# Kent County Infant Health Initiative

*Community Action Plan*

December 2005

HEALTH DEPARTMENT

*Caring today for a healthy tomorrow*

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# Introduction

In the spring of 2005, the Kent County Health Department received a grant award from the Infant Mortality Initiative of the Michigan Department of Community Health (MDCH). The grant funded the development of an infant mortality coalition and preparation of a community action plan to reduce infant mortality, particularly for African Americans. Kent County is one of eleven Michigan counties that received the grant due to high disparities between African American and white infant survival.

All grantees were asked by MDCH to take a fresh, innovative look at how to reduce the continuing gap between African American and white infant survival. If we are to narrow the gap in survival, we need a comprehensive strategy that addresses not only access to high-quality health care, but also adverse social and economic conditions that are risk factors for infant mortality.

In Kent County, the MDCH grant was seen as an opportunity to create a community action plan, building on existing efforts, that would be shaped by engaged and mobilized community members and owned by all sectors of the community. Kent County has a strong history of collaboration among organizations serving women, infants, and families, as demonstrated by the broad membership of Healthy Kent 2010 (see Appendix A for roster). Representatives from the public health department, area hospitals and health care organizations, human services providers, local business, the faith community, and the community at large comprise the Healthy Kent 2010 partnership, which is devoted to identifying common concerns, taking concrete steps to address those concerns, and sustaining a community-wide focus on building a healthy community.

One of the five priorities of Healthy Kent 2010 is infant health. The Infant Health Implementation Team (IHIT) has taken many steps to address the racial disparity in infant health survival in Kent County, responding to the data reported to the community by the Kent County Health Department and the analysis provided by the Fetal Infant Mortality Review (see Appendix B for the IHIT roster, FIMR roster and funders, and background on infant mortality). Initiatives such as Strong Beginnings, the Nurse-Family Partnership, and many other community-based programs, services, and efforts all contribute to a strong foundation for the intensified community action needed to increase the survival and health of all infants and to reduce the gap in the survival of African American infants.

The following steps were taken between May and October 2005 to meet the requirements of the state grant to address infant mortality. The Kent County Health Department contracted with Public Sector Consultants (PSC) to help design a community process that would quickly lead to an action plan for a Kent County Infant Health Initiative. Key steps included:

1. The Kent County Health Department and the leadership of the IHIT prepared a work plan for a Kent County Infant Health Initiative (IHI) that would meet the requirements specified by MDCH.

2. The work plan included the following key activities:

a. A community analysis, including a review of the data on infant mortality, community conversations to inform and to obtain the perspectives of community members, key informant interviews, and focus groups. The focus groups were conducted according to a protocol provided by MDCH.

b. A community summit to review the community analysis findings and to identify strategies and actions to address the barriers to healthy pregnancies and infants.

3. The IHIT met to review and refine a draft community action plan prepared by PSC. The IHIT then made the draft community action plan available on the Healthy Kent 2010 website and hosted two meetings for community summit participants to confirm that their ideas were reflected and to elicit their ideas for strengthening the plan. Based on the community review, PSC finalized the community action plan for review and approval by the IHIT and submission to the Kent County Health Department and MDCH.

# Summary of Proposed Actions

The 12 actions proposed by the community plan are summarized below. For details, see "Community Action Plan Recommendations," page 15.

## EDUCATION

1. Create a health improvement and pregnancy prevention education program for children and adolescents from school entry to graduation that can be used in multiple community settings

2. Enlist the local media in developing and delivering appropriate and consistent educational messages to children and adolescents and the entire community

3. Review and strengthen the community's programs that provide education to families

## COMMUNITY INVOLVEMENT AND LEADERSHIP

4. Convene a multigenerational community summit on preventing unplanned pregnancy to engage both community members and leaders of organizations from multiple sectors, e.g., business, education, the faith community, philanthropy, health care, public health, human services, and the media

5. Enlist the Grand Rapids African American Health Institute and other organizations in efforts to go beyond the traditional community leaders and promote the identification of leaders within the African American community

6. Continue the "community conversations approach in community-based settings, e.g., faith-based organizations and homes, to expand the dialogue about infant mortality and the strategies and actions under way and needed

## WOMEN- AND FAMILY-FRIENDLY COMMUNITY SUPPORTS

7. Inform both providers and recipients about the effects of racism and the quality of care provided and received

8. Create a mechanism for recipients of health care and health care providers to report and address poor quality and racist encounters

9. Establish a single, centralized contact for uninsured people who are seeking health care

10. Assess and strengthen the communication among organizations and agencies to improve the effectiveness of community supports for pregnant teens and women

11. Assess and strengthen the adequacy of transportation, access to nutritious food, and employment services for pregnant teens, women, and parents to improve the effectiveness of community supports to meet basic needs

12. Increase the capacity of existing programs to enhance the community's supports for pregnant teens, women, and their families

# Community Systems Analysis

The MDCH grant required completion of a "community systems analysis," which the Kent County Infant Health Initiative (IHI) defined as having the following key components:

- Reviewing the status of infant survival and populations at risk, using the most current findings and recommendations from the Kent County Fetal Infant Mortality Review and the Perinatal Periods of Risk (PPOR) analysis from the MDCH, which was updated by the Grand Rapids Medical Education and Research Center
- Engaging community members, agencies, and organizations in identifying barriers to healthy pregnancies and infants and the necessary and desirable community supports and services to address those barriers, including health care but not solely focused on health care

The following describes the process used to complete each aspect of the community systems analysis and the findings.

## REVIEW OF THE STATUS OF INFANT SURVIVAL AND IDENTIFYING POPULATIONS AT RISK

The Perinatal Periods of Risk (PPOR) analysis is a method for investigating and monitoring causes of fetal and infant deaths.[1] Fetal deaths are stillbirths (with a gestational age of 24 weeks or more) and infant deaths are deaths at less than one year of age of babies born alive. By analyzing the weight and age at death, PPOR provides an analysis that points to prevention and intervention strategies. The PPOR approach divides fetal and infant deaths into four risk intervention categories: maternal health/prematurity, maternal care, newborn care, and infant health. For each category, there are interventions that can promote healthy birth outcomes.

The MDCH provided each of the 11 grantees in the Infant Mortality Coalition Network with an analysis of its county's PPOR for the period 1998–2002. The Grand Rapids Medical Education and Research Center updated the PPOR analysis for Kent County African American population to include the most recent year of data (see table below). The PPOR analysis compares feto-infant death rates in the county to a reference group with a relatively low feto-infant mortality rate. By comparing a county's death rates to those of the reference group, the excess deaths in each of the four categories of risk can be determined. By examining the excess rate in each category, the best opportunities for reducing feto-infant mortality in the community can be identified. Kent County's PPOR is as follows:

[1] Developed by Dr. Brian McCarthy, Centers for Disease Control and Prevention.

| Perinatal Periods of Risk: African Americans, Kent County, 1999–2003 | | | |
|---|---|---|---|
| | Maternal Health/Prematurity | | |
| Excess Mortality Rate | 6.3 | | |
| Excess Deaths | 35.0 | | |
| | Maternal Care | Newborn Care | Infant Health |
| Excess Mortality Rate | 0.9 | 1.4 | 3.5 |
| Excess Deaths | 5.0 | 8.0 | 20.0 |

SOURCE: Grand Rapids Medical Education and Research Center.

The largest gap for African Americans in Kent County compared to the reference group is in the maternal health/prematurity risk category (i.e., an excess feto-infant mortality rate of 6.3). The next largest gap is in the infant health risk category (an excess rate of 3.5), followed by the newborn care category (an excess rate of 1.4).

Based on the PPOR analysis, Kent County should work on strategies to improve maternal health, prevent prematurity, reduce low birth weight, and improve infant health. The PPOR also suggests that the target populations for the maternal health/prematurity risk category should be childbearing age women, women with unintended pregnancies, pregnant women who smoke and/or may be substance abusers, and women in need of access to specialized perinatal care. The target populations for the infant health risk category should be infants at risk of suffocation and SIDS, poor nutrition, and unsafe home environments.

Community members who participated in the September 29 *Kent County Infant Mortality Community Summit, Giving Birth to Hope and a Future*, reviewed key information about the status of infant survival in Kent County, including the 2004 findings and recommendations from the Fetal Infant Mortality Case Review Team to the IHIT, which serves as Kent County's Fetal Infant Mortality Community Action Team. (See Appendix C for the community summit slide presentation.) In this way, fetal and infant mortality data was analyzed and translated into information that could lead to community action.

## COMMUNITY IDENTIFICATION OF BARRIERS TO HEALTHY PREGNANCIES AND INFANTS AND THE NECESSARY AND DESIRABLE COMMUNITY SUPPORTS AND SERVICES TO ADDRESS THOSE BARRIERS

The IHI carried out this part of the community systems analysis by directly engaging community members in conversations, conducting key informant interviews, and hosting a community summit. Also, preliminary observations were provided to the IHI by Renee Canady, consultant to the Michigan Infant Mortality Initiative, from two focus groups conducted by Teresa Branson, Kent County Health Department, one with adolescent parents and one with adult women of childbearing age. The findings from the community conversations, key informant interviews, and the focus group with adolescent parents

were presented at the *Kent County Infant Mortality Community Summit* on September 29, 2005. Community summit participants reviewed the findings before they identified actions that would have an impact on infant mortality, key steps that should be taken, and who must be involved. Strategies and actions proposed in the community action plan are based on the ideas that emerged at the summit, the findings from the community conversations, key informant interviews, and focus groups, and the review of data on infant survival in Kent County, including FIMR findings and recommendations. The findings from the community conversations, key informant interviews, focus groups, and the summit dialogue are summarized below.

## COMMUNITY CONVERSATIONS

Fifteen community conversations with a total of 183 participants occurred between August 16 and September 12, 2005, throughout the City of Grand Rapids. With the assistance of PSC, the Kent County Infant Health Initiative developed guidelines and tools (i.e., facilitator script, background information, conversation record, and sign-in sheet) for the community conversations and provided funding and training for facilitators and recorders from community-based organizations. A report detailing the themes that emerged from the conversations is found in Appendix D. Attachment A in that report lists the organizations that conducted the conversations. A compilation of the community conversations is available from Teresa Branson, Kent County Health Department, 616/ 632-7241. The themes are summarized below, under each question addressed in the conversations.

### *1. What stands out for you in the background information that has been shared?*

- There are so many complex factors associated with infant mortality.
- It is shocking that the chance of African American babies dying is three times greater than for white babies.
- It is discouraging and frustrating that Kent County has such a high infant mortality rate for both African American and white infants.
- Many women do not get adequate prenatal care, which is important for a healthy pregnancy.
- It is surprising to hear that there is a resource guide and screening tools, and that services are available.

### *2. Why do you think the rate of infant death is so high in Kent County? Why do you think it is particularly high for African American infants?*

- Lack of prenatal care and differential treatment due to income, race, and age
- Lack of education and communication
- Racism and lack of respect for African American women
- Personal behaviors
- Babies having babies

- The lack of support for proven programs, especially prevention
- Community attitudes

***3. What stands in the way of people having healthy pregnancies and raising healthy babies?***

- Lack of access to health care and poor continuity and quality of care
- A multitude of risk factors
- Lack of knowledge and understanding
- Lack of resources
- Poor communication
- Racism
- Lack of pregnancy planning and denial
- Lack of community resolve to address the issue

***4. The review of infant deaths shows that multiple stresses, mental illness, alcohol and drug use, smoking, violence, poor social support, lack of transportation, and difficulty accessing services are factors in infant deaths. What is working in our community to help women and families address these issues?***

- The programs and activities of community-based organizations that are helpful
- Positive messages from the media
- Community conversations and broad involvement

***5. In the background information some current efforts are identified. What else could be done to improve the health of mothers and babies, particularly African Americans?***

- More education and information
- More programs and services
- Addressing underlying social issues, such as racism and poverty, and increasing our understanding of why infant mortality occurs
- More caring by the community and broader community engagement in action
- More involvement and mentoring of fathers

***6. What stands out as the first step we need to take and who needs to be involved?***

- Expand community-wide involvement and action
- Provide more education
- Provide more prevention and early intervention programs and resources

## KEY INFORMANT INTERVIEWS

Individual interviews were conducted with 10 key community informants who are in positions of authority or influence in a variety of organizations and agencies in Kent

County. A set of questions was used to find out what key informants think needs to change in this community to keep mothers and infants alive and healthy, with a focus on reducing the disparity in survival between African American and white infants. The themes are summarized below, under each question asked during the interviews. A detailed summary of findings is available from the Kent County Health Department (616/632-7281).

Overall, the informants were aware of the community's work in the area of infant mortality and felt that the professional health care providers were aware of the data about infant mortality. They pointed out that Kent County, as well as many of their organizations, has been engaged in initiatives to address infant mortality for a number of years. Nearly all said that the Kent County community should be embarrassed or ashamed that they tolerate this situation: "How can this go on in a community that cares about its kids?" Some said that the issue is not awareness, but the need to move beyond awareness to intervention to goal; there is a need to focus on consolidating all that we know and implementing systemic interventions and measuring results.

### *1. What do you see as barriers or issues associated with women having healthy pregnancies and deliveries in this community?*

- Most commonly cited barriers
  - Access to care
  - Poverty related stressors and their impact on women
  - Lack of cultural competency/cultural sensitivity
  - Transportation
  - Lack of knowledge of importance of prenatal care and preconception health
- Not all of the disparity is a function of poverty—all African Americans experience higher rates of infant mortality
- Lack of resources for mental health and substance abuse, domestic violence prevention, and transportation
- Generational characteristics of both poverty and infant mortality
- Sources of frustration:
  - Successful programs are not brought to scale
  - No change in statistics over the years
  - Need to address and eliminate poverty without blaming the poor

### *2. What supports—both formal and informal—do women have in this community in order to have healthy pregnancies and to deliver healthy infants?*

- Extended families and churches—but they need access to timely, accurate information
- Various programs in the county (e.g., Healthy Start, hospital programs, Planned Parenthood, maternal support services, Strong Beginnings, community clinics, WIC)

- Some employers that have family-friendly policies and practices (e.g., transportation for employees, accommodations for breast feeding on the job, supportive, nonrestrictive hiring policies without stereotyping, access to child care and family leave)

### *3. What do you see as barriers or issues associated with parents providing healthy environments for their babies during the first year of life?*

- Violence, substance abuse and other mental health factors, smoking, lack of housing, low wages, access to insurance and health care, the effects of welfare to work policies on mothers without adequate childcare
- Overall effects of concentrated poverty
- Amount and quality of social support
- Racism, cultural insensitivity
- Intolerance and a perception that conditions are the fault of the mother: "Society is not supportive."

### *4. What supports—both formal and informal—do parents in this community have in order to provide healthy environments for their infants?*

- Everything is out there, but many services are complex to access.
- There has been an insurgence of new resources in the past few years, but there may not be a natural avenue for African Americans to participate (e.g., if they are not low income, they may not think a service pertains to them).

### *5. To what extent do you think the community is involved in supporting women at risk of an infant death, and who do you think are the key players that need to be involved in supporting the health of mothers and babies, and parents of infants?*

- The community has been talking about it for 20 years, but we have not seen a change.
- The hospitals and health community are spearheading several efforts.
- Basic attitudes in the community are not supportive—there is a lack of understanding of the issues people are dealing with due to the gulf between the "haves" and "have nots."
- The faith community is a powerful source of actual or potential support, but they can also be part of the potential community-wide barrier.
- Health care and community development has focused on specialty medical centers, but missed community needs for preventative health and mental health care and support for women and children.
- An issue like this is epidemic so it is a community responsibility throughout the community. Key players need to include parents, grandparents, church leaders, elected leadership, health department, and hospitals—a combined effort gets the best results.

- We have to figure out what we want people to do, what is the best way for the community to help? When a true need is shown and people are shown what to do, the community steps up.

### *6. What is the best way to identify and reach women who are at high risk for poor pregnancy outcomes (i.e., premature birth, low birth weight, infant death)?*

- Ask the women themselves; go to where the women are.
- Increase awareness and willingness of women to seek care so they can be seen before there is a problem; provide a friendly climate of services.
- Encourage providers to screen for medical, social, and economic risk factors.

### *7. What steps can be taken, and who needs to participate, to better use our community's assets and step up our efforts to reduce infant deaths overall and the disparities in survival between African American and white babies?*

- Increase understanding of long-term implications
- Move beyond awareness to action; create a call to action. If it is a priority as a community issue, rather than a women's issue or an African American issue, it can't be ignored.
- Share more information about what works and proofs from practice
- Bring proven interventions to scale and focus on prevention
- Implement systemic solutions based on scientific data and best practice and sustain them
- Money is not the only solution
- Government should be the catalyst to change; private and nonprofit sectors must deliver needed services
- Grassroots organizations have to step up; they need to be advocates and collaborators. Community organizations can take ideas and meld them into efforts that can be tested to help frontline agencies have more effect.
- Go beyond the traditional community leaders and let the community define its leadership
- Give everyone in the community something they can do as individuals

### *8. What should we be monitoring to track our progress in improving pregnancy outcomes and reducing disparities?*

- Gather specific data about birth outcomes, course of pregnancy, and service use from women
- Gather data on number of pregnancies, characteristics of the population groups, risk factors, causes of death, preconception and prenatal care characteristics
- Identify the women at highest risk and monitor them closely throughout their pregnancy
- Gather information on the births that did not result in poor outcomes (e.g., behaviors that prevent a child from dying)

- Take time to construct meaningful data that measures our objectives with measures that are sustainable over time

## FOCUS GROUPS

Two focus groups were conducted with African American women of varying ages who had experienced pregnancy. Following a focus group protocol provided by the Michigan Department of Community Health, women were asked about their experiences before, during, and after pregnancy. A full report of focus group findings will be provided to each of the 11 grantees, including Kent County, at a later date. The following preliminary observations were presented at the Kent County Community Summit on September 29.

- Planned pregnancy
  - Less likely for African American women
  - Neglecting to plan is a type of planning (if you know you can get pregnant and don't do anything to prevent it, that is planning)
  - Most expressed negative emotions surrounding their reaction to learning that they were pregnant
- Role of race
  - Participants consistently described extreme experiences of care that they perceived as neglectful or different
  - Noted inability to advocate for personal needs when the system failed to assess their needs
  - Noted lack of awareness or understanding of cultural/racial needs
- Role of economics
  - Noted differential treatment by insurance type
- Perceptions of care
  - Most women shared some incident of unacceptable care
  - Most women were satisfied with the care their children received

## ACTIONS DEFINED AT THE COMMUNITY SUMMIT

At the September 29 community summit, 124 participants reviewed key facts about infant mortality in Kent County and the findings from the community conversations, key informant interviews, and focus groups. Participants were then asked to have a dialogue in 20 small groups to identify actions that would have an impact on infant mortality, with a focus on reducing the gap in survival for African American infants compared to white infants. They also identified at least one key step that should be taken and who must be involved. The actions identified in the small group dialogue fall into three categories:

- Educating individuals and the community as a whole
- Involving the community and expanding community leadership
- Supporting and caring for women and families—"a woman- and family-friendly environment" in our community

A compilation of the actions and key steps identified appears in Appendix E. One report from the small group dialogue admonished “stop talking and start doing; no more talk.”

# Community Action Plan Recommendations

This community action plan recommends a goal, three objectives to help reach the goal, a strategy and actions needed to help reach each objective, and a method for measuring and monitoring results. The objectives reflect the three categories of action that emerged from the community summit. The strategies and actions are based on the summit dialogue, community conversations, key informant interviews, focus groups, and the analysis of fetal and infant mortality data. Existing efforts in the community are briefly highlighted in Appendix F, along with information that confirms that these efforts are consistent with best practices from the research literature. In this way, the community action plan presents the convergence of the community's concerns and interests and the existing efforts under way in the community—efforts that can be built upon to carry out the proposed actions through a mobilized community.

The highlights included in Appendix F do not include all existing programs, services, and initiatives; rather they include community-wide initiatives to strengthen collaboration among organizations serving pregnant women and to improve the health care system. Once the strategies and actions proposed by this community action plan are finalized, existing programs, services, and initiatives can be considered as assets in carrying out the plan, as well as any additional funding, e.g., a grant from the Michigan Department of Community Health. Based on the finalized actions and the resources directed to those actions, a work plan can then be developed, presenting a timeline for implementation, "deliverables," and responsible parties (see page 21, for recommendations on monitoring progress).

Before reviewing the proposed strategies and actions, it is important to acknowledge the principles that emerged from the comments of community members who participated in the community summit on September 29. These principles are cross cutting and apply to all proposed strategies and actions:

- The community should provide support to mothers as long as they desire those supports
- Leadership from the African American community should be directing efforts to help African Americans
- Young people should be part of all the steps we take to reduce infant mortality and other community problems
- We need to have the same love and respect for our neighbor as we have for ourselves

## GOAL, OBJECTIVES, STRATEGIES, AND ACTIONS

The goal of the community action plan is to reduce infant mortality overall in Kent County and reduce the disparity in survival between African American and white infants.

Progress toward the goal can be achieved through the following objectives.

- Objective 1: Educate individuals and the community as a whole
- Objective 2: Involve the community and expand community leadership

- Objective 3: Create "a woman- and family-friendly environment" in our community

### *Objective 1: Educate individuals and the community as a whole*

**Strategy**: Many community members identified the importance of improving education for individuals and for the community as a whole if we are to reduce infant mortality, particularly for African Americans. ***Increasing education efforts was consistently noted in the community conversations, the key informant interviews, and the community summit as a first step in reducing infant mortality.*** Several noted the importance of education at all levels, focused on children and adolescents, African American women, families, and the entire community. The following actions are proposed.

1. ***Create a health improvement and pregnancy prevention education program for children and adolescents from school entry to graduation that can be used in multiple community settings***

   The schools, faith-based organizations, local colleges and universities, and the Grand Rapids African American Health Institute should join forces to strengthen the education of children and adolescents by developing and implementing an age-appropriate curriculum for an education program for kindergarten through grade 12. Existing models and curricula should be reviewed for potential use. The education program should be designed so that:

   a. The key topics are healthy personal behaviors, family health, the risks of unplanned pregnancy, and infant mortality

   b. The information presented emphasizes ("boosts") self-respect and self-esteem, makes clear the choices confronted by children and adolescents, addresses both prevention and abstinence in order to reduce unplanned pregnancy, and describes the effects of racism

   c. Young people participate in the development and delivery of the educational program, with older adolescents placed in the position of informing and mentoring their younger peers, because children listen to their older peers. Beginning by using college students as mentors, the program would create a way for younger adolescents and children to move into mentoring roles over time and equip many adolescents in the community to be sources of information and support for their peers. Educational credit should be given to adolescents who deliver the program and/or the experience should be considered a way to meet a community service requirement.

   d. Schools, faith-based organizations (e.g., through parish nurses), and other community-based organizations can easily adopt the program by integrating it into existing health, family life, and spiritual education programming so that as many children and adolescents as possible in the community receive age-appropriate and consistent information and messages

e. Parents can participate as they now do in some of the existing sex education programs now under way in local schools

f. The program has a specific empowerment component for young, African American women focused on (a) unplanned pregnancy, (b) how to plan after becoming aware of pregnancy, and (c) the resources available to them, e.g., financial help. The program should help assure that young African American women receive the information that will help them get proper care and equip them to advocate for themselves to get the treatment and care they need.

g. The information presented by the program is based on evidence-based practices regarding educational content and delivery methods

2. ***Enlist the local media in developing and delivering appropriate and consistent educational messages to children and adolescents and the entire community***

Many community members said that positive messages from the media work. Radio, television, and other media should be enlisted in developing and delivering more educational messages to reach children and adolescents. The messages should be consistent with and drawn from the education program described in action #1 above, reinforcing the education program being delivered in multiple community settings, e.g., schools, after-school programs, church activities, etc. The advertising and messages we send should be about the community norm, not the "reality" of television and videos. The messages should be simple, repetitive, and catchy, perhaps in rap or delivered by local celebrities.

In addition to more messages designed specifically for children and adolescents, messages must be delivered to the community overall. The community conversations and the key informant interviews frequently cited community attitudes as ***standing in the way of healthy pregnancies and healthy infants***, i.e., there is intolerance and a perception that conditions are the fault of the mother; "society is not supportive." To influence these community attitudes, public service announcements, radio programs, and other efforts should be directed to the entire community about the issue of infant mortality. These efforts should present the statistics and what we as a community are doing about them, emphasizing the importance of healthy pregnancy and infants as a community priority. This information needs to be shared broadly, using messages that will get the facts to the community ("push awareness of the statistics"), using words that are clear and used by the community (e.g., "locked up versus incarcerated").

3. ***Review and strengthen the community's programs that provide education to families***

Existing programs that provide education to families (males included) should be reviewed to assure that the programs are nonjudgmental, emphasize prevention of unplanned pregnancy, and include follow-up and continued outreach. Educational events should also be offered in places where families congregate, e.g., offer passes to those who attend interactive educational sessions at the zoo, water parks,

or miniature golf courses. The community needs more family education programs and activities that bring families together to learn and grow, such as "FAST," a program that strengthens families.

### *Objective 2: Involve the community and expand community leadership*

**Strategy:** Community members said repeatedly that another first step must be to involve the entire community in the effort to reduce infant deaths and that the individuals who lead institutions and organizations must play stronger roles. Key informants hold similar views, indicating that everyone in the community should have something they can do as an individual and that infant mortality must be seen as a community priority, rather than a women's issue or an African American issue. The following actions are proposed.

4. ***Convene a multigenerational community summit on preventing unplanned pregnancy to engage both community members and leaders of organizations from multiple sectors, e.g., business, education, the faith community, philanthropy, health care, public health, human services, and the media.***

   Use the summit to bring the community action plan to life by establishing community action teams that help community members participate in carrying out the plan, with the support of community organizations, agencies, and institutions. Use the summit to launch the community action teams as a way to expand the involvement of families, churches, schools, health care providers, businesses, the media, and others in addressing the challenge of infant mortality—it will take more compassion and caring by the community and many more people speaking up ("thanks for the guide, but it takes all of us").

   The summit should be structured so that what people and organizations can do becomes clearer. As key informants said, "We have to figure out what we want people to do, what is the best way for the community to help? When a true need is shown and they are shown what to do, the community steps up." The summit could showcase supportive and effective examples within each sector of the community. For example, as noted in one key informant interview, some employers have family-friendly policies and practices (e.g., transportation for employees, accommodations for breast feeding on the job, supportive, nonrestrictive hiring policies without stereotyping, and access to child care and family leave). Examples of supportive and effective policies and practices could be highlighted as a way to promote similar actions by more members of the business community.

   Prior to the multigenerational summit, the leaders of organizations and institutions in this community must be prepared to participate more actively and to speak out about the issue so we can raise concern on a long-term basis ("don't let this forum be the only time we talked about this problem"). Let's have "straight talk to key players—the same conversation we had here should be shared in the board rooms, using the same language."

5. ***Enlist the Grand Rapids African American Health Institute, the Urban League, NAACP, the Nation of Islam, and African American sororities and fraternities***

***in efforts to go beyond the traditional community leaders and promote the identification of leaders within the African American community.***

One approach is to have informal meetings with women's groups in churches or in homes and provide mentoring and monetary support for them to participate actively as leaders in community action teams. Other communities, e.g., Pontiac, that have undertaken similar activities should be contacted for information and lessons learned.

6. ***Continue the "community conversation" approach in community-based settings, e.g., faith-based organizations and homes, to continually expand the dialogue about the issue of infant mortality and about the strategies and actions under way so that "we can in fact wake up to the reality and do something about infant mortality."***

   In this way, more community members will be informed and mobilized to participate in the actions identified as needed by the community. As one participant in a community conversation said, "We need to have more discussions like this that are intentional…we need to spend more time discussing the issues that affect us…the African American community." Community conversations focused on and with adolescents should be conducted, working with youth pastors and high school counselors to identify youth participants. A first step is to form an action team to continue the community conversations.

### *Objective 3: Support and care for women and families—create "a woman- and family friendly environment" in our community*

**Strategy:** Community members identified actions that would lead to a more "woman- and family-friendly environment." The actions fall into two main categories: improving health care access and quality and improving the effectiveness of support in the community for pregnant women, especially teens, and their families.

7. ***To improve health care quality a new initiative should be undertaken to inform both providers and recipients about the effects of racism and the quality of care provided and received.*** The initiative should disseminate the following information, particularly to parents, and enlist physicians in promoting the use of the screening tool provided in the Kent County Pregnancy Resource Guide:

   a. The type of care that pregnant women should expect to receive—in the words of a community member, now "you have to cry to get resources"

   b. The effects of racism and the importance of respect, compassion, cultural competency, the importance of supporting pregnant women to become actively involved in planning and decision making ("listen to me—be supportive—don't judge me"), and supporting—and expecting—men's involvement in prenatal care ("the partner is often the first one to see a mother's depression")

   c. The importance of more in-depth assessment during prenatal check ups, assuring that health care providers are using the screening tool provided in

the Kent County Pregnancy Resource Guide to determine what health and social services are needed and making sure that women are asked about barriers to care

Before this information is more broadly disseminated to parents and providers, a another core concept of prenatal care should be added, i.e., that every pregnant woman should be asked whether she wants her partner involved in her care, and, if so, every effort must be made to welcome and include her partner as much as possible.

In addition, continuing medical education credits should be established for cultural competency training.

8. ***To improve health care quality, a mechanism should be created for recipients of health care and health care providers to report poor quality and racist encounters.*** An example that could serve as a model for the development of such a mechanism is the recipient rights program in Michigan's community mental health services agencies. This model could be adapted for both prenatal care and support services, particularly the procedures for making and following up on complaints, including sanctions. The mechanism should also include a process, perhaps several, for informing and educating providers as a follow-up to complaints. The Grand Rapids African American Health Institute might consider leading a community action team to conduct follow-up activities.

   Once established, the public should be educated about the mechanism and how to use it when they have negative experiences.

9. ***To improve health care access, a single, centralized contact should be established for uninsured people who are seeking health care.***

10. ***To improve the effectiveness of community support for pregnant teens and women, communication among organizations and agencies should be assessed and strengthened so that health care and support services are better connected to meet people's needs.***

11. ***To improve the effectiveness of community support to help residents meet their basic needs (such as transportation, access to nutritious food, health care, and employment services), services should be assessed to assure that the specific needs of pregnant teens and women and mothers and fathers are addressed***. For example, Work First should require education of both individuals and service providers about planned and healthy pregnancies and the risks for infant mortality and should consider participation in programs as a way to meet work requirements. Also, to increase access to health care, the number of physicians who serve Medicaid recipients must be increased.

12. ***To enhance the community support for pregnant teens, women, and their families, the capacity of the following programs should be increased, as stated in the key informant interviews, "bring proven interventions to scale and increase prevention":***

a. Community outreach to increase access to prenatal care, using a diverse workforce of outreach workers, including men to connect with other men in the community

b. The Nurse-Family Partnership Program

c. The DADS program and Sankofa (Strong Beginning's dads program, if the pilot is successful)

d. Programs and services that help women improve their health (e.g., healthy diet, exercise, stress reduction)

## RECOMMENDED METHOD FOR MEASURING AND MONITORING PROGRESS

The following method should be used to measure and monitor the progress of the Kent County Infant Health Initiative. The method builds on the strong foundation of the work done by the Fetal Infant Mortality Case Review Team to help identify the issues associated with infant mortality in the community and the recommendations of the Healthy Kent 2010 Infant Health Implementation Team to address those issues in order to prevent future deaths. Key components of the method are as follows.

- The Healthy Kent 2010 Infant Health Implementation Team (IHIT) should prepare a work plan that describes the activities and time frame for implementing the actions proposed in this community action plan, building upon and refining existing initiatives and based on an assessment of the external and internal resources available to the community during 2006 and, as much as possible, beyond 2006.
- The IHIT should select measures that will help assess the progress of the work plan, including measures that indicate movement toward the objectives. The community action teams or work groups established to carry out the work plan should participate in the selection of those measures.
- The IHIT should establish a target for the reduction of the overall infant mortality rate and a target for the reduction of the gap in survival between African American and white infants. Target setting should be based on the ongoing Fetal Infant Mortality Review and the degree of implementation of the community action plan and any other recommendations from the Community Action Team that are implemented. The IHIT should apply the methodology for target setting promoted by Healthy People 2010 and the Michigan Department of Community Health.
- The IHIT should routinely and broadly disseminate information on the status of infant mortality, the actions under way, and progress toward the goals and objectives presented in the community action plan.

# Appendix A:
## *Healthy Kent 2010 Roster*

Lawrence Baer, PhD

Wayne Boatwright (Chairperson)
*St. Mary's Health Care*

J. Daniel Castro
*Azul Communications*

Barbara Hawkins Palmer (Coordinator)
*Kent County Health Department*

Ray Hoag, EdD

Andy Johnston
*Grand Rapids Area Chamber of Commerce*

Mary Kay Kempker-Vandriel, PhD
*Spectrum Health Healthier Communities*

Jane Konyndyk
*Deputy Director Program Services*
*Network 180*

Tom Peterson, MD
*Spectrum Health Healthier Communities*

Andre L. Pierre, Jr.
*Metropolitan Hospital*

Cathy Raevsky
*Kent County Health Department*

Beth Rogers, RN, MPA (Past Chair)
*Clinical Director*
*Peter C and Pat Cook Hospice Center of Holland Home*

Evert Vermeer

# Appendix B:

*Healthy Kent Infant Health Implementation Team 2005 Roster, Fetal Infant Mortality Review Roster and Funders, and Background on Infant Mortality*

## HEALTHY KENT INFANT HEALTH IMPLEMENTATION TEAM 2005 ROSTER

| Name | Organization |
|---|---|
| Kristin Gietzen | Arbor Circle Corp. |
| Emmy Ellis | Arbor Circle Corp. |
| Marguerite Morgan | Arbor Circle Corp. |
| Cathy Worthem | Arbor Circle Corp. |
| Nancy Renn | Booth Family Services |
| Kathy Bremer | Calvin College |
| Nathan Tonlaar | Calvin College |
| Genice Carde | Cherry Street Health Services |
| Rosalyn Bliss | Child & Family Resource Council |
| Bev Crandall | Child & Family Resource Council |
| Deborah Pitsch | Child & Family Resource Council |
| Makini Clifford | Community Representative |
| Ronnie VanBuran | Community Representative |
| Mary Williams | Community Representative |
| Betsy Boggs | Connections for Children |
| Dareather Greer | Delta Sigma Theta Sorority |
| Pat Crum | DeVos Children's Hospital |
| Marcy Rosen | Family Outreach Center |
| Joseph Moore | Fetal Infant Mortality Review |
| Peggy Burns | Gerontology Network |
| Jeana Huff | Gerontology Network |
| Carolyn E. Priester | Gerontology Network |
| Vicki Suliin | Gerontology Network |
| Bonita Agee | Grand Rapids African American Health Institute |
| Caroline Pyle | Grand Rapids African American Health Institute |
| Jennifer Raffo | Grand Rapids Medical Education and Research Center |
| Melissa Kuiper | Health Plan of Michigan |
| Nadia Brigham | Heart of West Michigan United Way |
| Regina Brookens | Higher Hope International Ministries |
| Will Page | Higher Hope International Ministries |
| Joe Jones | Jones, Gavin and Helmholdt, LLC |
| Michelle Seigo | Kent County Department of Human Services |
| Fran Compo | Kent County Department of Human Services |
| Carole Paine-McGovern | Kent County Family and Children's Coordinating Council |
| Dianna Baker | Kent County Health Department |

| | |
|---|---|
| Janis Coil | Kent County Health Department |
| Barb Hawkins Palmer | Kent County Health Department |
| Shanell Merriweather | Kent County Health Department |
| Bobby Peacock | Kent County Health Department |
| Karyn Pelon | Kent County Health Department |
| Cathy Raevsky | Kent County Health Department |
| J. J. Scott | Kent County Health Department |
| Sue Sefton | Kent County Health Department |
| Leslie Spurrier | Kent County Health Department |
| Sandy Walls | Kent County Health Department |
| Erin McGovern | Kent Intermediate School District |
| Mary Landale | March of Dimes |
| Cheryl Lauber | Michigan Department of Community Health |
| Paulette Dunbar | Michigan Department of Community Health |
| Kimberlee Miller | Metro Health Hospital—Breton Center |
| Julie Bonewell | Metron Home Health |
| Renee Canady | Michigan State University |
| Shelby Berkowitz | Michigan State University |
| Stephanie Snyder | Native American Community Services |
| Darlene VanOveren | Native American Community Services |
| Kim McCovey | Network 180 |
| Lisa Oliver-King | Our Kitchen Table |
| Katherine Humphrey | Planned Parenthood Center West Michigan |
| Suzy Reiter | Planned Parenthood Center West Michigan |
| Gloria Oosterhouse | Pregnancy Resource Center |
| Connie Warners | Pregnancy Resource Center |
| Michael Reagan | Project Rehab |
| Tenetia Pulliam | Salvation Army |
| Sarah MacDonald | Spectrum Health |
| Sue Mallow | Spectrum Health |
| Evelyn Philippi | Spectrum Health |
| Laura Zuidema | Spectrum Health OB Speciality Clinic |
| Ana Contreras | St. Mary’s Health Care |
| Sandy Wesorick | St. Mary’s Health Care |
| Pam Chapman | St. Philips Episcopal Church |
| Yvette McCutchen | Strong Beginnings |
| Peggy Vander Meulen | Strong Beginnings |
| Joanne McKenzie | United Methodist Community House |
| Kimberely Spencer | United Methodist Community House |
| Michelle Scott | Voices for Health |
| Denice Logan | West Michigan Medical Society |

## FETAL INFANT MORTALITY REVIEW ROSTER AND FUNDERS

Dr. Barbara Bradley
*Obstetrician*
*Spectrum Health*

Rhondo Cooper, MSW
*Invictus Program*
*Spectrum Health*

Tracy Cyrus, MSW
*Social Worker*
*DeVos Children's Hospital*

Dr. Mitchell DeJonge
*Neonatologist*
*DeVos Children's Hospital*

Rosemary Fournier, RN
*State FIMR Coordinator*
*Michigan Public Health Institute*

Colleen Jillson
*Nursing Supervisor*
*Kent County Health Department*

Cindy Hagerup, MSW
*MSS Coordinator*
*Breton Health Center*

Anne Logan, MSW
*Social Worker*
*Spectrum Health*

Sarah E. MacDonald, RN
*FIMR Coordinator*

Dr. Joseph Moore
*Obstetrician and FIMR Co-Director*

Lisa Oliver-King, MPH

Mary Paepke, RN
*Kent County Health Department*

Dr. Vincent Palusci
*Pediatrician and FIMR Co-Director*
*DeVos Children's Hospital*

Dr. Leonard Radecki
*Neonatologist*
*DeVos Children's Hospital*

Det. Sgt. Jack Stewart
*Kent County Sheriff Department*

Helga Toriello, PhD
*Geneticist*
*Spectrum Health*

Jarma Wells, MSW
*Social Work Supervisor*
*Metro Health Hospital*

### *Funders*

Kent County Health Department
Metro Health Hospital
Priority Health
Spectrum Health
St. Mary's Healthcare

## BACKGROUND ON INFANT MORTALITY

- The death rate for infants in the first year of life is often used as an indicator of the health and social well being of a community.

- While infant death rates have declined over the last 20 years for all population groups, there continues to be an alarming difference between the death rates for black and white infants.

- This difference exists at the national level and in our state. Kent County has a high infant mortality rate overall and is one of the counties in Michigan with the largest disparity: *the chance of dying before their first birthday is three times higher for black infants in Kent County*, compared to white infants.

- The direct *causes* of infant deaths are birth defects, disorders related to prematurity and low birth weight (born too early or too small), suffocation, sudden infant death syndrome (SIDS), and respiratory distress syndrome.

- Chances of infant death are higher if:
  - The baby has a low birth weight, especially when the baby is born too early
  - The mother is very young or older (rates are higher in mothers under age 20 and over age 40)
  - The mother smokes, and to some extent if the father smokes
  - The family and social environment is difficult (poverty, lack of social support, overcrowded housing conditions, mental health problems, including drug and alcohol abuse)
  - Health care is not available, hard to access, or poor quality

- The Kent County Fetal Infant Mortality Review team has taken a close look at events surrounding the deaths of 57 African American babies from 2000 to 2004. They discovered that
  - Low birth weight, prematurity, and preterm labor contributed to about one-half of the deaths.
  - Multiple stresses in the family were noted in over one-half of the deaths and contributed directly to 9 percent of the deaths.
  - Stress and/or mental health issues in the mother were strongly associated with substance abuse, violence, poor social support, family transition issues, lack of transportation, and difficulty accessing services.
  - First pregnancy before age 18, substance abuse, previous fetal losses, and sexually transmitted diseases, were very common among the mothers, although they only contributed directly to a few of the infant deaths.

- Town meetings, focus groups, surveys of providers, and clinic visits have been done to find out about the health of mothers and babies and ideas for reducing infant deaths. Some of the findings have shown:
  - Community members did not know infant deaths were so high and did not understand the importance of prenatal care.
  - Community members are concerned about mothers' behaviors—such as smoking and substance abuse—and the effect of these behaviors on infants.
  - Many women have difficulty getting early prenatal care.
  - Lack of respect for younger women and racial prejudice affect women's access to services.
  - Prenatal care providers did not all screen routinely for problems such as domestic violence, mental health, substance abuse, smoking, or transportation, and many providers did not know where to send women who need help with these problems.
- Some of the efforts to respond to the concerns raised by the community are described below:
  - A standard of care for every pregnant woman has been defined to promote a successful pregnancy outcome (13 Prenatal Care Core Concepts).
  - A screening tool and resource guide have been developed and distributed to assist providers in identifying client needs and making decisions about where to refer.
  - Programs have been started that use outreach workers and/or nurses to provide home visits and comprehensive support to mothers and babies, e.g., Healthy Start, Nurse Family Partnership, Maajtaag Mnobmaadzid (Native American Healthy Start), Strong Beginnings, and Maternal Support Services (MSS) and Infant Support Services (ISS).
  - A directory of transportation services has been developed and work is being done to develop a hotline to get help with transportation.
  - Training has been provided to help health care providers increase awareness of racism within the health care arena and improve cultural competency.

# Appendix C:
*Community Summit Slide Presentation*

## Giving Birth to Hope and a Future

Community Summit
Kent County Infant Mortality Initiative
September 29, 2005

## Welcome

- Tonight we will:
  - learn about the survival of infants in our community
  - hear about our community's response to infant mortality: our programs, our perspectives
  - identify actions that will help keep more infants alive and well

## Tonight's agenda

- Infant mortality in Kent County
- Our community's response
  - a panel on our programs and initiatives
- Our community's perspectives
  - what our community says about infant mortality
  - what actions should we take?
- Next steps

## Infant Mortality in Our Community

*Robert C.Richard, MD*
*Medical Director, Cherry Street Health Services*
*President, Kent County Medical Society*

## Infant Mortality

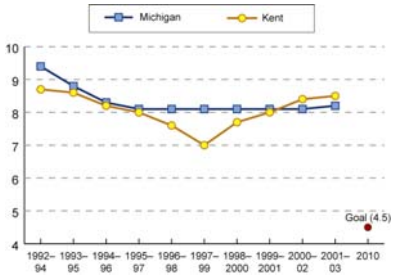
- The death rate for infants in the first year is an indicator of the health and social well-being of a community
- Infant deaths have declined in the U.S. over the last 20 years for all, but there is an alarming difference between death rates for African American and white infants

## Infant Mortality (cont.)

- Kent County has a high infant mortality rate overall

*8.5 deaths per 1,000 births*

## Three Year Moving Average Infant Mortality Rates in Kent County, State of Michigan, and 2010 Target for the United States




## Infant Mortality (cont.)

- Kent County is one of 11 Michigan counties with the largest disparity:

***The chance of dying before their first birthday is three times higher for black infants in Kent County than for white infants***

## Infant Mortality (cont.)

The disparity in survival for African American infants exists at the state and national level, as well as here in Kent County

## Infant Mortality (cont.)

- There are major direct causes of infant mortality
- There are risks that increase the chances that an infant will die

## Infant Mortality (cont.)

- The major direct causes are:
  - Birth defects
  - Disorders related to prematurity and low birth weight (too early, too small)
  - Suffocation
  - Sudden Infant Death Syndrome (SIDS)
  - Respiratory distress syndrome

## Infant Mortality (cont.)

- Chances are higher if:
  - The baby has a low birth weight, especially if born early
  - The mother is very young or older (rates are higher for mothers under age 20 and over age 40)
  - The mother smokes, and to some extent if the father smokes
  - The family and social environment is difficult (poverty, stress, lack of social support)
  - Health care is not available, hard to access, or of poor quality

## Infant Mortality (cont.)

- The Fetal Infant Mortality Review (FIMR) team studies infant deaths in Kent County
- A review of the deaths of African American babies from 2000 to 2004 shows that:
  - Low birth weight, prematurity, and preterm labor contributed to about one-half of the deaths
  - Multiple stresses in the family were present in over one-half of the deaths and contributed directly to 9% of the deaths

## Infant Mortality (cont.)

- The deaths of African American babies 2000–2004 (cont.)
  - Stress and/or mental health issues in the mother were present, e.g., substance abuse, violence, poor social support, family transition issues, lack of transportation, and difficulty accessing services
  - First pregnancy before age 18, substance abuse, previous fetal losses and sexually transmitted diseases were very common among the mothers

## Infant Mortality (cont.)

- At the state level, these psychosocial factors were found to be associated with infant deaths:
  - Poverty/(Medicaid)—**65.5%**
  - Multiple stressors/social chaos—**42%**
  - No social support—**28.2%**
  - Victim of violence—**20.9%**
  - Poor nutrition—**12.7%**

## Infant Mortality (cont.)

- Kent County FIMR Recommendations, 2004
  1. Decrease pregnancies before age 19
  2. STD screening and treatment (decrease premature labor)
  3. Proper dietary education
  4. Decrease substance exposure during pregnancy
  5. Ensure access to timely and appropriate prenatal care and delivery services

## Infant Mortality (cont.)

- Kent County FIMR Recommendations, 2004 (cont.)
  6. Provide timely assessment and social support within existing resources
  7. Assure the consistent assessment of mental health for all pregnant women
  8. Ensure cultural competency among providers, especially for the African American culture
  9. Develop a consistent message to the community on teen pregnancy, STDs, cultural competence
  10. Prevent SIDS

## Infant Mortality (cont.)

- There is no magic bullet—we will not eliminate infant mortality in the short run
- But together we can turn our community in the right direction—keeping more babies alive and well and reducing the disparity in survival for African Americans

## Our Community's Response

- Healthy Kent 2010, Barbara Hawkins Palmer
- Strong Beginnings, Peggy Vander Meulen
- Nurse-Family Partnership, Shanell Merriweather

## Healthy Kent 2010
*Barbara Hawkins Palmer*

- Communitywide effort
  - Collaborative effort – over 31 agencies and individuals
  - Current focus
    - Decrease low birth weight infants and infant deaths
    - Eliminate racial disparities
  - Improve the health system

## Healthy Kent 2010 (cont.)

- Goals
  - Ensure high-level, quality care to all pregnant women in Kent County
  - Eliminate the disparities in infant mortality
  - Improve access to quality prenatal care
  - Increase collaboration among organizations working with pregnant women

## Healthy Kent 2010 (cont.)

- Package of Activities—Strong Beginnings
  - Access to care
    - Prenatal Care Core Concepts
    - Communitywide prenatal screening tool
    - Resource and Referral Guide
    - Social marketing campaign
    - Transportation
    - Home visiting coordination
  - Racial prejudice
  - Pregnancy prevention
  - Fetal Infant Mortality Review (FIMR)
  - Advocacy

## Healthy Kent 2010 (cont.)

- Access To Care—Prenatal Care Core Concepts
  - 13 statements that define optimal prenatal care
  - Recommended by the state as a model for other communities
  - Foundation for the ongoing work of the Infant Health Implementation Team

## Healthy Kent 2010 (cont.)

- Prenatal Partnership Council
  - Implementation of the Prenatal Care Core Concepts
  - Participants are from prenatal care provider offices and clinics
  - Addressing issues in the clinical setting
  - Commitment to:
    - consistent, seamless, optimum prenatal care to all women
    - providing sources for best practice, assessments, and referral
    - holding each other mutually accountable for improving birth outcomes

## Healthy Kent 2010 (cont.)

- Access to Care—Assessment of Prenatal Care Practice
  - 2002 surveyed 47 prenatal care providers
    - Screening questions used were often informal, inconsistent, non-specific
    - No awareness of resources: 2% – 17%
    - 76% never, rarely, or only occasionally called other agencies for assistance
    - 33% did not screen for domestic violence, stress, depression, transportation, or ability to meet basic needs
    - Providers asked for screening tool and referral guide

## Healthy Kent 2010 (cont.)

- Access to Care Prenatal Screening Tool—Screening Tool Developed
  - Literature search, including ACOG guidelines
  - Studied Genesee County tool
  - Screening tool tested with 27 women in various settings
    - 26 said screen was “easy to understand”
    - 25 said “should ask these questions” during pregnancy
    - Average 5 minutes to complete (range 2–10 minutes)
    - Interest from clinic nurses

## Healthy Kent 2010 (cont.)

- Access to Care Kent County Pregnancy Resource Guide
  - Assists health care providers in the decision-making process of referrals
  - Components include
    - Screening tool
    - Decision trees
    - Topical index
    - Alphabetical listing of agencies
  - Partnership with the Child & Family Resource Council

## Healthy Kent 2010 (cont.)

- Social Marketing Campaign
  - Early and often prenatal care
  - Focus groups
    - African American women, aged 15–34
  - Media plan created
  - Fundraising campaign

## Healthy Kent 2010 (cont.)

- Transportation
  - Initiated the formation of the Emergency Needs Task Force Subcommittee on Transportation
  - Coordination & planning for transportation needs
  - Kent County Health Care Transportation Resource Directory
  - One-call hotline for medical transportation

## Healthy Kent 2010 (cont.)

- Cultural Prejudice & Institutional Racism
  - Racism identified by community as a root cause of infant mortality
  - Establish Health Care Action Team of the Summit on Racism
  - Promotion of the cultural competency training for health care providers

## Healthy Kent 2010 (cont.)

- Pregnancy Prevention
  - Over 40% of all live births in Michigan were unintended; 60% for women on Medicaid (MI PRAMS,1988 to 1999)
  - Women with unintended pregnancies are more likely to use tobacco and alcohol and to enter prenatal care late or not at all (MI PRAMS, Jan 2002).
  - FIMR Report recommends decreasing the number of pregnancies before age 19:
    - partner with schools and the faith community around abstinence and protected sex
    - educational programs directed at young males

## Healthy Kent 2010 (cont.)

- Pregnancy Prevention Strategies
  - Training seminar on new contraceptive methods and motivation techniques held October 2004
  - Advocacy
    - Proposal for reducing unintended pregnancies was sent to Michigan's Surgeon General
  - Resource Guide
    - A section on family Planning was included
  - Access to family planning options (including abstinence, pre-conception counseling, birth control, and emergency contraception)

## Healthy Kent 2010 (cont.)

- Fetal Infant Mortality Review (FIMR)
  - Investigates the events surrounding the death of a fetus/infant
    - Medical records
    - Home interview with mother and family
  - Makes recommendations that might prevent future deaths
  - Community Action Team (CAT)

## Healthy Kent 2010 (cont.)

- Advocacy
  - Redesign of the state's Maternal & Infant Support Services Program
  - Liaison with the Michigan Council on Maternal Child Health
  - Advocacy Coalition for Young Children & Their Families
  - Connections for Children
  - Healthy Mothers/Healthy Babies Coalition

## Healthy Kent 2010 (cont.)

- Strong Beginnings Launched
  - 2002, 2003, 2004 pursued federal Healthy Start grant
  - Received funding in 2004
  - Strategic Plan completed
  - State Infant Mortality Initiative grant
  - Creation of a new community plan starting today!
  - Together we can make a difference.

## Strong Beginnings

*Peggy Vander Meulen*

- Background
  - A program to reduce African American infant mortality
  - A partnership between community agencies:
    - GRAAHI
    - St. Mary's health Care
    - Cherry Street Health Services
    - Kent County Health Dept.
    - The Salvation Army
    - Metropolitan Hospital
    - Network 180
    - MERC
    - Spectrum Health: MOMS / HCD

## Strong Beginnings (cont.)

- Background (cont.)
  - Created by IHIT 2002, funded by federal Healthy Start 4-year grant 2004
  - Spectrum Health fiduciary, two-thirds funds to partners
  - 96 Healthy Start projects
  - Effective at improving birth outcomes

## Strong Beginnings (cont.)

- Program Description
  - Enroll 300 African American women
  - Pregnant, child under 2 years, in Grand Rapids
  - No income or insurance restrictions
  - Healthy Start requires:
    - Outreach
    - Case management
    - Education
    - Screening and referral for mental health
    - Improve overall health system

## Strong Beginnings (cont.)

- Accomplishments—Consortium
  - Consortium provides oversight and guidance
  - Ensures proper program direction and use of resources
  - Convened by GRAAHI
  - 20 members meet monthly
  - 10 are program or community participants

## Strong Beginnings (cont.)

- Accomplishments—Outreach and Case Management
  - Nine CHWs, each 30–35 families
  - Contact every 1–3 weeks
  - Follow through pregnancy till 2 years old
  - Social support, education, referrals
  - Outreach in appropriate locations
  - United Way 211 referrals
  - 252 women enrolled (84% of goal)

## Strong Beginnings (cont.)

- Accomplishments—Mental Health
  - Full-time Care Coordinator
  - Individual counseling & follow-up
  - Planning for a Stress Management Group
  - Enhanced services
  - Education for staff, health care providers, community
  - Emotional support for SB staff

## Strong Beginnings (cont.)

- Accomplishments—Education
  - Training for CHWs, case managers, program participants, health care providers, community
  - Effective Black Parenting
  - CHW training
  - Child development
  - Cultural competency
  - HIV/AIDS, depression, domestic violence
  - Breast-feeding, lead poisoning, nutrition

## Strong Beginnings (cont.)

- Accomplishments—Education (cont.)
  - Developing resiliency, Coping with stress
  - Self-esteem
  - Certification as Bridges out of Poverty Trainer
  - MOMS monthly groups
  - Fatherhood Initiative
  - Social Marketing

## Strong Beginnings (cont.)

- Accomplishments—Health System
  - Identified factors impact infant health
  - Core concepts prenatal and pediatric care
  - Screening tool and Pregnancy Resource Guide
  - Pediatrician survey
  - Transportation ENTF
  - Family Planning conference 180 participants
  - Anti-Racism Health Care Sector

## Strong Beginnings (cont.)

- Accomplishments—Health System (cont.)
  - Community mapping
  - New state Maternal Infant Health Program
  - Kent County Infant Mortality Initiative
  - Fetal Infant Mortality Review
  - OB Care Group
  - “Circle of Care” Booth Family Clinic
  - Advocacy:  MCMCH, national
  - National Healthy Start conference presentation, November

## Strong Beginnings (cont.)

- Accomplishments—Evaluation
  - Consent, enrollment, and data forms
  - Computer programs and staff training
  - Client satisfaction survey October
  - Health system evaluation: MIHP, prenatal referral system

## Strong Beginnings (cont.)

- Challenges
  - Coordination with multiple partners
  - Funding cuts
  - Lack of local resources to meet basic needs
  - Complexity of issue

## Strong Beginnings (cont.)

- Future Plans
  - Screening tool and referral guide for pediatricians
  - Support and education program for dads
  - Train breast-feeding peer advocates
  - New Network 180 support groups
  - Expand community participation on consortium
  - Work with KCHD & IHIT on strategic plan
  - Year-end program evaluation

## Nurse-Family Partnership

*Shanell Merriweather*

- An evidence-based program delivered by nurses in partnership with families using a variety of intervention strategies
- Began in Elmira, NY, in 1977, with research by Dr. David Olds; more research in Memphis, TN, in 1987 and in Denver, CO, in 1993

## Nurse-Family Partnership (cont.)

- Outcomes from the Elmira study 13 years after the service to the families enrolled in the research group ended included:
  1. **83%** Increased labor force participation by child's 4th birthday
  2. **79%** Reduction in child maltreatment among at-risk families
  3. **63%** Fewer sexual partners among the 15-year-old children
  4. **56%** Fewer emergency room visits where injuries were detected
  5. **44%** Reduction in maternal behavioral problems due to substance use
  6. **32%** Reduction in subsequent pregnancy

## Nurse-Family Partnership (cont.)

- The program is now provided in 20 states and serves 20,000 families a year. Grand Rapids was one of four cities in Michigan funded to deliver the program in 2004.

## Nurse-Family Partnership (cont.)

- Program Goals
  - Improve pregnancy outcomes through healthy behavior
  - Improve child health and development through support to parents
  - Improve families' economic self-sufficiency

## Nurse-Family Partnership (cont.)

- Theory and Research Based
  - Participants are first time, low-income women
  - Focus on client strength: "Follow your heart's desire."
  - Nurse-only model
  - Relationship-based

## Nurse-Family Partnership (cont.)

- Intensive Visit Schedule
  - Starts early in pregnancy (ideally less than 20 weeks gestation) and continues until the child is two years old
  - Weekly and biweekly home visits
  - Maximum caseload of 25 clients for each nurse (Grand Rapids has four nurses)

## Nurse-Family Partnership (cont.)

- Comprehensive Focus for Interventions within Six Domains
  - Personal health
  - Healthy environment
  - Life course development
  - Maternal role
  - Family and friends
  - Health and human services

## Nurse-Family Partnership (cont.)

- Kent County Evaluation Report: March 2004–June 2005
  - 76 women enrolled as of June 30, 2005
  - Median age 17 years
  - Median education 11 years
  - 97% unmarried
  - 74% unemployed
  - 77% Medicaid recipients
  - Race/ethnicity:
    - 87% African American
    - 3% Non-Hispanic white
    - 3% Native American
    - 7% Multiracial

## Nurse-Family Partnership (cont.)

- Outcomes for Michigan (based upon data from all four sites)
  - 13% reduction in number of mothers who continued to smoke during pregnancy
  - 45% decrease in the experience of domestic violence during pregnancy
  - Premature birth rate for African American clients was 10.4% (national NFP average, 11.8%)
  - Low birth weight for African American clients was 11.9% (national NFP average, 13.0%)

## Dinner

## What does the community say?

- 15 community conversations
- 10 key informant interviews
- 2 focus groups

## Community Conversations

*Wayne Boatwright*

## Community Conversations

- 183 community members participated in 15 community conversations conducted by community organizations
- "After the session, the group wanted to continue the discussion…several people said we need more discussions like this that are intentional."

## Community Conversations

| | |
|---|---|
| Baxter Community Center | Omega Psi Phi |
| Cornerstone-Women's Connect | Park School-Grand Rapids |
| Delta Sigma Theta | Salvation Army Booth Teen Living Center |
| Family Outreach | Salvation Army Transitional Living Housing |
| Grand Rapids Black Nurses Association | Traveling Grannies/Grandpas – Gerontology Network |
| Higher Hope International Ministries | United Methodist Community House |
| John M. Burgess Wellness Center-St. Philips Episcopal Church | West Michigan Medical Society |

## Themes from Community Conversations

- What stands out for you in the background information that has been shared?
  - There are so many complex factors associated with infant mortality.
  - It is shocking that the chance of African American babies dying is three times greater than for white babies.
  - It is discouraging and frustrating that Kent County has such a high infant mortality rate for both African American and white infants.
  - Many women do not get adequate prenatal care, which is important for a healthy pregnancy.
  - It is surprising to hear that there is a resource guide and screening tools, and that services are available.

## Themes from Community Conversations (cont.)

- Why do you think the rate of infant death is so high in Kent County? Why do you think it is particularly high for African American infants?
  - Lack of prenatal care and differential treatment due to income, race, and age
  - Lack of education and communication
  - Racism and lack of respect for African American women
  - Personal behaviors
  - Babies having babies
  - The lack of support for proven programs, especially prevention
  - Community attitudes

## Themes from Community Conversations (cont.)

- What stands in the way of people having healthy pregnancies and raising healthy babies?
  - Lack of access to health care and poor continuity and quality of care
  - A multitude of risk factors
  - Lack of knowledge and understanding
  - Lack of resources
  - Poor communication
  - Racism
  - Lack of pregnancy planning and denial
  - Lack of community resolve to address the issue

## Themes from Community Conversations (cont.)

- What is working in our community to help women and families address these issues?
  - The programs and activities of community-based organizations that are helpful
  - Positive messages from the media
  - Community conversations and broad involvement

## Themes from Community Conversations (cont.)

- What else could be done to improve the health of mothers and babies, particularly African Americans?
  - More education and information
  - More programs and services
  - Addressing underlying social issues, such as racism and poverty, and increasing our understanding of why infant mortality occurs
  - More caring by the community and broader community engagement in action
  - More involvement and mentoring of fathers

## Themes from Community Conversations (cont.)

- What stands out as the first step we need to take and who needs to be involved?
  - Expand communitywide involvement and action
  - Provide more education
  - Provide more prevention and early intervention programs and resources

## Key Informant Interviews

*Teresa Branson*

## Key Informant Interviews

- Interviews were conducted with 10 key community informants
- What needs to change in this community to keep mothers and infants alive and healthy, with a focus on reducing the disparity in survival between African American and white infants?

## Key Informant Interviews (cont.)

- Initial Reactions
  - Aware of the community's work in the area of infant mortality
  - Aware of the facts regarding infant mortality, but the statistics are overwhelming
  - "How can this go on in a community that cares about its kids?"
  - Overall community not aware; African American leadership and community are aware
  - Need to move beyond awareness to intervention to goal—consolidate all that we know, implement systemic interventions, measure results

## Key Informant Interviews (cont.)

- Barriers to Healthy Pregnancies
  - Are resources getting to the intended client, the most at risk, at the time needed?
  - Lack of resources for mental health and substance abuse, domestic violence, prevention, and transportation
  - Most commonly cited barriers
    - Transportation and late access to care
    - Poverty related stressors and their impact on women
    - Cultural competency contributing to access issues

## Key Informant Interviews (cont.)

- Barriers to Health Pregnancies (cont.)
  - Not all of the disparity is a function of poverty-all African Americans experience higher rates of infant mortality
  - Generational characteristics of both poverty and infant mortality
  - Sources of frustration:
    - Successful programs are not brought to scale
    - No change in statistics over the years
    - Need to eliminate poverty without blaming the poor
  - Money is not the only solution

## Key Informant Interviews (cont.)

- Supports for Healthy Pregnancies
  - Extended families and churches–but they need access to timely, accurate information
  - Various programs in the county (e.g., Healthy Start, hospital programs, Planned Parenthood, community clinics, WIC)
  - Businesses with supportive practices (e.g., accommodation of nursing mothers, access to childcare, transportation, employment and family leave policies)

## Key Informant Interviews (cont.)

- Barriers to Healthy Infants
  - Violence, substance abuse and other mental health factors, smoking, lack of housing, wages, access to insurance and health care, the effects of welfare to work policies on mothers without adequate childcare
  - Overall effects of concentrated poverty
  - Faith community—powerful source of actual or potential support, also part of a community-wide potential barrier
  - Intolerance and a perception that conditions are the fault of the mother
  - Health care and community development policies that miss community needs for preventive health and mental health care and support for women and children

## Key Informant Interviews (cont.)

- How can we step up our efforts?
  - Ask the women themselves; gather specific data about birth outcomes and service use from women; go to where the women are
  - Bring proven interventions to scale and focus on preventative health
  - Move beyond awareness
  - Government should be the catalyst to change; private and nonprofit sectors must deliver needed services
  - Share more information about what works and proofs from practice
  - Implement systemic solutions based on scientific data and best practice and sustain them

## Focus Groups – Teresa Branson

- African American women of varying ages who had experienced pregnancy
- What were their experiences before, during, and after pregnancy?

## Focus group findings

- Planned pregnancy
  - Less likely for African American women
  - Neglecting to plan is a type of planning (if you know you can get pregnant and don't do anything to prevent it, that is planning)
  - Most expressed negative emotions surrounding their reaction to learning that they were pregnant

## Focus group findings

- Role of race
  - Participants consistently described extreme experiences of care that they perceived as neglectful or differential
  - Noted inability to advocate for personal needs when the system failed to assess their needs
  - Noted lack of awareness or understanding of cultural/racial needs

## Focus group findings

- Role of economics
  - Noted differential treatment by insurance type

## Focus group findings

- Perceptions of care
  - Most women shared some incident of unacceptable care
  - Most women were satisfied with the care their children received

## Dialogues at Our Tables

- In light of all the information you have heard tonight, what three actions would have the most impact on infant mortality in Kent County?
- What is the first step?
- Who can make it happen?

## Table reports

- Please share one or two actions that you believe will have an impact on infant mortality in our community

## Next Steps

- Your ideas will be used to prepare a draft community action plan
- The action plan will be sent to all of you and you will be asked to identify ways to strengthen the action plan and to indicate the actions in the plan you would like to be involved in
- Next meeting

**Thank You for Working on Behalf of Hope and a Future for Our Infants**

# Appendix D:
## *Themes from the Community Conversations*

## COMMUNITY CONVERSATION PROCESS

The Kent County Infant Mortality Initiative is charged with developing a community action plan that proposes strategies to improve the health of mothers and infants, with a focus on reducing disparities in health outcomes. Understanding the views of community members regarding infant survival—perspectives on the issues, barriers, and solutions—is essential for the development of strategies and actions that will be effective and responsive to the concerns of the community.

This report summarizes the themes from 15 community conversations that occurred with 183 participants throughout the City of Grand Rapids between August 16 and September 12, 2005. The Kent County Infant Mortality Initiative developed guidelines and tools (i.e., facilitator script, background information, conversation record, and sign-in sheet) for the community conversations and provided funding and training for facilitators and recorders from community-based organizations. Attachment A lists the organizations that conducted the conversations. A compilation of the community conversations is also available from Teresa Branson, Kent County Health Department, (616) 632-7241. The compilation includes the content of the community conversation records, organized under each theme. Questions raised and personal stories shared by participants are also included in the compilation.

## THEMES FROM THE DIALOGUES

### *1. What stands out for you in the background information that has been shared?*

Five themes capture the majority of statements by participants about what stood out for them in the background information.

*There are so many complex factors associated with infant mortality.*

Many participants were surprised at the complexity of the causes and the risk factors for infant mortality. Several were struck by the role of stress, smoking (including smoking by the father), nutrition of the mother, and low birth weight. Several were surprised that maternal age is a risk factor, especially for women over the age of 40.

*It is shocking that the chance of African American babies dying is three times greater than for white babies.*

Many participants said that the rate of death for African American babies compared to white babies is shocking and of great concern. They noted with dismay that despite an overall decline in the infant mortality rate, the gap between African Americans and whites is increasing.

*It is discouraging and frustrating that Kent County has such a high infant mortality rate for both African American and white infants.*

Participants were surprised that Kent County, with its resources, programs, and attention to the issue of infant mortality, has one of the state's highest infant mortality rates.

*Many women do not get adequate prenatal care, which is important for a healthy pregnancy.*

Participants were struck by both the importance of prenatal care and the fact that many women in Kent County are not getting adequate prenatal care. Some participants found this surprising because they believe that "doctor's offices and health centers are all over the place." Many participants said that fear, shame, and denial lead women to delay prenatal care and not seek support services.

*It is surprising to hear that there is a resource guide and screening tools, and that services are available.*

Some participants had never heard of a guide to community resources and did not know that screening tools are available. Some participants were surprised that prenatal care providers do not routinely screen women for risk factors. They were unaware that programs to help pregnant women are in place and think that knowledge of those programs is "not out there."

### *2. Why do you think the rate of infant death is so high in Kent County? Why do you think it is particularly high for African American infants?*

Seven themes emerge from the comments made by participants.

*Lack of prenatal care and differential treatment due to income, race, and age*

Many participants think that the rate of infant death is so high in Kent County stems from women lacking prenatal care because they have no health care insurance or poor insurance. Participants believe that lack of access to health care for African Americans is a particular problem. Participants also state that doctors treat patients differently based on their insurance coverage, economic status, and race; these cultural prejudices deter women from care. The lack of African-American health care providers is seen as a problem: "There are not enough minority care providers to provide care to African-American patients."

Participants also viewed fear about revealing their pregnancy as a factor that prevents young women from seeking care, services, and support, and contributes to poor infant health outcomes. They noted that disapproval, especially for teens who are pregnant, leads to shame and denial that often delays prenatal care.

*Lack of education and communication*

Many participants said that the lack of sex and health education, at home and school, does not prepare young people to be informed and responsible. Participants said that parents are not communicating with their children (e.g., "My information came from the street.") and that institutions, such as schools and churches, refrain from moral education.

### *Racism and lack of respect for African American women*

Participants said that racism has had a significant impact on families in this community, contributing to poverty, unhealthy environments, poor education, and a lack of resources, all of which are factors in infant mortality. The prevalence of continuing racial bias in the community was noted, along with the belief that the predominately white community does not have an interest in preventing infant deaths among African Americans. A lack of respect for African-American women was seen as a contributor to high infant mortality rates. Participants note that African-American women, especially young women, don't get the same information and treatment that white women receive. One participant said that this community has a stereotypical view of African American families, seeing them as "sick or in need of repair, and only in terms of the mother and her baby…excluding fathers altogether."

### *Personal behaviors*

Participants said that unhealthy living, including poor nutrition, smoking, alcohol abuse, and drug use, contribute to the high infant mortality rate. Unhealthy eating habits were mentioned often, as were the lack of money for vitamins and proper food.

### *Babies having babies*

Participants said that there are too many teen pregnancies and that sometimes teens who don't know they are pregnant continue drinking and smoking, not knowing it could harm the baby. The cycle of teen mothers who also had teen mothers was noted as an issue.

### *The lack of support for proven programs, especially prevention*

According to participants, funds are not being put into programs that have been proven to reduce infant mortality. They said that too many dollars go to prenatal and postnatal health care but not enough for prevention.

### *Community attitudes*

Participants said that in addition to having stereotypical views of African American families, the community assigns too much responsibility for sexual behavior to young women and places blame. As one participant said, because the community is a "teaching city," it "treats people as guinea pigs so someone can learn." Some participants said that infant mortality has been seen as a health care issue, and not a community issue.

## *3. What stands in the way of people having healthy pregnancies and raising healthy babies?*

The many barriers identified by participants as standing in the way of people having healthy pregnancies and raising healthy babies fall into eight main categories.

### *Lack of access to health care and poor continuity and quality of care*

The most frequently mentioned barriers are those related to the difficulties involved in getting early prenatal care, the challenges presented by women seeing several different providers over the course of their pregnancy, and the poor quality of the health care they receive. Specific issues raised about the quality of care included the perception that lower

quality care is provided to those without health insurance and that physicians do not listen to and respect African-American women.

### *A multitude of risk factors*

Participants said that there are many risk factors that stand in the way of healthy pregnancies. They highlighted stress for the mother due to unsafe and nonsupportive living environments, alcohol and drug abuse, and smoking. By far, participants noted stress and the lack of support as key risk factors.

### *Lack of knowledge and understanding*

Participants said that a lack of knowledge and understanding is a barrier across the board—among parents, young people, and service providers. Participants noted that sex education does not start early enough, young people lack "medical literacy" (understanding healthy behavior and health risks), people do not understand how to access care and the need for prenatal care, and patients do not know what questions to ask doctors nor do they understand the terminology used by health care providers.

### *Lack of resources*

Poverty was mentioned by many participants, who cited specific barriers such as lack of financial resources, telephones, and transportation.

### *Poor communication*

Participants said that poor communication and the lack of open communication stands in the way of healthy pregnancies and raising healthy babies, specifically noting that parents, schools, and churches are not really talking with kids and that the media do not convey messages that help, such as not promoting good nutrition.

### *Racism*

Participants noted that racism is a barrier because it leads to lack of respect, unfair assumptions, misconceptions about African-American women, and a lack of "palatable" information for African American families.

### *Lack of pregnancy planning and denial*

According to participants, unplanned pregnancies are barriers to healthy pregnancies. They noted that too many young people having children are not ready to become parents. Also cited was the impact of denial of pregnancy, which can lead to avoiding prenatal care and potential health risks.

### *Lack of community resolve to address the issue*

Participants highlighted the lack of a true community resolve to solve the problem of infant mortality, saying: "If this was a political priority, then something successful would have been done by now."

### ***4. The review of infant deaths shows that multiple stresses, mental illness, alcohol and drug use, smoking, violence, poor social support, lack of transportation, and difficulty accessing services are factors in infant***

***deaths. What is working in our community to help women and families address these issues?***

While a few participants said that nothing will ever work until basic needs are met and the issue of racism is addressed, participants cited three types of things that work in the community to help women and families address the multiple factors related to infant deaths.

*The programs and activities of community-based organizations that are helpful*

By far, the things most frequently by participants as working in our community are (a) programs and services and (b) the activities of community-based organizations. A range of those programs and activities were mentioned; however, participants focused on WIC (Women, Infants, and Children's Supplemental Nutrition Program), the MOMS Program, and several mentoring activities like Traveling Grannies/Grandpas, the YWCA's "Girls Like Me," and the sorority and fraternity programs for adolescents.

*Positive messages from the media*

Participants said that positive messages from the media are working, especially ads on television and those that have been developed by and for adolescents. They said television and radio reaches everyone.

*Community conversations and broad involvement*

Participants said that community conversations, forums, and focus groups are working and the broad involvement of friends, family, and groups like fraternities and sororities is working.

***5. In the background information some current efforts are identified. What else could be done to improve the health of mothers and babies, particularly African Americans?***

Five themes emerge from the responses of participants regarding what else could be done to improve the health of mothers and babies, particularly African Americans.

*More education and information*

Many participants said that families and young people must be better educated about the importance of healthy behaviors in general and how to prevent teen pregnancy; women must be informed about the importance of their health in general and the risk factors affecting pregnancy, and the community should be "saturated with information" about pregnancy resources; both men and women should be educated about the health of infants; providers need to be educated about the role of stress and where to refer people for help; and the community needs to be more open-minded regarding issues of sex, making it acceptable to "talk about it everywhere, even in churches, schools, and home."

*More programs and services*

Many participants said that existing programs and services should be strengthened and that programs should be more widespread. Specifically mentioned are family support groups; community centers; community outreach; positive activities for adolescents;

walk-in clinics for medical care, especially for low-income people; counseling by churches for spiritual support; birth control for men and women; advocates that will meet with all new parents in the hospital after the arrival of a newborn; parenting classes; moral, spiritual, and emotional support for teen mothers; programs that teach good nutrition on a budget; fun and educational after-school programs at the elementary level; and affordable daycare.

### *Addressing underlying social issues, such as racism and poverty, and increasing our understanding of why infant mortality occurs*

According to participants, the underlying issues related to infant mortality should be addressed. These issues include eliminating racism, providing jobs and increasing economic development, improving transportation, and reducing substance abuse. Several participants expanded on the issue of racism, noting the need to eliminate differences in treatment based on skin color and that more people of color need to be in positions of influence. A better understanding by the community of the causes infant mortality is needed, including more research as to what works in other communities, particularly for minority populations. To increase understanding of the problem, one participant suggested the participation of African Americans in the community's review of infant deaths (i.e., interviews conducted by the Fetal-Infant Mortality Review team).

### *More caring by the community and broader community engagement in action*

Participants said that the community must be more broadly engaged, including leaders from business, education, philanthropy, the media, and government, in reducing infant mortality. They suggested more community conversations and focused summits with teens, adults, and churches. Also noted by participants was the need for the community to demonstrate caring rather than being judgmental. Participants said that the media has a key role in making the community aware that African-American babies are dying at an alarming rate and that something can be done about it. They stressed the need to make sure there is action by the community.

### *More involvement and mentoring of fathers*

Participants said that male involvement in the process of improving health for families, particularly African American families, is essential. They said this will require a cultural shift that brings fathers into the picture, recognizes their important role, and supports educating and holding them accountable. Mentoring and peer-to-peer educators for African Americans were cited as needed strategies.

## *6. What stands out as the first step we need to take and who needs to be involved?*

Participants identified three areas where they believe the first step should be taken.

### *Expand community-wide involvement and action*

Participants said that the involvement of "all parts" of the community must be expanded. They suggested that actions should be built on what the entire community says is needed. Participants identified the "parts" of the community that need to become more involved, e.g., teachers, counselors, health care providers, Department of Human Services workers,

area businesses, city government, clergy, social service organizations, and families (especially fathers). Participants suggested more community summits and meetings, with leadership from African Americans. As one participant noted, "It begins with our communities working together… There needs to be action from our conversations."

### *Provide more education*

Many participants said that the most urgently needed tool for combating infant mortality, particularly in the African-American community, is more education. Specifically, they said that more must be done immediately to prepare and educate parents, especially new mothers and fathers. The focus of participant comments was on "each one, teach one," that each of us has a responsibility to share information that can contribute to healthy pregnancies and healthy infants. Several participants said that more mentoring is needed and should be carried out by volunteers from all areas of the community, e.g., parents, pastors, doctors, and politicians.

### *Provide more prevention and early intervention programs and resources*

Several participants said that a first step is to provide more programs and support during pregnancy and the first year of life, e.g., "…identify every pregnant woman in Kent County, offer them health care access, educate them, and assign a healthcare manager to monitor them for a year." Participants said that more money should be put into prevention and early intervention programs that are accountable and get results.

## ATTACHMENT A

- Baxter Community Center
- Cornerstone-Women's Connect
- Delta Sigma Theta
- Family Outreach
- Grand Rapids Black Nurse
- Higher Hope International Ministries
- John M. Burgess Wellness Center – St. Philips Episcopal Church
- Omega Psi Phi
- Park School – Grand Rapids
- Salvation Army Booth Teen Living Center
- Salvation Army Transitional Living Housing
- Traveling Grannies/Grandpas – Gerontology Network
- United Methodist Community House
- West Michigan Medical Society

# Appendix E:
## *Compilation of Actions and Key Steps Identified at the Community Summit on September 29, 2005*

***Three actions that would have an impact on infant mortality***

- Outreach
- Education in grade schools
- Bring info to the people (advertising)
- Get info out through radio programming
- Education to family (males included)
- Non-judgmental prevention and follow up
- Have males involved
- Sex education
- Have more information (and programs) at schools and churches—go where they are
- Education and outreach to the adolescents and ask their thoughts and opinions
- Teach self-respect and boost self-esteem
- Promote education to adolescents about prevention, not just abstinence, in an effort to prevent unplanned pregnancy
- Educate providers and recipients of care on what type of care they should expect to receive
- Mare sure African American women get the proper information in order to get proper treatment and care
- Teach African American women to advocate for themselves and empower themselves
- Increase education at all levels
- Education at all levels
- Reach kids at home and other places
- Communication
- Have public conferences or organizations to spread the information to the public so that we can in fact wake up to the reality and do something about infant mortality
- Continue with “this” community dialogue and education at churches and media
- Where are our CEOs, directors, and those individuals who control institutions that control our environment and our situations, as well as control the purses?
- Straight talk to key players—the same conversation we had here should be shared in the board rooms, using the same language
- More in depth assessment at/during time of prenatal check ups
- Screening tool for doctors to determine what services are needed on both health and social levels

- Ask about barriers to care; not easy to access services ("you have to cry to get resources")
- Overall support of pregnant teens and women (i.e., education, transportation, and early detection)
- Can we create a greater focus on creating a women-friendly environment
- Women need adequate care
- Support as long as the mom desires
- Provide basic needs to reduce stress
- Better medical support (understanding of culture)
- Men take part in medical care
- Decrease stress
- Women take care of themselves
- Prenatal care
- Clinics
- Continue Nurse-Family Partnership program
- Expand community health workers and make sure they are diverse workers
- Teenage pregnancy prevention and empowering young women
- Increase self-esteem at all levels
- Better communication between organizations and agencies
- Connect other health and medical people together to meet the needs of the patient
- Create a mechanism to report out when care is not adequate—quantifiable numbers should determine investigation; sanctions including dismissal of ability to provide care to Medicaid and Medicare recipients, in some cases monetary
- Can we tie financial penalties for repeated violations?
- There should be complaint officers to follow up on complaints of poor treatment
- Educate public regarding negative experiences and whom they can speak to about it so it is not repeated
- Are we looking too far ahead? Should we focus early on with environment, education?
- Address issues of unplanned pregnancy, to plan after becoming aware of pregnancy, and have resources available to them
- Improve the overall health of the mother (eating habits, stress levels, etc.)
- Family activities that bring families together to learn and grow together

### *One key step that should be taken and those who should be involved*

- Share this information with others; use words that are clear and used by the community (e.g., locked up versus incarcerated)
- Educate our children; talk to adolescents about prevention of pregnancy; inform adolescents of the issue; work with elementary and middle school kids through after-school and extra-curricular activities; more positive role models in the community; teach kids about family at an early age—how to raise a family

- Education and awareness (of the problems and the existence of what is being done)
- Education and awareness
- Education for the entire community
- Better understanding
- Push the awareness of the statistics
- Education and everybody should be involved; all of us need to be involved
- Build education for parents into sex education for adolescents (Henry School an example)
- Educating the mother and adolescents with regard to available financial help, e.g., insurance and what it provides
- Teach abstinence
- Teach difference between lust and love
- Schools must start education about infant mortality in grade school
- Advertising and messages we send kids, e.g., videos, should be about the community norm, not the "reality" of TV
- More community involvement; it takes all of us ("Thanks for the guide, but it takes all of us")
- More compassion and caring by the community—takes people speaking up
- Prepare the leadership in this community so they speak out about the issue; raise concern on a long-term basis ("don't let this forum be the only time we talked about this problem")
- Get the person who is pregnant actively involved in planning and decision making; get men involved in prenatal care—help them take part (partner is often the first one to see mother's depression)
- Increase leadership on the issue
- Long-term focus on the issue
- African Americans helping African Americans
- Create a coordinated access team across systems to broker needed care service to promote better communication and break barriers as prevention
- Meet basic needs (transportation, food, healthcare)
- We need to have love and respect for our neighbor as we do for ourselves, and incorporate the young people of the future with the many steps we should take toward an impact on infant mortality and any other community problems
- All family members, churches, schools, media, doctors must be involved
- Listen to me—be supportive—don't judge me
- Cut red tape ("don't ask me to fill out more papers")
- Improve self-esteem in young African American girls and boys; teach them about choices
- There should be a process for complaints by health care professionals as well as recipients of care; medical charts need to be monitored for discrepancies in care and agencies and institutions disciplined as needed

- Develop educational process to improve the impact of cultural competency of providers
- More responsibility for doctors and their services
- DADS program needs to be implemented
- Work First should require education of both individuals and service providers
- Stop talking and start doing; no more talk

Copies of the Kent County Pregnancy Resource Guide and screening tool, the Infant Health Implementation Team Activities Report, and the Fetal Infant Mortality Report are available by contacting Barb Hawkins-Palmer, Healthy Kent 2010 Coordinator at (616) 632-7281.

# Appendix F:
## *Highlights of Existing Efforts*

### *Objective 1: Educate individuals and the community as a whole*

| **Existing Efforts** |
|---|
| Community Goal, 2001–2004 plan: 85 percent of pregnant women in Kent County will be aware of community resources to ensure a healthy pregnancy (Healthy Kent 2010 IHIT) |
| FIMR Recommendations: ensure access to timely and appropriate prenatal care and delivery services; and prevent SIDS |
| Prenatal Care Pregnancy Resource Guide created and distributed (includes core concepts, screening tool, decision trees to find community services, list of agency programs for identified needs, and listing of agencies and their services) |
| Endorsement of guide by health and human service providers pending |
| **Best Practices** |
| Educate pregnant women on signs of preterm labor (e.g. March of Dimes resource materials) |
| Use health care providers to connect women to community resources |

| **Existing Efforts** |
|---|
| Community Goal, 2001–2004 plan: the IHIT will actively promote abstinence from alcohol, tobacco, and other drugs during pregnancy. |
| Mother's Day Campaign to raise awareness of the effects of drinking alcohol during pregnancy |
| **Best Practices** |
| Implement health outreach worker models that are effective in providing educational information to pregnant women and families with young children and connecting them with social services and other resources (e.g., Maternal Infant Health Outreach Worker program and Nurse Family Partnership). |

| **Existing Efforts** |
|---|
| Community Goal, 2001–2004 plan: there will be a 25 percent increase in programs whose goal is to prevent unintended pregnancies (Healthy Kent 2010 IHIT) |
| FIMR Recommendations: (1) Decrease pregnancies before age 19; (2) develop a consistent message to the community on teen pregnancy and STDs |
| Supported COACH, a program that work with young girls to build self-esteem, provide mentoring, and work on goal setting |
| Identified existing resources for pregnancy prevention |
| Supported the Family Planning Medicaid Waiver |
| Developed Toolkit of Resources (articles, websites, and other materials) |
| **Best Practices** |
| Reduce sexual activity and increase contraceptive use in adolescents through: |
| Clinic-based counseling |
| Service learning programs for adolescents |
| School-based sex education that promotes both abstinence and contraceptive use |
| Children's Aid Society holistic program including family life and sex education |

### *Objective 2: Involve the community and expand community leadership*

### *Objective 3: Support and care for women and families—create "a woman friendly and family friendly environment" in our community*

| Existing Efforts |
|---|
| Community Goal, 2001–2004 plan: 85 percent of health care providers will use a standardized approach to prenatal care (Healthy Kent 2010 IHIT) |
| FIMR Recommendations: decrease premature labor through STD screening and treatment; proper dietary education; decrease substance exposure during pregnancy; and assure consisten assessment of mental health for all pregnant women |
| Prenatal Care Pregnancy Resource Guide created and distributed (includes core concepts, screening tool, decision trees to find community services, list of agency programs for identified needs, and listing of agencies and their services) |
| Continuity of care protocol developed |
| Standard set of educational information for pregnant women |
| Training sessions to introduce the standardized approach to prenatal care |
| **Best Practices** |
| Use screening tools for detecting risk and intervention techniques for reducing alcohol, tobacco, and drug use during and after pregnancy. |
| Screen for domestic violence at entry to care and during third trimester |
| Use prenatal screening tools to identify women at risk for postpartum depression and currently suffering from depression |
| Put in place policies/procedures for follow-up and/or referral when indicated. |
| Establish and enhance linkages between health care providers and community intervention and treatment programs |

| Existing Efforts |
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| Community Goal, 2001–2004 plan: the IHIT will assess the current effects of racial prejudice in the healthcare system. (Healthy Kent 2010 IHIT) |
| FIMR Recommendation: ensure cultural competency among providers, especially for the African American culture |
| Developed educational materials on the effects of racial prejudice in the healthcare system and conducted the Summit on Racism |
| Develop a consistent message to the community on cultural competency |
| Provided community training sessions, i.e., Health Care Action Team Roundtable and the People of Color Task Force training sessions on cultural competence |
| **Best Practices** |
| Disseminate practitioner guidelines for prenatal care and preterm birth prevention (e.g., Institute for Clinical Systems Improvement). |
| Implement models for group prenatal care (e.g., Centering Pregnancy). |

| Existing Efforts |
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| Healthy Kent 2010 Emergency Needs Taskforce Subcommittee on Transportation |
| Health care transportation resource directory |
| One-call hotline for medical transportation |