pool of the DRC to reflect the demography of its service area.  
● To increase the level of awareness of volunteer and staff personal sensitivities as well as cultural competence.  
● To make the DRC more accessible to volunteers and clients from diverse ethnic, cultural and religious backgrounds.  
● To provide mediation and communication skills beyond the mediator community. |
| Specific activities, methods, tools implemented | ● Conducted 40-hour multi-cultural community mediator training for participants representing minority communities.  
● Participated in the Minorities in ADR Conference, Capital University.  
● Participated in the Muslim Peacebuilding, Justice and Interfaith Dialogue Conference, American University.  
● Moderated the Sheriff’s Candidate Forum for the 2008 elections.  
● Conducted a nationwide online survey with follow-up telephone interviews on training programs for diversity and cultural competence in community mediation settings in 2009. (Please see Diversity Project Report). |

Please highlight efforts in infant mortality reduction and elimination of
| institutionalized racism | • Conducted two focus groups with social service providers and clients to assess need for conflict management skills in social service settings where conflict involved diversity issues.  
• Wrote curriculum for a two-day workshop to promote racial and ethnic understanding and teach conflict resolution skills to service providers and administrators in social service agencies, schools, and community centers to positively impact the social determinants of health in our community.  
• Hosted Diversity workshop led by Maryland's Mediation and Conflict Resolution Office for mediators in Michigan  
• Conducted pilot workshop using the 2-day diversity and conflict resolution curriculum for social service providers.  
• Collaborated with Washtenaw County Sheriff's Department to hold Speak Peace West Willow Rally, Ypsilanti Township, an event to promote peaceful relationships and resolution of conflict among neighbors in West Willow.  
• Hosts the Mediator Brown Bag Series, a continuing education offering for mediators. The Series includes presenters from different cultural backgrounds. The presenter provides cultural insight into how conflict is handled and tips on how the mediator can intervene without offense.  
• Collaborates with Washtenaw Intermediate School District and Eastern Michigan University's Gear Up and Bright Futures Program for the Truancy Mediation Program.  
• Will be presenting “Navigating the System and Conflict Resolution” at the Community Health Advocate Training led by Washtenaw County Health Department. |
| Organizational Partnerships | • State Court Administrative Office  
• Michigan Dept of Community Health  
• Ypsilanti Health Coalition  
• Washtenaw County Sheriff Department  
• Washtenaw Intermediate School District  
• Center for the Education of Women (University of Michigan)  
• Neutral Zone (Ann Arbor)  
• Rick Solomon (Ann Arbor Center for Developmental and Behavioral Pediatrics)  
• Zena Zumeta (Mediation Training and Consultation Institute, Ann Arbor)  
• Jewish Family Services, Power, Inc  
• Community Action Network  
• Village Initiative  
• Corner Health Center |
<p>| Intended Health Outcomes | • To improve the social cohesion of communities in service area, reduce conflict, and reduce stress. |
| Recommended | • See “Resources” link at <a href="http://www.thedisputeresolutioncenter.org">www.thedisputeresolutioncenter.org</a>. Links |</p>
<table>
<thead>
<tr>
<th>Resources</th>
<th>are provided for 20 community dispute resolution program centers located throughout the state, books on mediation, conflict resolution, and professional associations.</th>
</tr>
</thead>
</table>
| Dissemination of Findings | • The Diversity Project Report can be found on the DRC website.  
• The curriculum for the Social Service Provider workshop is being revised and will be disseminated through workshops offered by the DRC. |
| Resulting Policy/Practice Changes | • Prioritized commitment to ensure that diversity is reflected among the staff, Board, and volunteer mediators.  
• Increased focus on opportunities to expand programs that meet the original objectives.  
• Expanded workshop offerings.  
• Increased capacity to apply for health-related grants and projects related to diversity and conflict management skills.  
• Stronger partnerships with other agencies in service area. |
| Funding Sources and Amount (separate local, state, federal) | State:  
• MDCH Health Disparities Reduction and Minority Health Section ($25,000 Capacity Building Grant)  
• Michigan State Court Administrative Office  
  Local:  
• Washtenaw County Government |
| Challenges to Future Work | • Support for collective action when each agency has individual goals for their respective agency and limited resources.  
• Raising awareness that racism is a fundamental issue and how conflict management skills can be used to reduce health disparities. |
| Lessons Learned | • Strong relationships with organizational partners and grantors are vital to maximize resources and capabilities of the grantees in order to meet the requirements of grants.  
• No one effective model exists for addressing diversity issues in one’s community. |
| Next Steps | • Continued development of workshop curriculum and other resources addressing conflict resolution in mediation centers and the wider community. |
Genesee County Health Department

“REACH 2010/REACH US”

Contact Person: Shannon Brownlee

sbrownlee@gchd.org

810-341-7661

<table>
<thead>
<tr>
<th>Why/How Started</th>
<th>• During the planning phase of REACH 2010, approximately 25 focus groups were held with the population of focus (African Americans). One of the questions: why are black babies dying three times the rate of others was asked of each group. Racism was the common answer given amongst all groups. Because we were instructed by CDC to develop a community action plan based on input from the community it was imperative that we address the role of race and racism in reducing racial and ethnic health disparities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Involvement in Work</td>
<td>• A planning phase began in 1999, followed by a seven year implementation phase (2000-2007). In 2007, the REACH Coalition was designated as a Center of Excellence in the Elimination of Health Disparities (CEED), 2007 – 2012.</td>
</tr>
<tr>
<td>Initiative Goal</td>
<td>• To reduce racial and ethnic health disparities, with a particular focus on African Americans and infant mortality through population focused and systemic structural interventions that embody community engagement and cultural relevance.</td>
</tr>
<tr>
<td>Target Population</td>
<td>• African American infants and families in Genesee County, Michigan.</td>
</tr>
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</table>
| Initiative Objectives | • Reduce the disparity in infant mortality through multi-faceted practice and evidence-based interventions in Genesee County, Michigan, using a 3-theme approach:  
  ○ Community Mobilization  
  ○ Enhancing the Babycare System  
  ○ Reducing Racism. |
| Specific activities, methods, tools implemented | **Program Descriptions:** |
| Community Mobilization | • **Community Dialogue Sessions** guide participants through a structured dialogue to develop supportive relationships and learn from each other about infant mortality, African American culture, racism, and systemic community health care and economic problems, and then lead them to develop |
a plan of action to combat these issues. This process has yielded two particularly active action groups: Black Men for Social Change and Women Taking Charge of Their Health Destiny.

- **Community Media Campaign** raises awareness about racial differences in infant mortality, communicates culturally-relevant messages important to reducing African American infant mortality, and reinforces the work of REACH activities.
- **Community Windshield Tours** provide a visual perspective to healthcare providers and others working within Genesee County to assist them in gaining an understanding of the neighborhood environmental conditions and experience of women and families at risk for poor birth outcomes.

### Enhancing the Babycare System:

- **Maternal and Infant Health Advocates (MIHAs)** work directly with pregnant women, new mothers and families in high risk zip codes, providing support and helping them navigate appropriately and successfully through the medial/social services systems.
- **PRIDE Medical Services Committee** concentrates its work on the clinical environment in Genesee County. Comprised of maternal/infant health hospital administrators, obstetricians and gynecologists, perinatologists, neonatologists, pediatricians, social workers, nurses, and representatives of the largest health insurer and other healthcare organizations in the County, the committee works to increase healthy birth outcomes, especially among African American, by influencing health policies and supporting training and research.
- **“Cultural Competency in Health Care” Curriculum** is offered at the University of Michigan-Flint to educate future healthcare professionals about issues impacting health disparities.

### Reducing Racism:

- **African Culture Education Development Center** provides an environmental milieu and curriculum that supports a positive view and understanding of pride and respect of African Americans and their culture. It challenges and changes the thinking of participants.
- **Undoing Racism Workshops** are designed to help participants develop their own analysis of history, culture, and power relationships. They move beyond a focus on the symptoms of racism to an understanding of what it is, where it comes from, how it functions, why it persists and how it can be undone.
| Organizational Partnerships | • Flint Odyssey House/Health Awareness Center  
• Genesee County Community Action Resource Department (GCCARD)  
• Genesee County Health Department (Central Coordinating Agency)  
• Greater Flint Health Coalition  
• Hurley Medical Center  
• Programs to Reduce Infant Deaths Effectively (PRIDE)  
• Priority Children  
• University of Michigan/Prevention Research Center  
• YOUR Center |
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<tr>
<td>Intended Health Outcomes</td>
<td>• In 2005, Genesee County, Michigan experienced its greatest drop in the infant mortality disparity. Due to the economic decline and the reduction in local resources, the disparity rate is on an increase.</td>
</tr>
<tr>
<td>Recommended Resources</td>
<td>• Community focus groups and an extensive literature reviews were conducted.</td>
</tr>
<tr>
<td>Dissemination of Findings</td>
<td>• The REACH US Coalition disseminates findings on the local and national levels. Presentations and journal articles have also been developed.</td>
</tr>
<tr>
<td>Resulting Policy/Practice Changes</td>
<td>• Evaluation is underway to assess systems and policy changes that have come about as a result of REACH 2010 and REACH US with special emphasis on anti-racism activities.</td>
</tr>
</tbody>
</table>
| Funding Sources Amount? | • Centers for Disease Control and Prevention (CDC) based in Atlanta, Georgia.  
• Phase I – REACH 2010: Approximately $6.6M over 7 years  
• Phase II – REACH US: Approximately $4.2M over 5 years |
| Challenges to Future Work | • Genesee County REACH US is a Community Based Public Health (CBPH) project. Although CBPH is becoming more widely accepted, it is not how public health is “traditionally” practiced. The Coalition has experienced some institutional policies and systems barriers which could have adversely affected the partnership. CBPH partners and grassroots organizations face this challenge in moving forward as we work to prove the legitimacy of CBPH. |
### Lessons Learned
- Despite years of medical advances, disparities in infant mortality persist. In order to effectively address disparities in infant mortality, a life-course perspective with a focus on the social determinants of health, particularly racism, must be taken. To adequately address the social determinants of health, grassroots organizations must be engaged from the onset of program development and MUST be an equal partner.

### Next Steps
- As stated earlier, an enhanced evaluation is underway to identify the impact of REACH activities, more specifically, the systems, institutions, and policy changes have occurred as a result of work.
- Our goal is to produce training manuals and videos, best-practice tools, and publish. We will continue to provide technical assistance to others wanting to implement REACH activities in their communities.

### Community Action Plan:

**Community Action Plan - A Multi-faceted Life-course Approach**

- **Fostering Community Mobilization**
- **Enhancing the Baby Care System**
- **Reducing Racism**

Genesee County Health Department 8/8/2011
Grand Rapids African American Health Initiative

Contact Person: Shannon Wilson

shannon.wilson@graahi.org

616-331-5831

Website: [www.graahi.org](http://www.graahi.org)

<table>
<thead>
<tr>
<th>Why/How Started</th>
<th>● This agency was born out of the Grand Rapids Urban League with the intent to concentrate solely on the health of African Americans in the community. Health disparities for African Americans were drastic for many health issues including: infant mortality, diabetes, cardiovascular disease, among other health concerns. At one point, Grand Rapids had the largest disparity for African Americans in infant mortality in the state of Michigan. This agency felt that improving the health of this population would help to improve the overall health of the general population as well.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Involvement in Work</td>
<td>● This agency has functioned since 2004.</td>
</tr>
<tr>
<td>Initiative Goal</td>
<td>● To improve the overall health status of African Americans in Kent County by improving the quality of health care available to this demographic in Michigan.</td>
</tr>
<tr>
<td>Target Population</td>
<td>● Kent County African Americans.</td>
</tr>
<tr>
<td>Initiative Objectives</td>
<td>● This agency intends to create health parity in Kent County through education, advocacy, and research in the community and health care settings.</td>
</tr>
</tbody>
</table>
| Specific activities, methods, tools implemented | Educational efforts:  
  ● Diabetes FACE Program- a diabetes management programs that has an African American educator come once a month to educate on eating, exercise, etc.  
  ● Chronic Kidney Disease- education on this disease to increase awareness.  
  ● Hypertension/Cardiovascular Disease- education on this disease to increase awareness on the “silent killer” through one-on-one conversation with a doctor.  
| Please highlight efforts in infant mortality reduction and elimination of |  

| institutionalized racism | Brochures created for the African American population to increase awareness on the 10 leading causes of death and how they are affected by social determinants of health.  
| | “The Last Straw” – an educational game to increase awareness in teenagers about the social determinants of health.  
| Advocacy Efforts: | Round table panel discussions with Blue Cross Blue Shield doctors on health care reform and its effects on African Americans.  
| | Grant from State of Michigan to look at social determinants of health through GIS mapping in Grand Rapids communities. The mapping breaks down education and income levels through the communities to analyze potential years of life lost to pinpoint areas to reallocate resources.  
| | Collaborating with Grand Rapids “Strong Beginnings” Healthy Start Program on infant mortality work.  
| Organizational Partnerships | Grand Rapids “Strong Beginnings” Healthy Start  
| | Spectrum Health  
| | Healthier Communities  
| | Metro Health hospital  
| | Mercy Health  
| | Grand Valley State University  
| | Alliance for Health  
| Intended Health Outcomes | To reduce disparities in the 10 leading causes of health for African Americans in Grand Rapids.  
| Recommended Resources | *Unnatural Causes*  
| | Office of Minority Health Website  
| | *A Gardner’s Tale*  
| Dissemination of Findings | See website (www.graahi.org).  
<p>| Resulting Policy/Practice Changes | None at this time. |</p>
<table>
<thead>
<tr>
<th>Funding Sources and Amount (separate local, state, federal)</th>
<th>• Unable to report at this time.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenges to Future Work</td>
<td>• Funding.</td>
</tr>
<tr>
<td></td>
<td>• It seems that health disparity has lost its “flare.” The challenge is to keep people in control interested in the underrepresented communities by reinvented an approach of looking at the issue, i.e. social determinants of health.</td>
</tr>
<tr>
<td>Lessons Learned</td>
<td>• True community collaboration is essential.</td>
</tr>
<tr>
<td></td>
<td>• While it is important to engage the local community, it is equally important to include those who deliver health care to ensure disparities are reduced.</td>
</tr>
<tr>
<td>Next Steps</td>
<td>• To continue with a two-pronged approach that works with the community and the health care system through education and advocacy work.</td>
</tr>
<tr>
<td></td>
<td>• Improve research and advocacy efforts in the next year.</td>
</tr>
</tbody>
</table>
Grand Rapids “Strong Beginnings” Healthy Start

Contact Person: Peggy Vander Meulen

[Email address and phone number]

Website:

[Link to Strong Beginnings]

[Link to Infant Health Coalition]

| Why/How Started                                                                 | • In 2003, Grand Rapids had the highest African American infant mortality rate of any city in Michigan. Furthermore, there was a considerably high disparity between African American and White infant death rates. Because of this issue, an application was submitted for funding from federal Healthy Start Strong Beginnings.
|                                                                             | • In 2011, Strong Beginnings received a W.K. Kellogg Foundation grant that will allow it to expand beyond Grand Rapids to cover all of Kent County, to expand its system-level work, and to develop a fatherhood program for African American males. |

| Length Involved in Work                                                    | • This project began when funding was granted at the end of 2004, client recruitment began in Feb. 2005.
|                                                                             | • The Kellogg-funded program expansion began in June, 2011. |

| Initiative Goal                                                          | • The goal of Strong Beginnings is to improve birth outcomes and maternal and child health for the African American population. |

| Target Population                                                         | • African American Women who are pregnant or have a child under two years old. |

<p>| Initiative Objectives                                                     | Strong Beginnings works at the community level to improve the overall system of health care. The agency also works to improve these outcomes for African American mothers and infants: |
|                                                                         | • Decrease infant mortality |
|                                                                         | • Decrease the incidence of low birth weight and very low birth weight babies |
|                                                                         | • Increase breastfeeding initiation and duration |
|                                                                         | • Improve child spacing / reduce rapid repeat pregnancies |
|                                                                         | • Improve access to mental health services |
|                                                                         | • Increase percent of women with adequate prenatal care |</p>
<table>
<thead>
<tr>
<th>Specific activities, methods, tools implemented</th>
<th><strong>Direct Community Action:</strong></th>
</tr>
</thead>
</table>
| • Increase access to medical home and dental care  
  • Decrease stress and depression | 

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<tr>
<th></th>
<th><strong>Direct Community Action:</strong></th>
</tr>
</thead>
</table>
|  | ▶ This organization has teams of community health workers, nurses, and social workers who recruit and engage high risk mothers. The community health workers form part of the case management team in conjunction with MIHP nurses and social workers. Services provided include home visits to:  
  □ Provide social support  
  □ Offer health education  
  □ Help set life goals and plans to achieve them  
  □ Conduct screenings and assessments  
  □ Make referrals to needed services (e.g., family planning, GED, housing, food pantries, jobs).  
  ▶ This organization has two full time mental health therapists who provide individual counseling for mothers with serious issues like depression and bipolar disorder. The organization also provides support groups for these mothers.  
  ▶ The organization also employs an education coordinator who provides educational opportunities to the community at large. Specific classes offered include but are not limited to:  
  □ pre-conception health & family planning  
  □ safe sleep  
  □ domestic violence  
  □ nutrition  
  □ HIV/AIDS and STIs  
  □ Effective Black Parenting courses  
  ▶ The organization also offers weekly breastfeeding support groups for clients and community members.  |
|  | **System Level Action:** |
|  | **Local:** |
|  | ▶ This organization has an *Infant Health Coalition* which consists of 65 members on 12 different committees that work with community organizations to help create system changes. Some of the committees include but are not limited to:  
  □ Breastfeeding Task Force  
  □ Response to Racism  
  □ Interconception Care  
  □ Pregnancy Prevention,  
  □ Perinatal Mood Disorders.  |
|  | **State:** |
|  | ▶ Ms. Vander Meulens currently sits on the executive board of the   |
Michigan Counsel for Maternal & Child Health.

- Since this is a Healthy Start Project, the agency collaborates with the 5 other Healthy Start Programs in Michigan. These agencies collaborate to work on infant mortality summits, and are currently evaluating health outcomes of women enrolled in Healthy Start versus those who are not enrolled.
- Ms. Vander Meulen also sits on the advisory board of the Pregnancy Risk Assessment Monitoring System (PRAMS). In this role, she helps with things like selecting questions to be included in Michigan’s surveys, finding ways to increase survey return rates, and helps in analyzing response surveys. Ms. Vander Meulen then uses the data from the surveys at the local level to guide in planning decisions.
- This agency works with Partners for a Racism Free Community which does organizational assessments of institutions within the community on racism. From these assessments, the project offers action plans for the institution on how to change policy and practice to eliminate racism.

| Organizational Partnerships | Healthy Kent 2020 - Infant Health Coalition  
| Kent County Health Department  
| Spectrum Health  
| St. Mary’s Health Care  
| Grand Rapids African American Health Institute  
| Arbor Circle  
| Cherry Street Health Services  
| Metro Health  
| The Salvation Army  
| Michigan State University |

| Intended Health Outcomes | For African American mothers and infants:  
| Decrease infant mortality  
| Decrease the incidence of low birth weight and very low birth weight babies  
| Increase breastfeeding  
| Improve child spacing & decrease unintended pregnancy  
| Improve access to mental health services  
| Decrease stress and depression  
| Improve access to prenatal care, medical home, family planning services and dental care |

| Recommended Resources | Organization assessment tools from Partners for A Racism-Free Community  
| “Lines: The Lived Experience of Race” (film) – discussion guide to be developed  
<p>| Tool-kits of resources related to cultural humility, hidden bias and racism for providers and consumers (being developed with Response to Racism Committee) |</p>
<table>
<thead>
<tr>
<th>Dissemination of Findings</th>
<th>• The agency sends reports of findings to funders, holds presentations at national and regional conferences, and has also published a journal article on their mental health program in <em>The Source</em>.</th>
</tr>
</thead>
</table>
| Resulting Policy/Practice Changes | • The agency sets aside funding for sending staff to trainings on healing racism.  
• The agency also ensures that language within contracts for newly hired employees ensures culturally competency in their staff. |
| Funding Sources (For current year 2011) | • Federal Healthy Start: $750,000  
• Kellogg Foundation grant: $895,000  
• March of Dimes: $25,000  
• CareSource Foundation grant: $7,000  
• Patterson Foundation grant: $6,000 |
| Challenges to Future Work | • Working with multiple partners can be difficult in trying to keep everyone happy, on the same page, and working towards the same goal.  
• Expanding the agency partnerships while maintaining high standards with good outcomes.  
• Raising awareness on racism and its impact on health outcomes because many are unaware racism still exists.  
• Community health care providers have limited time to attend anti-racism workshops. |
| Lessons Learned | • To reach such a large goal, it is better to work with many partnerships that function through teamwork.  
• When using multiple partnerships, it is best to have strong commitments to one common goal. |
| Next Steps | • *Strong Beginnings* is working to expand their program throughout Kent County and to include fathers.  
• Strengthen breastfeeding support groups and challenge hospitals to pursue WHO Baby Friendly status.  
• Create toolkits for health care providers and consumers from the Response to Racism workshops.  
• Increase staff participation in working with Partners for A Racism-Free Community (see State Level Action). |
### Why/How Started
- 2005. The project began as ICHD’s first effort to join in the national effort spearheaded by the National Association of City and County Health Officials to transform public health practice within a social justice/health equity framework.

### Length of Involvement in Work
- Six years.

### Initiative Goal
- To transform the practice of public health within a social justice/health equity framework, using facilitated dialogue as the primary vehicle for change.

### Target Population
- The public health work force and interested members of the community (including county residents and employees and leaders of other organizations).

### Initiative Objectives
- Develop the capacity among ICHD staff and community members to facilitate workshops and activities that raise awareness of oppression and privilege based on race, class, gender, and other types of difference, and their impact upon community health.
- Establish a foundation for an ongoing learning community organized around creating health equity.
- Provide a four-day workshop experience for all ICHD employees (approximately 330 people) and interested non-employees (approximately 120 people).
- For workshop participants, create an understanding of the meaning of the following core concepts as aids to the engagement of others on issues of health equity:
  - the difference between health disparity and health inequity;
  - how the social determinants of health create differing opportunities for well-being among groups of people;
  - the four levels at which oppression and change operate;
| Specific activities, methods, tools implemented | Provided training for facilitators (10-12 days) in partnership with MSU Extension Services. Approximately 45 people trained.  
Maintained team of approximately 15 HESJ Facilitators who facilitate workshops and other dialogue activities in the community.  
Developed 4-day HESJ Workshop model to be provided to ICHD employees and community members.  
Provided (as of August 2011) seventeen 4-day workshops. Also provided the workshop to employees of two other public health agencies.  
Established and coordinated the Facilitators Guild, a monthly gathering to improve facilitation skills and model facilitated dialogue as an alternative vehicle for civic discourse and change.  
Piloted Health Equity Youth Academy for area youth (in process).  
Developed Equity Action Team as a community entity to carry forward specific activities aimed at creating health equity. (In process)  
Developed a dialogue-based assessment tool for health departments wishing to initiate an exploration of a similar transformation strategy. (In process)  
Developed a guidebook for health departments wishing to initiate an exploration of a similar, dialogue-based transformation strategy. (In process)  
Monitored and documented the use of dialogue in four other health departments in the U.S.  
Assisted in the development of the book *Tackling Health Inequity through Public Health Practice: From Theory to Action* (Oxford Press, 2010). |
| Please highlight efforts in infant mortality reduction and elimination of institutionalized racism | - How *uneearned privilege* operates across multiple *target* and *nontarget groups*.  
- The difference between *traditional* and *modern forms* of oppression.  
  - Develop strategies for engaging with others on issues of oppression, privilege, health inequity, and social justice.  
  - Identify what it means to adopt and apply a health equity/social justice framework for improving the community’s health.  
  - Identify any personal changes that workshop participants are committed to making as a result of participation in this workshop. |
| Organizational Partnerships | • National Association of City and County Health Officials.  
• MSU Extension Services.  
• Michigan Department of Community Health. |
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<tr>
<td>Intended Health Outcomes</td>
<td>• Over time, the reduction of health disparities by race, ethnicity, and socio-economic status for all leading causes of early death in Ingham County. This is a very long-term objective, based upon the theory that institutional racism and class oppression are root causes of persistent social and health inequities, which must be confronted explicitly in policy and practice.</td>
</tr>
</tbody>
</table>
| Recommended Resources | • *Tackling Health Inequities through Public Health Practice; From Theory to Action*. (Oxford Press, 2010).  
• NACCHO web-based Health Equity training (in process). |
| Dissemination of Findings | • Primarily through the W.K. Kellogg Foundation which has funded the initiative, presentation at state and national conferences, and publication of written materials documenting process and findings. |
| Resulting Policy/Practice Changes | • Establishment and definition of Health Equity as core value of ICHD.  
• Establishment of 2 positions within ICHD: Health Equity and Social Justice Coordinator and Environmental Justice Coordinator.  
• Mandatory participation in HESJ workshops by all ICHD employees. |
| Funding Sources and Amount (separate local, state, federal) | • **FOUNDATION GRANTS**  
• Note: Much of the funds from WKKF were used to support other departments or organizations. Locally applied funds are shown in parentheses  
• 2005 – 2008: WK Kellogg Foundation: $188,000  
  (Local amount: $55,000)  
• 2006 – 2011: WK Kellogg Foundation: $1.5 million  
  (Local amount: $120,000)  
• 2009 – 2012: WK Kellogg Foundation: $400,000  
  (Local amount: $260,000)  
• **STATE**  
• 2010: MDCH: Traction to Action Project: $25,000  
• **LOCAL**  
• Ingham Co. Health Department General Fund:  
  $150,000 annually (approx.) for 1.75 F.T.E. |
| Challenges to Future Work | • Individual resistance to concepts such as unearned privilege and the racism as root causes of health inequity.  
| | • Political will to confront racism, classism, and other forms of oppression at the policy level.  
| | • Accustomed regulatory, categorical approaches to public health practice within the discipline as a whole.  
| Lessons Learned | • Importance of adequate time to create relative safety and trust for challenging conversations to occur.  
| | • Core values associated with dialogue facilitation when applied to issues of oppression and privilege, and the need for transparency regarding these values and concepts. (Core values include compassion, enfranchisement, transparency, inquiry, stillness, and synergy.)  
| | • The need to address root causes of health inequity explicitly, vs. tackling inequity merely at the level of social determinants.  
| | • The importance of addressing change simultaneously at the level of the community (through involvement of non-employees in the work), internal work force, and department leadership.  
| Next Steps | • Continue to provide regular workshop opportunities.  
| | • Offer workshops to other departments and organizations, for a standard fee.  
| | • Produce several written resources capturing the lessons learned and providing guidance to other departments.  
| | • Begin work-unit level dialogue processes to define changes in practice as they pertain to specific divisions of the health department.  
| | • Define and implement Equity Action Circle.  
| | • Seek funding for possible DVD resource demonstrating the use of dialogue as a vehicle for transforming public health practice. |
InterTribal Council of Michigan Healthy Start Project:

Local Health Systems Action Plan

Contact Person: Elizabeth Kushman

[ekushman@charter.net](mailto:ekushman@charter.net)

906-440-5660

<table>
<thead>
<tr>
<th>Why/How Started</th>
<th>• Being a Healthy Start Project, it is required to have the Local Health Systems Action Plan that looks at health issues from a systems level. The Project Consortium Statewide Advisory Group directed this project to analyze racism and discrimination and how they affect quality, access, and use of services by Native American and American Indian populations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Involvement in Work</td>
<td>• 10 years</td>
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</tbody>
</table>
| Initiative Goal | • Identify and better understand how the perinatal health care system works and does not work effectively.  
• Identify, understand, and begin to address institutionalized racism and the role it plays in perpetuating health disparities. |
| Target Population | • American Indian pregnant women and parenting families  
• Providers and administrators in the health care systems  
• Policy makers and program developers |
| Initiative Objectives | • See Local Health Systems Action Plan below |
| Specific activities, methods, tools implemented | • See Local Health Systems Action Plan below |

Please highlight efforts in infant mortality reduction and elimination of institutionalized racism.
| Organizational Partnerships | • Michigan Department of Community Health  
  o Vital Records Division  
  o Bureau of Family, Maternal and Child Health  
• Michigan Infant Mortality Summit  
• Tribal Clinics  
• County Health Departments  
• Hospitals |
|-----------------------------|--------------------------------------------------|
| Intended Health Outcomes    | • Improved Birth Outcomes for American Indians  
• Lower levels of stress for families  
• Greater levels of comfort in accessing and using services for American Indians |
| Recommended Resources       | • “Speaking with One Voice” booklet see dissemination of findings. (PRIMEnahsspeakingwithonevoice) |
| Dissemination of Findings   | • The InterTribal Council held a summit on best practices and key issues facing Native American communities.  
• Reports findings to Healthy Start.  
• Presentations given at APHA, Michigan Infant Mortality Summit, and Healthy Equity & Healthy Disparity Conference in Ypsilanti, Michigan. |
| Resulting Policy/Practice Changes | • Working with state of Michigan to analyze and report birth certificate and infant mortality statistics for Native American/American Indians in a more accurate way.  
• Working with state of Michigan on program evaluation and creating studies.  
• Invited to provide representation on state initiatives such as the governor’s Infant Mortality Steering Committee, and PRIME Project Steering Committee.  
• Affect change in hospitals to make a more culturally sensitive environment for Native American/American Indian patients. |
| Funding Sources and Amount (separate local, state, federal) | • Core Healthy Start Funding  
• PRIME |
| Challenges to Future Work   | • Long-term system investigation takes a back seat to the demands and daily needs of providing direct community services to Native American/American Indian mothers and infants first.  
• It is hard to articulate this type of work in meetings because people are not used to thinking along the lines of anonymous institutionalized racism. The conversation becomes very abstract and difficult to grasp.  
• Discussions involving racism are difficult because often people treat it as the elephant in the room. Just now |
becoming comfortable with language in the issue.

Lessons Learned

- Keep at it. Don’t give up!
- Work through the discomforts.
- Remain open-minded.
- Consult the work of national experts and leaders to find a framework to help you organize and target strategies.

Next Steps

- PRIME is providing formalized structure and framework in an organized and dedicated way of approaching the issue of health equity. Continue working this project.
- This project will be participating in the PEDIM ALC by having a core team traveling to training seminars state-wide.

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**Michigan Inter Tribal Healthy Start ~ Local Health System Action Plan**

**DOMAIN 1—COLLABORATION & PARTNERSHIP:** Collaborate with existing agencies to improve access to quality maternal and child healthcare (MCH) services for Native American families

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Priority Activity</th>
<th>Time</th>
<th>Collaborators</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Maintain communication &amp; collaboration between the MI Department of Community Health and the MITC</td>
<td>1. Participate in the development of a proposal for a statewide Regional Perinatal System intended to ensure universal access to appropriate specialized care and community level support services for all</td>
<td>Begin Year 1</td>
<td>Tribal governments; urban Indian organizations; Title V partners; providers &amp; agencies; Healthy Start staff &amp; administrative personnel; community stakeholders</td>
</tr>
<tr>
<td></td>
<td>II. Strategize ways to build &amp; maintain partnerships for sustainability of existing MCH services for Native families</td>
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<td></td>
<td>1. Inform all MITC Healthy Start sites about the viability of becoming MIHP (Maternal Infant Health Program) providers; 2. Ensure Native American representation on State MIHP Implementation Workgroup; 3. Provide technical assistance to MITC sites in MIHP certification and reimbursement systems; 4. Expand the number of Tribal sites offering on site Medicaid and MICHild (SCHIP) enrollment.</td>
<td>Begin Year 1 On-going</td>
<td>Local &amp; statewide stakeholders; Tribal governments &amp; communities; urban Indian organizations; Title V partners; MCH providers, hospitals and service agencies; Healthy Start staff &amp; administrative personnel</td>
</tr>
</tbody>
</table>

**DOMAIN 2—SYSTEMS CHANGE:** Pursue changes in perinatal systems that will enhance quality of care, increase access to effective healthcare services, and improve outcomes for Native American populations

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Priority Activity</th>
<th>Time</th>
<th>Collaborators</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Advocate for inclusion of Michigan Inter-Tribal Council in Title V planning and priority setting</td>
<td>1. Promote regular communication between MITC and the State Title V personnel; 2. Ensure that MITC shares program data with State Title V personnel to identify priority MCH issues for Michigan’s Native American population</td>
<td>Begin Year 1 Begin Year 2</td>
<td>HS nurses &amp; outreach workers; HS Project Director, Evaluator, Consultant staff; Title V staff; policy makers; MDCH</td>
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<tr>
<td></td>
<td>II. Facilitate the</td>
<td></td>
<td>Participants; Consortium;</td>
</tr>
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<td></td>
<td>Design and perform a Needs Assessment to</td>
<td>Begin</td>
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</tbody>
</table>
development of culturally competent health care policies for Native Americans | ascertain what a culturally competent maternity care system would look like to program and community participants | Year 2 | HS nurses & outreach staff; HS Project Director, Evaluator, Nurse Consultant

**DOMAIN 3—ACCURATE TRACKING AND ANALYSIS OF AMERICAN INDIAN DATA:** Implement comprehensive data collection for minority populations to accurately assess & monitor health status & health disparities

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Priority Activity</th>
<th>Time</th>
<th>Collaborators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prioritize efforts to improve accuracy of population-specific data for American Indians that will provide program planners with information necessary for MCH policy change</td>
<td>1. Collaborate with the State to draft training protocols and communications for providers &amp; Vital records staff regarding race &amp; ethnicity; 2. Work with Tribes regarding accurate reporting for birth certificates; 3. Insure continuation of the Native American FIMR (Fetal &amp; Infant Mortality review), managed by MITC Healthy Start; 4. Use FIMR findings to explore preventable causes of fetal/infant death; 5. Communicate “Lessons Learned” from FIMR to MCH program designers &amp; policy makers, providers, &amp; community members, via conference presentations, position papers, &amp; meetings.</td>
<td>Begin Year 2 Begin Year 1 On-going In process Begin Year 3</td>
<td>Tribal Health Directors, Health Boards, community members; Tribal Governing Councils; MDCH—FIMR &amp; Title V; social workers; MCH providers; MCH &amp; women’s health programs; HS Consortium; FIMR network</td>
</tr>
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</table>

**DOMAIN 4—IMPACT OF RACISM ON BIRTH OUTCOMES AND MATERNAL AND INFANT HEALTH:**

Reduce disparities in pregnancy outcomes due to racism in the health care system.

<table>
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<tr>
<th>Strategy</th>
<th>Priority Activity</th>
<th>Time</th>
<th>Collaborators</th>
</tr>
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<tbody>
<tr>
<td>I. Raise awareness among providers about the prevalence of racism (overt and unconscious) and its impact on perinatal health disparities.</td>
<td>1. Contribute to and participate in statewide staff training efforts related to addressing racism and the role of stress in maternal and infant health disparities; 2. Collaborate with other Healthy Start Projects in Michigan to address the impact of racism on minority populations</td>
<td>Begin Year 2 Begin Year 1</td>
<td>stakeholders; Tribal governments &amp; communities; urban Indian organizations; Title V partners; MCH providers, hospitals and agencies; all Healthy Start staff.</td>
</tr>
<tr>
<td>II. Raise awareness among consumers about their rights; how to report instances of discrimination based on race/ethnicity.</td>
<td>1. Present information on the impact of racism; 2. Provide advocacy training for Healthy Start staff focused on helping clients improve relationships with healthcare providers; 3. Explore strategies for stress-management including support &amp; facilitated discussion groups</td>
<td>Begin Year 1 Begin Year 2 Begin Year 2</td>
<td>participants; Tribal governments &amp; communities; urban Indian organizations Healthy Start staff &amp; administrative personnel</td>
</tr>
</tbody>
</table>
### Jackson County Prenatal Task Force

**Contact Person:** Amy Schultz  
*Amy.Schultz@allegiancehealth.org*  
*517-841-7433*

| Why/How Started | • Research over a twelve month period in Jackson County revealed many common factors contributing to infant deaths. Factors included smoking, drug and alcohol use, depression, domestic violence, and unplanned pregnancies. Specific statistics showed that 49% of infant deaths were due to preterm birth, and 17% of infant deaths were sleep related. Furthermore, 55% of mothers smoked during pregnancy or in the postpartum period. Finally, 51% of mothers had an unplanned pregnancy.  
• Jackson County Prenatal Task Force recognizes that these causes for poor infant outcomes are preventable through improved education and adequate prenatal care. |
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<tbody>
<tr>
<td>Length of Involvement in Work</td>
<td>• The Prenatal Task Force has been operating in Jackson since 2004, the House to House program has been in place since 2007.</td>
</tr>
<tr>
<td>Initiative Goal</td>
<td>• The goal of Jackson County Prenatal Task Force is to reduce infant mortality rates by developing and implementing programs that target women of childbearing age for risk reduction education and access to health and community resources.</td>
</tr>
</tbody>
</table>
| Target Population | • Jackson County women of childbearing age.  
• Specifically high-risk women African American and low-income women in the Partnership Park area of downtown where there is the highest incidence of Infant Mortality. |
| Initiative Objectives | • Prevent pre-term labor and delivery  
• Decrease tobacco, alcohol and other drug use  
• Decrease unintended pregnancies.  
• Increase assessment and referral for domestic violence and mental health issues.  
• Increase awareness of safe infant sleep practices.  
• Improve collection and use of vital statistics on infant mortality. |
| Specific activities, methods, tools implemented | • House-to-House is a neighborhood-based community peer education program. Women recognized as ‘natural helpers’ within the target population are recruited as peer educators. The women receive training on House to House curriculum,
Please highlight efforts in infant mortality reduction and elimination of institutionalized racism

| Organizational Partnerships | • Aware, Inc.  
• Born Free  
• Center for Family Health  
• Community Action Agency  
• Department of Human Services  
• Allegiance Health  
• Prevention and Community Health  
• Health Plan of Michigan  
• In the Beginning  
• Jackson County Community Foundation  
• Jackson County Health Department  
• Jackson Public Schools  
• Lifeways  
• March of Dimes  
• Planned Parenthood  
• United Way of Jackson County  
• Women First Services |
| Intended Health Outcomes | • Improve maternal health  
• Reduce infant mortality rates. |
<table>
<thead>
<tr>
<th>Recommended Resources</th>
<th>• Review-based recommendations from the Fetal and Infant Mortality Review.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissemination of Findings</td>
<td>• FIMR Annual Reports</td>
</tr>
</tbody>
</table>
| Resulting Policy/Practice Changes | • Building connections to resources  
• Creating neighborhood health advocates |
| Funding Sources and Amount (separate local, state, federal) | • March of Dimes  
• James A. and Faith Knight Foundation  
• Sigmund Foundation  
• United Way Teenage Pregnancy Prevention Initiative  
• Michigan State Medical Society  
• Jackson County Community Foundation  
• Jackson County Prenatal Task Force Budget: $143,712  
• House-to-House Budget: $25,000. |
| Challenges to Future Work | • Peer educators are difficult to keep accountable and in the program. Retention is an ongoing challenge. |
| Lessons Learned | • True outreach requires meeting the women where they are at, rather than expecting them to come to us. Establishing trust has been an important step in the process. |
| Next Steps | • Continuing to evolve the program model to ensure sustainability. |
Kalamazoo Health and Community Services:

Healthy Babies Healthy Start

Contact Person: Carmen Sweezy

lcsweezy@kalcounty.com

269-373-5165

Website: [http://www.kalcounty.com/hsd/](http://www.kalcounty.com/hsd/)

<table>
<thead>
<tr>
<th>Why/How Started</th>
<th>This agency was created in response to high infant mortality rates, in particular in the African American population.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Involvement in Work</td>
<td>This agency has been involved in this work since 1997.</td>
</tr>
<tr>
<td>Initiative Goal</td>
<td>This agency is dedicated to decreasing infant mortality, and eliminates racial disparities in perinatal health.</td>
</tr>
<tr>
<td>Target Population</td>
<td>Women living in Kalamazoo 49007, 49001 and 49048 zip codes.</td>
</tr>
<tr>
<td>Initiative Objectives</td>
<td>Among others: Improve infant birth weight and decrease prematurity.</td>
</tr>
<tr>
<td>Specific activities, methods, tools implemented</td>
<td>Community education strategies. Case management with home visitations.</td>
</tr>
<tr>
<td>Organizational Partnerships</td>
<td>Grass roots organization with collaboration from community: hospitals medical care providers faith based organizations community based organizations governmental units.</td>
</tr>
<tr>
<td>Recommended Resources</td>
<td>None at this time.</td>
</tr>
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</tbody>
</table>
| Intended Health Outcomes | Healthy infants with appropriate weight.  
                          | Healthy mothers. |
| Dissemination of Findings | Presentations  
                          | Journals  
                          | Reports |
| Resulting Policy/Practice Changes | None at this time. |
| Funding Sources | U.S Department of Health and Human Services  
                          | Health Resources and Services Administration (all federal funds) |
| Challenges to Future Work | Funding. |
| Lessons Learned | Value of flexibility.  
                          | Value of program rooted in local community needs. |
| Next Steps | Continue writing federal grants for continued funding. |
Kent County Health Department

Contact Person: Karyn Pelon

karyn.pelon@kentcountymi.gov

616-632-7122

Website:

http://www.accesskent.com/Health/HealthDepartment/

http://www.accesskent.com/Health/HealthDepartment/Publications/

http://www.accesskent.com/Health/HealthDepartment/Health_Promotion/Infant_Health.htm

http://www.healthykent.org/index.php

<table>
<thead>
<tr>
<th>Why/How Started</th>
<th>• The Kent County Health Department (KCHD) and Healthy Kent 2010 have continually monitored data and developed responsive plans of action to address racial/ethnic disparities in infant mortality. KCHD/Healthy Kent 2010 held community conversations and a community summit to identify strategies to address disparities in infant mortality and the affects of racism on health.</th>
</tr>
</thead>
</table>
| Length of Involvement in Work | • In the spring of 2005, the KCHD received a grant from the Michigan Department of Community Health (MDCH). The grant funded the support of an infant mortality coalition, a community action plan to reduce infant mortality, particularly for African Americans, and implementation of an evidence-based Interconception Care (IC) Program.  
• The Kent County Health Department also has a Nurse Family Partnership (NFP) Program through the Community Nursing Division. NFP services focus on fostering healthier pregnancies, improving the health and development of children and encouraging self-sufficiency through planning for future pregnancies, continuing education and securing employment. |
| Initiative Goal | • Reduce infant mortality, primarily the African American health disparity. |
| Target Population | • Kent County residents, clients, professionals and providers. |
### Initiative Objectives
- Work towards community and systems change to promote cultural competence among healthcare providers.
- Address a Life Course Perspective that focuses on improved maternal health and birth outcomes.
- Recognize and address the linkage between racism and the disparity in infant mortality.
- Conduct asset mapping to identify community assets and gaps in service for high-risk IC clients to determine new programs or interventions that address health inequities.

### Specific activities, methods, tools implemented
- Development and implementation of Cultural Competency Curriculum for Health Care Professionals (5 modules, 12.5 hours of training).
- Town Hall Meetings that looked at 1) pregnancy prevention, 2) access to quality care that address social determinants of health and 3) racism.
- Strong Beginnings is a Federal Healthy Start program that provides direct services and works at the system level for change.
- The Healthy Kent 2020 Infant Health Implementation Team (IHIT) does work at the systems level on breastfeeding, perinatal care, fatherhood, safe sleep and transportation.
- The Responding to Racism (R2R) Action Team (part of the IHIT):
  - Hosted two half day trainings on unintentional blindness, cultural humility and anti-racism. The training provides a gradual introduction to engaging discussion on white privilege and institutional racism. Trainings use the Unnatural Causes film.
  - Developed toolkits for consumers and providers on responding to racism including information on organization and self assessments, patient rights and health care standards of culturally appropriate care.

### Organizational Partnerships
- Kent County Health Department
- Strong Beginnings (Federal Healthy Start)
- Healthy Kent 2020 (Infant Health Implementation Team, Fetal Infant Mortality Review (FIMR)
- Spectrum Health
- Cherry Street Health Services
- Planned Parenthood of West and Northern Michigan
- Baxter Wholistic Health Center

### Intended Health Outcomes
- Decrease infant mortality, primarily the African American health disparity.
| **Recommended Resources** | • NACCHO Local Health Department National Coalition for Health Equity  
• Bob and Aleicia Woodrick Diversity Learning Center (Grand Rapids Community College)  
• Health Resources and Services Administration Maternal and Child Health  
• National Center for Cultural Competence (NCCC). |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| **Dissemination of Findings** | • Kent County Infant Health Initiative Annual Report  
• Annual Fetal Infant Mortality Review Report  
• Healthy Kent 2020 Reports  
• Key Informant Interview, Community Conversation, and Focus Group Final Reports |
| **Resulting Policy/Practice Changes** | • Incorporating delivery of Interconception Care into the Maternal Infant Health Program (MIHP)  
• Staff trainings for IC providers, staff and partners on Creating Inclusive Healthcare Environments |
| **Funding Sources and Amount (separate local, state, federal)** | • Racial and Ethnic Approaches to Community Health /Legacy grants from Genesee County (Federal/Centers for Disease Control and Prevention); Year one/$30,900, Year two/$25,000 and Year three/$25,000  
• Kent County Health Department (General Fund), $169,985  
• Practices to Reduce Infant Mortality through Equity (PRIME), state, $2,000 |
| **Challenges to Future Work** | • Continued funding  
• Promising practices  
• Increasing awareness  
• Partners understaffed |
| **Lessons Learned** | • Listen to community input and provide reports, outcomes, and programs back to the community.  
• Find innovative ways to reach providers outside of face to face contact, for instance online surveys and resources. |
| **Next Steps** | • Convening community partners in a forum to establish a client-centered Community Plan of Action for addressing health inequities, including racism and discrimination, and developing a community asset mapping report to target interventions for IC clients.  
• Identify methods to disseminate consumer and provider toolkits statewide and online. |
Michigan Minority Health Coalition

Contact Person: Dr. Othelia Pryor

opryor@michiganmhc.com

517-337-0705

Website: www.michiganmhc.com

| Why/How Started | • While Dr. Pryor was involved in a health education project that investigated health disparities in the African American community, she realized the similar disparate health outcomes of all people of color in Michigan. It also became evident that despite the multiple interventions targeted towards these issues, the differences in health outcomes experienced by these communities were not decreasing. Dr. Pryor also realized that although the community programs in place served a beneficial function for individuals, these programs seemed ineffective in addressing overarching issue of health disparities in the community. Therefore, she wanted to start an organization that looks at ways of addressing systemic changes for communities of color that would analyze the problem from a system-wide view.  
• It was often not the case that organizations from different racial/ethnic groups to work together on social issues. However, given that these organizations shared one common bond, “that of dying prematurely” she believed that this could be a focal point on which the coalition could be formed. Therefore, the issue of health disparities became the focal point of this new organization-the Michigan Minority Health Coalition. |
| --- | --- |
| Time Involved in Work | • Dr. Pryor has been working in communities of color since 2002.  
• The Michigan Minority Health Coalition (MMHC) started in January of 2006. |
| Initiative Goal | • MMHC is a statewide consortium dedicated to developing strategies and creating partnerships that will improve the health status of Michigan’s ethnic and racial minority populations.  
• More specifically, the coalition intends to improve access to minority health initiatives that serve to increase community partnerships by providing a persistent and continuing focus on eliminating disparities in the health status of Michigan's racial and ethnic populations. The Coalition collaborates with state, local and private sectors to advance community |
empowerment, to engage in health promotion and to support disease prevention strategies.

| Target Population | • Individuals and organizations who are interested in issues relating to health disparities, health equity, and the disparate health outcomes of people of color in Michigan are welcomed members of the Coalition. |
| Initiative Objectives | • Expand MMHC to ensure geographical, cultural, and ethnic diversity representing various health organizations and/or individuals in Michigan.  
• Develop a communication network that helps to foster partnership and collaborative relationships around health disparities and related health issues.  
• Provide advocacy opportunities that empower community members regarding initiatives effecting health disparity and health equity issues.  
• Resolve issues of health equity and racism through upstream system changes.  
• Passage of PA 653, Michigan’s Health Disparity Law.  
• Correct health disparity for people of color in Michigan through work that focuses on health equity, institutional racism, and upstream system changes. |
| Specific activities, methods, tools implemented | • MMHC has partnered with several organizations to participate several *Lunch and Learn Sessions* for various organizations. MMHC representatives have met with members of the legislative to share information on health disparities and health equity.  
• MMHC representatives have participated in National and Statewide information gathering and strategy sessions to identify effective uses of national, state, regional, and community data and resources that support the investigation of minority health issues. These meetings have been hosted by the MDCH Health Disparity Reduction and Minority Health Section, the National Office of Minority Health, and other organizations.  
• Hosted annual Regional Advocacy Leadership Summits on issues relating to health disparities and health equity.  
• MMHC representatives sit on various statewide and national committees to ensure that minority perspectives are considered.  
• Facilitate communication and collaborative efforts among organizations involved in minority health issues.  
• Published a website, www.ACA4U.org, which includes a public service announcement developed by the Michigan Minority Health Coalition that appeared on local Lansing
television stations on the Patient Protection and Affordable Care Act (PPACA). This PSA pointed out how the Act will impact all individuals with special resources directed to minority people. The PSA aired over 200 times during the last two weeks of March to celebrate the first anniversary of the PPACA. MMHC representatives are collaborating with Michigan Department of Community Health on the social determinants of health that impact asthma. We are a partner with them on a United States Department of Housing and Urban Development housing grant, as well as communicating services available through local churches and community partners.

- MMHC serves as a distribution center for activities, functions, events, research findings, and conferences that impact the minority community.
- MMHC has representatives on the Michigan Biotrust Project and the Michigan Consumers for Healthcare Advancement to ensure that a minority perspective is considered in policy discussions. Representatives focus on how the data and research will be used and the possible impact on communities of color. Representatives also want to ensure that current and future benefits from the program will be communicated and available for minority communities.
- MMHC and their partners have participated in MDCH Health Disparity grants and events to celebrate Minority Health Month.
- MMHC hosts an annual Regional Patient Advocacy Leadership Conference that focuses on issues pertinent to minority advocates.
- **MMHC gives presentations to local and statewide organizations to educate them on issue pertinent to minority health issues.**
- **MMHC and its partners have testified before the House Health Policy Committee and other legislative bodies.**
- **MMHC, along with other nonprofits and the Kirwan Institute are currently authoring a White Paper on the benefits of health equity in the state of Michigan that will be submitted to the Governor.**

**Organizational Partnerships**

- Ingham County Health Department
- **MDCH Health Disparity Reduction Minority Health Section**
- MOSES- Metropolitan Organizing Strategy Enabling Strength
- Lansing Latino Health Alliance
- Cristo Rey Community Center
- Various Lansing churches
- Greater Lansing African American Health Institute
- Michigan Legislative Black Caucus
<table>
<thead>
<tr>
<th>Intended Health Outcomes</th>
<th>• A provision of health equity in which all individuals in Michigan can participate. This will mean that there must be system-wide changes that will ultimately mean that communities of color will no longer suffer from disparate health outcomes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissemination of Findings</td>
<td>• Our findings are incorporated into the educational work and presentations that we do.</td>
</tr>
<tr>
<td>Resulting Policy/Practice Changes</td>
<td>• Successful passage of PA 653 • House Health Policy hearing on health disparities • A larger collaboration of organizations of health disparity issues</td>
</tr>
</tbody>
</table>

- All Around the World African American Museum
- Mid-Michigan Affiliate Susan G. Komen for the Cure
- American Cancer Society
- National Kidney Foundation
- Black Social Workers
- Lansing Community Mental Health
- Oxford Court Block Club of Ypsilanti
- Individuals interested in health disparities
- Nottawaseppi Huron Band of the Potawatomi
- GlaxoSmithKline
- Michigan League of Human Services
- Joy Southfield Free Clinic
| Funding Sources | • GlaxoSmithKline  
|                | • MDCH Grants  
|                | • Pharmaceutical grants for various projects |
| Challenges to Future Work | • Expansion of the coalition to other geographic areas  
|                | • Capacity building for the organizations  
|                | • Increased staffing  
|                | • How to make the issue of health disparities a part of all policy discussions and decisions. Trying to ensure that the impact to minority communities will be considered when health and policy decisions are being made.  
|                | • Proving that health equity is not just an issue for people of color but is perceived as a Michigan issue.  
|                | • Ensuring that health equity is a part of the larger discussion on the revitalization of the Michigan economy. |
| Lessons Learned | • Dr. Pryor has been disappointed that the issues of health disparity and health equity are not taken more seriously. Given the changing demographics of the US, it is predicted that, by 2040, 50% of the inhabitants of the US will be people of color. Consequently, if nearly half of the population is experiencing ill health outcomes that impact their ability to function and participate fully in society, the economic health and security of the US could possibly be affected. |
| Next Steps | • MMHC is currently planning the 2011 Regional Patient Advocacy Leadership Conference. The conference will be held in Lansing, Michigan on October 28th. The topic is *Improving Quality in the Health Care Reform Era: Innovative Healthcare Delivery Systems in Communities of Color*. The announcement and registration information is on the MMHC website.  
|            | • Supporting the MDCH Health Disparities Reduction Office of Minority Health Section initiatives Working to ensure the PA 653 is the structural backbone in Michigan that supports minority health initiatives  
|            | • Working to ensure that the minority community is aware of the impact of PPACA  
|            | • Linking with organizations to ensure that the expansion of the healthcare workforce involves full participation of individuals from minority communities. |
National Kidney Foundation

Contact Person: Kristie King

KKing@nkfm.org

800-482-1455

Website: www.kidney.org

<table>
<thead>
<tr>
<th>Why/How Started</th>
<th>● This initiative started in May of 2011 with the Health Disparities grant from Michigan Department of Community Health.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Involvement in Work</td>
<td>● Fifteen months involved in this work.</td>
</tr>
<tr>
<td>Initiative Goal</td>
<td>● This initiative is focused on building a coalition that will address the Social Determinants of Health.</td>
</tr>
<tr>
<td>Target Population</td>
<td>● African Americans within Inkster, Michigan.</td>
</tr>
</tbody>
</table>
| Initiative Objectives | ● Formation and mobilization of a Multi-Disciplinary Team to oversee and guide project activities.  
● Engage in capacity building training opportunities.  
● Initiate a community dialogue and conduct a comprehensive community health assessment.  
● Develop a plan for addressing main concerns/issues and health disparities identified in the community.  
● Provide Health Disparities Reduction in Minority Health with data collected and develop an action plan as a strategy for Phase II. |
| Specific activities, methods, tools implemented | ● Needs assessment (THRIVE tool) (Change Tool)  
● Focus groups  
● Monthly meetings  
● See Image 1 and 2 on pg. 57 |

Please highlight efforts in infant mortality reduction and elimination of institutionalized racism |
| Organizational Partnerships | • Faith based systems  
• Community foundations  
• Community agencies/organizations  
• City government  
• Housing  
• Inkster Public Schools  
• Community members  
• Block clubs  
• Businesses |
<table>
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<tbody>
<tr>
<td>Intended Health Outcomes</td>
<td>• To reduce the rates of chronic kidney disease for residents in Inkster community, as well as to focus on reducing high blood pressure, diabetes, and obesity which are some of the main contributing factors to this disease.</td>
</tr>
</tbody>
</table>
| Recommended Resources | • National Diabetes Education Program  
• CDC website  
• Office of Minority Health |
| Dissemination of Findings | • Findings disseminated through coalition members at monthly meetings. |
| Resulting Policy/Practice Changes | • Community workgroups established to address areas of priority to address throughout city.  
• City Resolution signed by city council/mayor regarding health as a priority in the city of Inkster.  
• The Inkster Task Force adopted the Gardening Initiative which was included as part of the Living Healthy Initiative signed by the Mayor and City Council of Inkster. This initiative partners with local gardeners to offer fresh fruit to the community since there are no commercial grocery stores in Inkster.  
• Inkster Public Schools incorporated the gardening initiatives as part of school initiatives. |
| Funding Sources and Amount (separate local, state, federal) | • Michigan Department of Community Health  
• Office of Women’s Health  
• Center for Disease Control |
| Challenges to Future Work | • Continue ongoing synergy & community motivation  
• Ongoing organizing  
• Recruiting volunteers  
• Targeting and engaging areas that are seen and often not heard in the change process and/or have lack of access to resources  
• Funding sources |
Lessons Learned

- Community involvement from all levels is important to the accomplishment of health changes.
- Designation of time and agency resources are important to facilitate.

Next Steps

- Applying for ongoing funding opportunities.
- Continue to develop coalition agenda.

Image 1.

Inkster’s Community’s Continuum of Needs to Assets
(Least to Greatest # of Elements in Place)

Needs → Chronic Disease Management
- Leadership
- Physical Activity
- Nutrition

Assets → Tobacco Use

Final CHANGE Tool Results for Inkster – March 2011

Image 2.

THRIVE Tool Summary of Findings
Infant Mortality Reduction-Oakland County Health Division

Contact Person: Lynn McDaniels MSN, APRN-BC

mcdanielsl@oakgov.com

248-424-7059

Website:

http://www.oakgov.com/health/healthy_lifestyles/healthy_pregnancy.html

| Why/How Started | • In 2000, there was a significant African-American disparity in the infant mortality rate. In response to this, Oakland County began examining infant deaths in Pontiac through the Fetal & Infant Mortality Review (FIMR) process. In 2002, this project expanded to include the city of Southfield because of the disparity in the African-American rate.

• Oakland County provides public health nurse home visits to pregnant women and infants following delivery. During that time, several initiatives were undertaken including: teen pregnancy prevention, teen pregnancy school-based programs, expectant parent classes, well-baby clinics, and Early Periodic Screening, Diagnosis, and Treatment Program. |
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Length of Involvement in Work</td>
<td>• Oakland County has been providing services with an emphasis on infant mortality reduction for over 30 years.</td>
</tr>
<tr>
<td>Initiative Goal</td>
<td>• To identify the contributing factors to the African-American infant mortality rate in Pontiac and Southfield.</td>
</tr>
<tr>
<td>Target Population</td>
<td>• African American populations of Pontiac and Southfield.</td>
</tr>
<tr>
<td>Initiative Objectives</td>
<td>• Once the contributing factors were identified, Oakland County mobilizes both communities to address the issues contributing to infant mortality.</td>
</tr>
<tr>
<td>Specific Activities</td>
<td>Field Nursing Home Visits</td>
</tr>
<tr>
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<td>--------------------------</td>
</tr>
<tr>
<td></td>
<td>Approximately 14,000 home visits are made annually to high-risk clients to emphasize infant health promotion.</td>
</tr>
</tbody>
</table>

| Nurse Family Partnerships | Full caseload of 100 clients maintained. Ongoing home visit service provided by four PHNs. |

| WIC | In efforts to offer and provide PHN services to all Pontiac / Southfield pregnant women, a Field PHN is frequently present at Pontiac and Southfield WIC sites. The PHN sees every pregnant woman accessing WIC services, and a referral is written for Field Nursing services. The PHN then continues with follow-up to the client, maintaining the relationship initiated at WIC. This has resulted in a significant number of antepartum referrals. |

| WIC | In efforts to offer and provide PHN services to all Pontiac / Southfield pregnant women, a Field PHN is frequently present at Pontiac and Southfield WIC sites. The PHN sees every pregnant woman accessing WIC services, and a referral is written for Field Nursing services. The PHN then continues with follow-up to the client, maintaining the relationship initiated at WIC. This has resulted in a significant number of antepartum referrals. |

| Fetal & Infant Mortality Review (FIMR) | OCHD staff convened a diverse, multidisciplinary group of professionals from the community to examine all infant deaths in Pontiac and Southfield. Information derived from these case reviews is conveyed to the members of the Community Advisory Committees for recommendation and action. |

| CRIB NOTES Classes | It was identified by the Infant Mortality Reduction workgroup that the young adolescent population is where we need to begin to provide education related to preventing infant mortality. As a result, a group of PHNs developed and implemented a series of classes, “CRIB NOTES’ using potential babysitters as the target audience. The goal was to increase awareness related to risk factors, including both child and personal health, which contribute to infant mortality. The classes involved multidisciplinary approach, involving an OCHD health educator and nutritionist and include hands-on experiences and discussions about making healthy choices, tobacco prevention, nutrition, infant/child and personal safety, growth and development. Classes were presented at several middle schools throughout the county. |

| Children’s Village | A PHN is permanently assigned at Children’s Village. To address our infant mortality message, the PHN offers presentations related to safe relationships, infant safe |
sleep, reproductive health, and prevention of shaken baby syndrome.

Infant Mortality Reduction Display Board

The Infant Mortality Reduction Display Board is displayed at many community sites throughout the year. Opportunities included: churches, Oakland University, Oakland Community College, Michigan FIMR Training, OCHD Health Division offices, OCHD WIC at Oakland Pointe, parenting fairs, and the 4 H Fair.

Private Physician Liaison Activities

During the year various attempts have been made to form liaison relationships with significant OB practices. We continue to work on this initiative in both Pontiac and Southfield.

Other OCHD initiatives

Nurse-On-Call is available during work hours for phone consultation, and referral.

All high-risk pregnant women are referred to see the OCHD Nutritionist.

OCHD clinics provide pregnancy testing and testing for infection. Referrals are made for Field Nursing services for all pregnant clients that are receptive.

PHNs at WIC (Southfield and Pontiac) provide immunizations, assessment and referral for Field Nursing services.

Oakland County Jail – In the past, a PHN provided weekly service to pregnant women in the jail. Upon release, a referral was made for continued Field Nursing services by this PHN.

Community Baby Shower sponsored by OCHD to provide an opportunity for client teaching and referral to area resources.

Clients are provided assistance (on a walk-in basis) with enrollment in MOMS, MIChild, and Healthy Kids Programs.

Organizational Partnerships

Partners with the organizations on the Best Start for Babies- Oakland Community Action Team.

Intended Health Outcomes

Lower African American infant mortality rates for Pontiac and Southfield.

Healthy lifestyles for the African American women of Pontiac and Southfield before they become pregnant.
|---------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| **Resulting Policy/Practice Changes** | Oakland County places more emphasis on the contributing factors for prematurity like infection, nutrition, and substance use.  
Oakland County is also going to focus more towards inter-conception care during public health nurse home visits, as well as initiate public health nurse home visits early in the pregnancy as opposed to afterwards. |
| **Funding Sources** | Primarily county funding  
MCH Block Grant  
MDCH grant for Nurse-Family Partnership  
DHS Prevention grants |
| **Challenges to Future Work** | Funding.  
Maintaining community partner interest in a depressed economy. |
| **Lessons Learned** | Local health departments need to be leaders in the initiative to decrease infant mortality, but involvement of community stakeholders is essential. |
| **Next Steps** | Oakland County is organizing to create breastfeeding initiatives.  
Oakland County continues to initiate public health nurse home visits early in African American women’s pregnancy. |
Saginaw County Department of Public Health

Contact Person: Dawn M. Shanafelt

dshanafelt@saginawcounty.com

989-758-3853

Website: [www.saginawcountypublichealth.org](http://www.saginawcountypublichealth.org)

<table>
<thead>
<tr>
<th>Why/How Started</th>
<th>• The Saginaw County Infant Mortality Review was started in 1991 with a grant from ACOG/NFIMR. Saginaw was one of the original eight Fetal Infant Mortality Review (FIMR) grants and is one of the few programs which sustained activity after the initial year grant period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Involvement in Work</td>
<td>• Formerly since 1991 with a retrospective study of infant deaths back to 1980 having been done.</td>
</tr>
<tr>
<td>Initiative Goal</td>
<td>• Reviewing every infant death since 1991 to determine patterns in cause of death. This resulted in the Healthy Start grant being obtained from HRSA by the Saginaw Cooperative Hospitals, Inc., a non-profit medical education corporation associated with the College of Human Medicine at MSU.</td>
</tr>
<tr>
<td>Target Population</td>
<td>• African American women residing in Saginaw County, Michigan.</td>
</tr>
<tr>
<td>Initiative Objectives</td>
<td>• To reduce the racial disparity existing between African American and Caucasian infant mortality rates in Saginaw County.</td>
</tr>
</tbody>
</table>
| Specific activities, methods, tools implemented | • Focus groups conducted to determine patient’s views of healthcare system in Saginaw County.  
• Conducted numerous Physician Grand Rounds and community educational session regarding cultural awareness.  
• Public Awareness campaigns regarding infant mortality reduction on issues like signs and symptoms of preterm labor, breast feeding, and prenatal care among other topics.  
• Hundreds of community awareness events attended to educate the public on infant mortality and racial disparity.  
• Success Great Beginnings Healthy Start Program  
• Instituted risk assessments to be conducted at local OB/GYN providers including the Four P’s Plus of Ira Chasnoff. |
| Organizational Partnerships | • Partnerships with all, but not limited to the following:  
  • Local healthcare providers  
  • Federally Qualified Health Centers  
  • School Districts  
  • Community Mental Health Authority  
  • Law Enforcement  
  • Colleges and Universities  
  • Michigan State University Extension Office  
  • Black Sororities  
  • Faith Based Community  
  • Teen Parent Services  
  • Child Abuse and Neglect Council  
  • Great Start Collaborative  
  • Project LAUNCH  
  • Civic groups |
| Intended Health Outcomes | • Decreased Infant Mortality rates in the African American population. |
| Recommended Resources | • Resources that have been shared by Healthy Start Programs through the National Healthy Start Association. |
| Dissemination of Findings | • Community/Town Hall meetings and forums  
  • Newsletter publications  
  • Press conferences  
  • Television and news stories  
  • Communication and presentations for medical providers  
  • Meetings with elected officials  
  • Community awareness and education events |
| Resulting Policy/Practice Changes | • Numerous recommendations made over the years that have resulted in practice changes by medical care providers:  
  • Referral and education materials being made available.  
  • Standardized responses after infant loss/miscarriages standardized.  
  • Safe sleep education being standardized by Covenant HealthCare as part of educational binder given to all patients and teaching provided “in hospital.”  
  • Education to local emergency medical transporters regarding the hospital equipped in Saginaw County to deal with pregnancy related emergencies.  
  • Training of law enforcement personnel regarding death scene investigation after an infant death.  
  • Teaching regarding infant mortality being included in the religious community. |
- All infant deaths being reviewed in Saginaw County.
- Medical providers examining their prescribing practices of addictive medications to pregnant woman.

| Funding Sources and Amount (separate local, state, federal) | Various funders:  
|----------------------------------------------------------|--------------------------------------------------|
|                                                          | Michigan Department of Community Health funds.  
|                                                          | HRSA funds.  
|                                                          | Private funds (i.e. Saginaw City Rotary donating funds for sleep sack and education to be provided to every woman delivering a baby in Saginaw County). |

| Challenges to Future Work | Decreasing funding streams  
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<tr>
<td></td>
<td>Higher risk families as the result of the economic hardships being experienced in the State of Michigan (i.e. higher crime rates, increased poverty, increased unemployment, and housing shortage).</td>
</tr>
</tbody>
</table>

| Lessons Learned | Reducing infant mortality will only be achieved through a multi-disciplinary holistic approach. Infant mortality is a highly complex issue and requires a multi-faceted, complex solution to reduce it.  
|                | It is also extremely important to note that initiatives also needed to be derived after extensive assessment of the communities in which they are provided. Each community, although similar, has differing factors that will impact the success of such initiatives. |

| Next Steps | None to report at this time. |
Washtenaw County Coalition for Infant Mortality Reduction

Contact Person: Monique Reeves, MD, MPH

reevesm@ewashtenaw.org

734-544-3058

Website: www.3xmorelikely.com

<table>
<thead>
<tr>
<th>Why/How Started</th>
<th>• Washtenaw County was one of eleven counties that received infant mortality funding through Healthy Michigan fund. From this funding, Washtenaw County Health Department developed the Washtenaw County Coalition for Infant Mortality Reduction. This Coalition research infant mortality data through focus groups and mini-PRAMS surveys. Because of these efforts, this Coalition sponsors Three Times More Likely, which is an African American women’s health campaign.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Involvement in Work</td>
<td>• 2 years</td>
</tr>
<tr>
<td>Initiative Goal</td>
<td>• Washtenaw County Coalition for Infant Mortality Reduction works to reduce racial disparities in infant mortality and in low birth weight/premature delivery.</td>
</tr>
<tr>
<td>Target Population</td>
<td>• African American women in three target demographic areas of Washtenaw County, ages 15-30 years old.</td>
</tr>
</tbody>
</table>
| Initiative Objectives | • Educate young women in childbearing years on how to be healthy before you become pregnant.  
• Promotion of pre-conceptual health as critical in reducing prematurity and low-birth weight. |
| Specific activities, methods, tools implemented | Three Times More Likely:  
• An African American women’s health campaign that trains community members to spread the word to women in the African American community of Washtenaw County on how to prevent infant deaths and stay healthy during childbearing years.  
• Community volunteers are trained in educating women on the importance of achieving and maintaining optimal pre-conceptual health. Topics discussed include: good nutrition, dental care, vitamins, as well as dialogue on the issue of |
<table>
<thead>
<tr>
<th>institutionalized racism</th>
<th>health disparity in infant mortality.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organizational Partnerships</strong></td>
<td>• The Corner Health Center</td>
</tr>
<tr>
<td></td>
<td>• Washtenaw Area Council for Children</td>
</tr>
<tr>
<td></td>
<td>• Health Improvement Plan of Washtenaw County</td>
</tr>
<tr>
<td><strong>Intended Health Outcomes</strong></td>
<td>• Improve African American birth outcomes and decrease disparity in infant mortality for Washtenaw County.</td>
</tr>
<tr>
<td><strong>Recommended Resources</strong></td>
<td>Please see contact website for links to these resources:</td>
</tr>
<tr>
<td></td>
<td>• Washtenaw County Health Resources: List of local agencies and phone numbers to contact for assistance with a variety of health services, ranging from alcohol abuse, to emergency housing, to weight management.</td>
</tr>
<tr>
<td></td>
<td>• A Healthy Baby Begins with You: The Office of Minority Health’s national campaign to reduce infant mortality.</td>
</tr>
<tr>
<td></td>
<td>• Healthy You Now: A website community and online bimonthly magazine dedicated to supporting women of color on their journey to achieve an optimal lifestyle of health and wellness.</td>
</tr>
<tr>
<td></td>
<td>• PLAN FIRST: Free health insurance plan available to women ages 19-44 in Michigan. Provides income-eligible women free family planning services such as clinic or gynecologist visits, pap smears, birth control prescriptions, contraceptive supplies and devices, lab tests and treatment for sexually transmitted infections</td>
</tr>
<tr>
<td></td>
<td>• When the Bough Breaks: Episode from the PBS series <em>Unnatural Causes: Is Inequality Making Us Sick?</em>, available at the Ann Arbor District Library.</td>
</tr>
<tr>
<td><strong>Dissemination of Findings</strong></td>
<td>• Quarterly reports printed as part of the grant process.</td>
</tr>
<tr>
<td><strong>Resulting Policy/Practice Changes</strong></td>
<td>• None at this time.</td>
</tr>
<tr>
<td>Funding Sources and Amount (separate local, state, federal)</td>
<td>• REACH Grant from Genesee County.</td>
</tr>
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<td>-----------------------------------------------------------</td>
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</tr>
<tr>
<td>Challenges to Future Work</td>
<td>• Funding.</td>
</tr>
<tr>
<td>Lessons Learned</td>
<td>• Too early to tell at this time.</td>
</tr>
<tr>
<td>Next Steps</td>
<td>• In the planning phase of the second grant year.</td>
</tr>
</tbody>
</table>
Wayne County Department of Public Health

Contact Person: Vinny Taneja

Email: vtaneja@co.wayne.mi.us

Phone: 734-727-7045

Website: [http://jointcenter.org/hpi/pages/wayne-county-mi](http://jointcenter.org/hpi/pages/wayne-county-mi)

<table>
<thead>
<tr>
<th>Why/How Started</th>
<th>● Wayne County Department of Public Health is a part of the national learning community organized by the Joint Center for Political and Economic Studies’ Health Policy Institute that consists of 16 PLACE MATTERS teams. PLACE MATTERS works with its teams to identify the complex root causes of health disparities (e.g., employment, education, poverty, and housing; also known as social determinants of health) and define strategies to address them.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Involvement in Work</td>
<td>● Wayne County Department of Public Health has been involved with this work since June of 2006.</td>
</tr>
<tr>
<td>Initiative Goal</td>
<td>● The goal of the Infant Mortality Reduction Project is to examine social determinants (employment, education, social isolation of women, social perception of women, and racism) of health that affect disparate rates of infant mortality, make recommendations for upstream strategies to reduce the disparity and promote equity among target populations.</td>
</tr>
<tr>
<td>Target Population</td>
<td>● African American women (and other minority women) and their newborn infants.</td>
</tr>
</tbody>
</table>
| Initiative Objectives | ● Distribution of “White Paper” to Stakeholders informing them of the problem. Have a committed group of Stakeholders that champion and/or implement strategies that increase self assurance and self reliance in women.  
● Increased Community Dialogue on valuing womanhood and the value of improved preconception and inter conception health.  
● Institutionalization of policies that value womanhood |
| Specific activities, methods, tools implemented | ● Infant Mortality Reduction Steering Committee - used logic model to develop “White Paper” which informs stakeholders of the problems of infant mortality in Wayne County and how some of these social determinants of health impact pregnancy outcomes.  
● Place Matters Design Lab – Hosted a summit to explore relationships among race, racism, and health inequities. The |
| in infant mortality reduction and elimination of institutionalized racism | summit included opportunities to explore ideas and strategies plans to address and mitigate structural racism, share progress, milestones achieved, and future plans to address social determinants of health, engage in teambuilding activities that support the continued development and implementation of county strategy plans, convene and network with colleagues participating in PLACE MATTERS counties.  

- **Training** - In October 2010, Human Impact Partners (HIP) provided training to the Wayne County team on how to conduct Health Impact Assessments (HIAs). The training was also offered to agency and community partners.  

- **Health impact assessments** – These were done on existing or proposed policies impacting infant mortality. (one of first counties to do this). Examined gender equity in pay and its effects on the health of women overall, as well as pregnancy outcomes. Currently examining education funding in Michigan and the effects on the health of women overall, as well as pregnancy outcomes.  

- **White Paper – Already Broken** – A detailed examination of the identified social determinants, their current effects on health status, maternal and child health outcomes complete with recommendations for improvement. |

| Organizational Partnerships | - Wayne County/Detroit Infant Mortality Steering Committee: Stakeholders include:  
  - Wayne County Department of Public Health  
  - Wayne County Health and Human Services  
  - Detroit Department of Health and Wellness Promotion  
  - Michigan Department of Community Health  
  - Wayne State University  
  - University of Michigan School of Public Health  
  - Detroit Environmental Justice  
  - State and local government  
  - Detroit Medical Center  
  - Henry Ford Health System  
  - Oakwood Health Systems  
  - Wayne County – Health Start, Michigan Chronicle  
  - Michigan Public Health Institute – Child Death Review  
  - MOSES  
  - St. John Health Systems  
  - Tomorrow’s Child |

| Intended Health Outcomes | - The goal is to improve preconception and inter-conception health and hence pregnancy outcomes in order to achieve the ultimate goal of reducing infant mortality and the disparities in infant mortality. |
| Recommended Resources | Joint Center for Political and Economic Studies’ Health Policy Institute PLACE MATTERS website - [http://jointcenter.org/hpi/pages/place-matters](http://jointcenter.org/hpi/pages/place-matters)  
| Dissemination of Findings | Staff presented the health impact assessment to the legislatures in Lansing and Washington, D.C. during Equal Pay day events in April 2011.  
| | HIA abstract has been accepted for presentation at the APHA National Conference in Washington D.C. in November 2011.  
| | Plans are currently underway for the dissemination of the White Paper. |
| Resulting Policy/Practice Changes | Wayne County Department of Public Health’s implementation of Health Impact Assessment has provided decision-makers need sound and objective data that will analyze the impact their decisions will have on the health of communities, and help avoid unexpected health consequences and unanticipated costs. The use of this valuable practice has elevated the role of health in decision-making in Wayne County by providing a combination of procedures, methods, and tools by which a policy, plan, or project may be examined as to its potential effects on the health of a population, and the distribution of those effects within the population. |
| Funding Sources and Amount (separate local, state, federal) | Kellogg Foundation  
| | Human Impact Partners |
| Challenges to Future Work | The potential for partners to run out of steam with the extra work in combination with other work-loads.  
| | Changes do not happen short-term. There needs to be a general commitment to be willing to wait even a year for changes to begin. |
| Lessons Learned | The importance of having someone consistent from the education community to attend meetings and partner with them.  
| | The importance of networking and collaborating with partners that are also working to reduce disparities and promote equity.  
| | The importance of sharing your findings and disseminating your work to others |
| Next Steps | Create additional opportunities for dialogue and civic engagement through meetings and community events.  
| | Establish/strengthen partnerships to design, implement and sustain interventions that support high school completion.  
| | Improve employment opportunities and advocate for equal pay.  
| | Increase awareness regarding the link between the social |
- Provide support networks and social structures for girls and women throughout the lifespan.
- Engage boys and men to understand and appreciate their roles in nurturing women.
- Create/maintain partnerships to develop and maintain efforts to promote positive images of girls and women through mentoring and media campaigns.
Selected Resources

**Articles**


**Films**


**Recordings, Webinars and Toolkits**


Reports


CityMatCH, AMCHP, NHSA. (2011). *Taking the First Steps: Experiences of Six Community/State Teams Addressing Racism’s Impacts on Infant Mortality.* Omaha, NE: CityMatCH at the University of Nebraska Medical Center.


Front Cover Images


2 http://www.minnpost.com/stories/2008/08/14/2961/the_next_america_a_majority_of_minorities
Acknowledgments

Alethia Carr, RD, MBA
Michigan Department Community Health, Bureau of Family, Maternal & Child Health, Director

Kristen Conover, RN, BSN
MPH Candidate 2012, University of Michigan School of Public Health,
Health Behavior Health Education

Brenda Jegede, MPH, MSW
Michigan Department Community Health, PRIME Project Coordinator

Jennifer White, MSPH Candidate 2012
The Johns Hopkins Bloomberg School of Public Health, Department of Population, Family &
Reproductive Health

PRIME Local Learning Collaborative

October 12 – 14, 2011
Michigan Premier Public Health Conference