CityMatCH Presents First “How-to-Do PPOR” Workshop at MCH Epi Conference

Since 1997, in partnership with CDC, the March of Dimes and several major cities, CityMatCH has led national efforts to validate, enhance and adapt the PPOR approach for greater use in mobilizing U.S. cities to reduce feto-infant mortality.

In conjunction with the annual Maternal and Child Health Epidemiology Conference held in Clearwater Beach, Florida on December 13th-16th, 2002, CityMatCH staff and national faculty shared concepts about PPOR by offering approximately forty workshop participants the opportunity to:

- Recognize and understand all components of the PPOR Approach;
- Learn how to assess “community readiness;”
- Achieve a common understanding of what it takes to conduct the first phase of analysis;
- Learn how to shift focus from PPOR data to using the PPOR approach for systems change; and
- Obtain certification to participate in upcoming CityMatCH PPOR Level 2 activities.

For more information about the Perinatal Periods of Risk Approach and CityMatCH efforts to reduce infant mortality in U.S. cities, see the related article on page 11, “Building Urban MCH Capacity.”

The next “How-To-Do” PPOR Training will be held during the 2003 AMCHP Annual Conference, “Mobilizing to Eliminate Health Disparities” March 8 - 12 at the Crystal Gateway Marriott in Arlington, VA.

'How-To-Do’ PPOR Training will be part of the Pre-Conference Skills-Building Workshops taking place on March 8. If you are interested in attending, please contact LaToya Williams at CityMatCH, 402-561-7500.

"Supported in part by Grant No. 3 U93 MC 00120-11 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services."
Learning is richer and better when you do it with others, and navigating through a complex array of learning opportunities can be safer if you don't try to do it alone.

A kickoff event afforded participants opportunities to learn about leadehship, team navigation, and strategic to get measurable and intended results for improving urban women and children's health.

Kay Johnson, President, Johnson Consulting Group, and Magda Peck, CityMatCH CEO, served as navigation guides through a series of exercises:

1. **Really Unequal Treatment?** At the start of the Conference, teams were given materials needed to crack the first “case,” based on a scenario about using the results of the recent Institute of Medicine (IOM) report, “Unbalanced Truth: Confronting Racism and Ethnicity in Health Care.” All of the thirty teams met the deadline for handing in a unified response.

2. **True Confessions.** Team conversation about systems building was the warmup needed for the “Confessions” plenary session. Amos Smith, Director of Health Grantmaking for the Community Foundation for Greater New Haven (CT) and Aruna Ayala, Section Manager of Special Studies for the County of Los Angeles (CA) Office of AIDS Programs and Policy at the County of Los Angeles Department of Health Services shared their views on what it takes to overcome bureaucratic troubles that can plague local public health systems. Participants heard their “true confessions” of how better, more integrated systems for women, children and families can emerge from persistence and teamwork.

3. **Aha! Roundup.** The final morning of interCHANGE, each Navigation Team generated its “Top Ten” list of concepts learned that would be most useful in their work back home. (Selected “Aha!” listed below) This exercise encouraged cross-fertilization of ideas and fostered synthesis of the three-day event.

### Building Urban MCH Capacity

*“Building Urban MCH Capacity” has been funded by the Centers for Disease Control and Prevention (CDC) to assist urban public health leaders with new assessment and surveillance tools and training. One of two focus areas in this cooperative agreement is the Perinatal Periods of Risk (PPOR) Approach to Reducing Infant Mortality in U.S. Cities. This joint initiative of CityMatCH at the University of Nebraska Medical Center, the CDC, the National March of Dimes Birth Defects Foundation and HRSA/MCHB to monitor and investigate fetal-infant mortality.*

#### CityMatCH will continue to advance the dissemination, utilization and integration of the PPOR Approach in U.S. urban areas. Intensity strategies are grouped into three levels:

- **Level One: General Communications,** offers general information about the PPOR approach, dissemination of best practices and enhanced peer exchange.

- **Level Two: Learning Network,** is for communities using or planning to use the PPOR approach. Level Two will increase knowledge, awareness, understanding and integration of systems among urban health departments and community partners who are using the Perinatal Periods of Risk: Members will have access to information about emerging best practices using proven communication vehicles and tools.

- **Level Three: CityMatCH member departments** and their partners will implement the full PPOR approach, attend one of the CityMatCH on-site training workshops, and submit their report to CityMatCH about their experience.

### Eliminating Perinatal HIV Transmission: An Urban Strategy

*“Eliminating Perinatal HIV Transmission: An Urban Strategy” was funded by CDC to strengthen prevention of HIV-related disease and disability among women and children in U.S. cities. This partnership builds upon the previous cooperative agreement, “Preventing Perinatal Transmission of HIV in U.S. Cities.” CityMatCH will continue to disseminate information on the epidemiology, new science and best practices of perinatal HIV prevention to urban MCH and HIV community-based local partners, foster collaborative cross-city learning, targeting selected urban communities, and involves additional communities to become involved in a learning network. Strategies, models and tools to address issues and better understand individual cases of perinatal HIV mortality and morbidity will be enhanced and adopted. Intensity strategies are grouped into three levels:*

1. **Level One: General Communications** will disseminate information and present strategies to professionals involved in the care of pregnant women and their children.

2. **Level Two: Urban Learning Network** will increase information and communication about perinatal HIV prevention to and among the most affected urban areas. Participants will receive city-specific HIV/AIDS rates, related surveillance data and emerging prevention strategies, engage in electronic discussion; participate in cooperative learning; and have opportunities to partner with original Urban Learning Cluster cities and attend workshops and/or skill-building sessions at the annual CityMatCH Conference.

3. **Level Three: Urban Prevention Collaborative (UPC)** builds upon the current Learning Cluster to further strengthen capacity, foster teams-based shared leadership and promote greater systems integration between MCH and HIV-UPC. Working groups will conduct feasibility studies on select issues and report findings and recommendations to the CDC and other national partners.

**CityMatCH Conference.**

Level Three: Urban Prevention Collaborative (UPC) builds upon the current Learning Cluster to further strengthen capacity, foster teams-based shared leadership and promote greater systems integration between MCH and HIV-UPC. Working groups will conduct feasibility studies on select issues and report findings and recommendations to the CDC and other national partners.

**Sad Passing:** Linda Jenstrom, a charter member of the Metropolitan Washington HIV Services Agency and a core member of DC’s HIV Urban Learning Cluster, passed away in November. She will truly be missed.
Woven throughout iCancCHANGE were the hands-on exercises and conversations among pre-selected Navigation Teams (see page two).

The Institute of Medicine (IOM) report, “Unusual Treatment Confronting Racial and Ethnic Disparities in Health Care” (see related story below) was the basis for the first Navigation Team Exercise. Using a fictional city and exemplary data, a case study (“Really Unusual Treatment?”) was developed by CityMatch CEO Magda Peck and Kay Johnson, Johnson Consulting. To open the case, Magda Peck presented an overview of the IOM report. The opening case study also simulated a discussion among members of an urban working group on minority health and focused teams’ attention on IOM report findings and recommendations. Results of this and other Trilogy Navigation Work in developing greater awareness of and strategies to address unequal treatment are described here.

The IOM’s general recommendations called for activities to “(1-2) increase awareness of racial and ethnic disparities in health care among the general public and key stakeholders,” and “(1-2) increase health care providers’ awareness of disparities.” In response to these recommendations, Navigation Teams were called upon to list probable allies and possible opposition in addressing unequal treatment. Faith-based communities were the most commonly listed group of probable allies. Coalitions concerned with racial, ethnic and vulnerable populations also were frequently mentioned.

Navigation Teams also saw opportunities to engage consumer organizations, community-based organizations and the media. Health providers – particularly physicians – were about equally likely to be seen as probable allies or as possible opposition. Possible opposition included social conservatives along with administrators of health care facilities or managed care organizations who might fear negative publicity.

The IOM Report also recommended data collection and monitoring activities to:

(7-1) “Collect and report data on health care access and utilization by patient’s race, ethnicity, socio-economic status, and where possible, primary language.”
(7-2) “Include measure of racial and ethnic disparities in performance measure.”
(7-3) “Monitor progress toward elimination of minority health care disparities.”

A second challenge posed to Navigation Teams called for identification of three maternal and child health indicators/measures that could be used to monitor or detect disparities, discrimination and unequal treatment. More than 25 potential measures were identified, including those in Table 1.

In addition to this Navigation Team exercise, iCancerCHANGE participants had an opportunity to learn from other chapters’ experiences regarding racism and racial disparities in maternal and child health (see page nine).

### TABLE 1. Measuring “Unequal Treatment” in MCH:

<table>
<thead>
<tr>
<th>MCH Measures/Indicators</th>
<th>% of women who receive follow-up to an abnormal pap smear</th>
<th>Reasoning/Value</th>
<th>Possible Data Sources</th>
<th>Medical records</th>
<th>Breast &amp; Cervical Cancer Screening Program records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of satisfaction with care</td>
<td>Use instrument questions which point to barriers, perceptions of discrimination, experiences related dissatisfaction with health care.</td>
<td>Surveys</td>
<td>Focus groups</td>
<td>Interviews</td>
<td>Outreach reports</td>
</tr>
<tr>
<td>Length of maternal or infant post-partum hospital stay</td>
<td>Assess whether or not pattern of discharge varies by race/ethnicity (adjusted by severity and other risk factors).</td>
<td>Hospital discharge data</td>
<td>Medicaid data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of patient or referrer group “lost to follow-up”</td>
<td>May be influenced by satisfaction with experience in care or by level of effort on part of provider.</td>
<td>Managed care and similar data sets (e.g., showing length of enrollment with primary care provider)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration or type of health education</td>
<td>Race and ethnicity may influence the amount of time or the content of health education provided, based on evidence or based on bias.</td>
<td>Survey Provider record review data</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


### 1. Unusual Treatment: Confronting Racial and Ethnic Disparities in Health Care (2002): This report from the Institute of Medicine is available through the National Academies Press (NAP), located on the web at: [http://www.nap.edu/books/010082653/html](http://www.nap.edu/books/010082653/html).

Press releases published on the NAP website state, “According to a recent survey, some U.S. minorities believe they would receive better healthcare if they were of a different race or ethnicity. A new Institute of Medicine report presents compelling evidence supporting these perceptions.”

“Minorities tend to receive lower-quality health care than whites do, even when insurance status, income, age, and severity of conditions are comparable,” says Unusual Treatment: Confronting Racial and Ethnic Disparities in Health Care. Although myriad sources contribute to these disparities, some evidence suggests that bias, prejudice, and stereotyping on the part of health care providers may contribute to differences in care.”

2. For more information about Navigation Team Learning, contact CityMatch at 402-561-7550.
Emerging Best Practices

Replicable and Emerging Best Practice Profiles

Each year CityMatch members have been asked to profile a successful MCH effort in their communities. As part of the unique dissemination model that is “TermsCHANGE,” current PPR, HIV, and HIV teams were asked to submit “Best Practice Profiles.” Each team submitted a profile of a recent innovative activity, strategy or lesson learned that strengthened their capacity to serve women, children and families. Selected presentations were published under the Emerging MCH Practices sessions at TermsCHANGE 2002.

Additionally, all teams were instructed to craft posters to communicate findings and summarize results, and some were recognized with awards. Phoenix PPR received an award for “Effective Communication” for outstanding development and use of effective tools to communicate and promote PPR locally. The STAR Award was given to the Philadelphia PPR Team for using PPR data to focus and promote effective feto-infant mortality prevention strategies. (See page for more details).

Special thanks to the March of Dimes for hosting the poster reception and for being a great partner in Saving Babies, Together.

~ Translating Evidence into Effective Practice ~

Claude Earl Fox, Director of the Urban Health Institute, at the Johns Hopkins University, Baltimore, MD, and William M. Sappenfield, Medical Epidemiologist and MCH EPI Team Leader, Division of Reproductive Health/NNCH/DPHR; Centers for Disease Control and Prevention, Atlanta, GA met onsite in a restaurant-style table before TermsCHANGE 2002 participants. Fox and Sappenfield shared their thoughts in a conversation about the importance of going beyond what is known from the literature and published reports into evidence-based practice and data-driven policies in public health. A systematic approach that asks the right questions, gets the complete information we need to effectively and appropriately answer, thoughtfully evaluates the new information gained, and uses the findings to create, change and enhance policy and programs is ideal, but seldom practiced. What will it take to change how we do business?

Emerging MCH Best Practice Profiles

Atlanta, GA: Enhanced Perinatal Case Management
Baltimore, MD: Partnering to Give Baltimore’s Babies the Best Start
Chicago, IL: The Perinatal Acts of Risk: Chicago Region 3
Colorado Springs, CO: Colorado Springs CARES About Child Care
Columbus, OH: The Good, the Bad, and the Ugly: Working Towards Better Data in Columbus, OH
*Detroit, MI: Mandated Parenting Assistance Services (MAPS) Parenting Education
*Durham, NC: The Role of Indigenous Lay Health Advisors in the Minority Infant Mortality Reduction Effort Experience 1993-1997
Hartford, CT: Improving Access to Care
*Jacksonville, FL: The Magnolia Project: A Pre-Intervention Conceptual Approach to Reducing Infant Mortality
Jacksonville, FL: Working Together to Prevent Perinatal HIV In Our Community
Kansas City, MO: Best Infant Health Model
Los Angeles, CA: About Me and With Me: Reaching the Hardest to Reach Women in Los Angeles County
*Los Angeles, CA: Using Participatory Action Research to Implement a Results-Based Evaluation System
Louisville, KY: Emerging Practices from MCH Partnerships
*Nashville, TN: Basketballs for Babies: A Safe Place to Sleep
*New Haven, CT: Providing Leadership to Regionalize New Haven’s Perinatal Health Systems
Norfolk, VA: Perinatal HIV Prevention Campaign
*Orlando, FL: Save Our Babies
*Philadelphia, PA: Domestic Violence Among Immigrant Communities in Philadelphia
Philadelphia, PA: Weaving HIV Services and Reproductive Health Care in a Public Health Setting
Phoenix, AZ: PRAMS & PPR: Catalysts for Community Change
Raleigh, NC: Full Bloom Community Engagement
Salt Lake City, UT: The Collaborative Pediatric Practice at the South Main Public Health Center
San Diego, CA: Interagency Collaboration in the Development and Distribution of Perinatal Health Brochure
*St. Petersburg, FL: Modified BRFS Results of Female Minorities Populations in Pinellas County, FL
Tucson, AZ: Amplifying Child Fatality Review Findings Using a PPR Framework
Waco, TX: A Portrait of Health Issues: GIS in Monitoring Health Status
Washington, DC: Braided Programs and Systems Change for Perinatal HIV Prevention

* These profiles were selected and presented during the Emerging MCH Practices’ Session at termsCHANGE 2002, and are available online at www.citymatch.org

~ Conference Proceedings ~

Barbara Ferrer:
Deputy Director, Boston Public Health Commission

Levels of Racism: A Gardener’s Tale

The following allegory was used by Camara Jones in her video presentation to participants at TermsCHANGE 2002: “A gardener has two kinds of seed, red and pink, and two flower boxes. One contains rich soil and one has poor, rocky soil. The gardener favors red flowers over pink, so she plants the red seed in the rich soil and the pink seed in the poor soil. Year after year, the rains water the sun, and the gardener harvests the flowers. But she never changes the soil. The red flowers flourish in the rich soil, but the pink flowers languish—the strongest make it to middling height, the weakest die. The gardener notices the difference, but soon forgets her original decision to put poor soil in one flower box and rich soil in the other. ‘It’s really good that I liked red flowers because they’re much prettier,’ she thinks.

The analogy to institutionalized racism arises from the flowers being contained in separate boxes, and it is perpetuated by the gardener failing to fertilize or mix the soil. An example of personally mediated racism would be if she purposefully removed a stray pink seed that found its way into the red flower box. Internalized racism results when the pink flowers, realizing they are all scraggly, say to the bee, “Don’t bring me any of that stinking pink pollen, bring me the high-quality red pollen,” believing that there is something inherently inferior about their own kind.

It all goes back to institutionalized racism,” says Jones. She suggests that if society would address institutionalized forms of racism: mix up the soil, mix up the seed, fertilize; then the personally mediated and the internalized forms would also disappear.

Participant Pearl: The conference exceeded my expectations. Each day offered new and different topics and ways to share. The final plenary was excellent - hopefully will spur us on to address and act on important issues.

Barbara Ferrer:
Deputy Director, Boston Public Health Commission

Race and ethnicity are not equivalent: race, a classification system set up to perpetuate and create white privilege and oppress people of color, is a political concept; ethnicity is a cultural concept.

To undo institutional racism within the health care system, one has to dismantle current systems of organization and move to participatory structures and strategies that allow people served to be leaders and decision makers. We must ‘clean up our own shop,’ and promote an ‘anti-racism’ work environment; develop a mission, goals and objectives and an institutional commitment to undoing racism, with performance measures so that we can be held accountable. We must build and support community partnerships as a way of reaching many voices, work to increase diversity at all levels, create tools that look at institutional racism, and measure and review progress over time. We are creating learning circles and work teams that enable people to set goals and objectives, do their own measures and work in non-hierarchical settings.

We are creating a grievance process to address racism and are reviewing sick leave, bereavement and family leave policies, mechanisms for better recruitment and retention of people of color and uniform standards for collecting information on race and ethnicity.

Sponsoring “Undoing Racism” training for others including contracted providers is a key part of this process. We are working across other city departments such as schools, police, housing, prisons and human services. We link contract funding to efforts that reduce disparate health indicators in contracts requiring collection of race and ethnicity data, annual reports with information on health outcomes by ethnicity, projects to reduce documented disparities (we are providing funding to support those projects) and assessment of institutional and community cultural competency.

Public Health must shift focus from personal health behaviors to institutions and systems, retaining and retooling staff, and must work with existing coalitions and leaders who are already addressing racism, and shift resources.

Camara Jones:
Research Director on Social Determinants of Health, CDC

For more of the great presentations offered at TermsCHANGE 2002, visit the website www.citymatch.org. Click on video CHANGE. Camara Jones video presentation is available on line, and copies can be ordered from CityMatch.
Undoing Racism, for Social Justice

There are many contributors to health disparities, including intergenerational exposures that include social, cultural, and environmental factors; socioeconomic status or social environment; health behaviors; health care differences and access; accumulative historical, and racism. Different combinations of these factors may contribute to adverse health outcomes. Many of these factors contribute, but don’t entirely explain gaps between African Americans and Whites in rates of pre-term delivery. Racism is an independent contributor, acting as both an independent stressor and interacting with other factors.

Camara Jones’s article, “The Gardener’s Tale,” is a good allegory for how racism plays out over time and impacts individuals, communities and institutions. Social factors that occurred many years ago set the stage for health disparities today. Population-risk accumulation is defined as experiences that build inter-generationally. Historical experiences of slavery, segregation, and discrimination, created the original disparities that continue to impact health.

Michael Lui: African Americans babies born to mothers who experience racial discrimination during pregnancy are three times as likely to be born with very low birthweight compared to babies whose mothers did not have this experience. There is a direct relationship between residential segregation and infant mortality. In American cities, the more segregated the city, the higher the infant mortality rate.

The more racial discrimination African American high-school women experience, the more likely they are to smoke cigarettes. Among African American college students, the experience of racial discrimination is actually the strongest predictor of cigarette smoking.

We know racism is stressful; often you can’t fight it and you can’t run away from it. In the face of repeated or chronic stress, the body loses its ability to self-regulate. If you were pregnant and had all these stress hormones, they may initiate a biological cascade leading to preterm delivery or other adverse effect on the placenta blood flow, leading to uterine growth restriction. These stress hormones can interact with brain chemicals to program anxiety and depression, can act on blood vessels to cause them to lose elasticity, can alter metabolism and put one at a higher risk for hypertension, heart disease and stroke.

Stress suppresses the immune system, increasing susceptibility to certain types of infections and cancers. As a response to infection, the body assumes an inflammatory system. As soon as a threat is identified, the immune system is activated, it starts to shut itself off, so it doesn’t damage the body’s systems. Chronic or repeated stress reduces one’s ability to shut off the inflammatory response. If you subject a group of black and of white women to mistreatment, the blood pressure of the African American women will be higher due to stress.
**Skills for Change**

**Managing Organizational Change**

Framed against a backdrop of sweeping changes in leadership, resource and the organization of local public health agencies, this workshop enabled participants to see and seize change as a necessary, inevitable, and often welcome chance to improve maternal and child health. Peck illustrated steps involved in the change process, and shared effective tools and strategies to better manage organizational transitions.

- **Pearls from Peck**
  - Our ability to work on behalf of the changes we want to see in the world depends on the quality of our relationships, the quality of our communications, and the stories we tell ourselves.
  - Conversation is the way we humans think together. Real change begins with the simple act of people talking about what they care about.
  - When we make the space to speak, to be heard, to listen to others, we are able to make sense of our everyday experience, heal divisions and forge connections, and recommit our human capacity for resourcefulness and resilience.

**Communicating Results**

This hands-on workshop offered participants the basics of effective public health communication from a practice perspective.

- Unique skills are needed for local health departments and their partners to articulate their most promising and proven practices to targeted audiences to better disseminate their results, and this skills-builder showed participants how.

- **Pearls from Churchill**
  - Communications messages must reach people, persuade them of the validity of the information, and convince them to take appropriate action. How does one best create an effective message?
  - Remember your 5C’s: Single Overriding Communications Objective. What is new? What works best? Who is affected?
  - Steps in a Successful Public Health Marketing Campaign:
    1. Develop rapport with our public.
    2. Be patient and persistent.
    3. Repeat, modify, and update.
    4. Use all appropriate avenues.
    5. Ultimately speak person-to-person.

**THE MATERNAL AND CHILD HEALTH JOURNAL**

Published under the auspices of the Association of Maternal and Child Health Programs (AMCHP), Association of Teachers of Maternal and Child Health (ATMCH) and CircMatCH.

The journal aims to provide the first exclusive forum to advance the scientific and professional knowledge base to the MCH field. The journal encourages an active dialogue across the full spectrum of the MCH field to address new issues and concerns that confront us, to strengthen our current practices and policies, and to improve further the health and well-being of MCH populations. The MCH Journal welcomes all articles that strengthen the maternal and child health field. Subscription and other information available online at: http://www.cklweronline.com/issn/1592-7873

**Writing and Publishing “Best MCH Practices”**

Current public health journals could benefit from more articles about best practices in the field, but not enough of us know how to get ‘what works’ into print for others to emulate. Dr. Kotcheluck’s teaching focused on the art and the skills of preparing for scientific publications. With a combination of presentation and facilitated discussion, participants learned how to translate proven practices into articles for the literature.

- **Pearls from Kotcheluck**
  - Why publish: to share your experiences, inform colleagues of a new program, gain public publicity, validate a program’s success, advance practice or scientific knowledge, for personal reward/advancement, because you enjoy writing, or because it is a requirement of your job, and many other motivations.
  - What are the five key areas of focus of the *Maternal and Child Health Journal*: MCH epidemiology, demographic and health status assessment, innovative MCH service initiatives, implementation of MCH programs, MCH policy analysis and advocacy, MCH professional development.
  - Professional journals should be only one part of a project’s Dissemination Strategy: A good dissemination strategy should define specific audiences and target them with specific messages, there are multiple venues for dissemination: brochures, websites, NCEMCH newsletters, conference presentations, and others.

**Balancing Competing Priorities: Bioterrorism & MCH**

What are the risks and opportunities for women and children and four public health capacity to serve them in an era of bioterrorism? Roundtable discussion led by Betty Thompson, Director, Health Access and Assurance Nashville-Davidson County (TN) Health Department.

- Described how other urban health departments are balancing their MCH agendas amid the continuing threat from prevention and safety to security. Excerpts from each panelist follow:
  - Carolee Douglas: Look at what you have in terms of being an MCH leader or a person with a particular interest in MCH and then at what you might have to sell to this widely diverse and multidisciplinary group, sometimes people that you either have not interacted with or maybe have interacted with on an entirely different level for emergency response.
  - I can see the benefits in particular, of bioterrorism preparedness being more closely connected to maternal and child health. We have a lot to bring to the table.
  - The very first priority was to determine the most important existing MCH services and programming and rank that with priority, because it was clear that you weren’t going to have the energy to take on new activities and at the same time, grieve and moan over what couldn’t get done during this time of preparing and gearing up. That was very important in terms of leadership. If we have it clear, it will be easier to help our staff redirect their work and the work of others.

**Lawrence Sands:** It makes no sense to develop a separate system or process in public health separate from the other emergency management systems. You need to develop a system in public health that integrates smoothly and seamlessly with your community’s emergency management system.

- When your agency goes into emergency response mode, you’re a new agency, a whole different organization. You are no longer the organization you were the day before when you were doing your routine activities, you now reorganized to respond to an entirely different level for emergency response.

**Mike Fraser:** NACCHO has been working on bioterrorism preparedness at the local level since about 1999, when the first bioterrorism grants were released to states. We have a little bit of experience and certainly learned a lot more since September 11th, 2001.

For those not directly involved with the smallpox vaccination policy in your jurisdiction, consider asking about this. As I understand MCH, one of the core functions is immunization or at least assuring immunizations are taking place. To have the folks working on bioterrorism in one place and the folks doing the immunizations in another makes no sense to me.

**Participant Pearl:** I was especially impressed that one of the topics was on bioterrorism relating to MCH: thanks to [Carolee Douglas].

- Finally, a clear understanding.

**Skills for Change**

**ROUND TABLE PARTICIPANTS**

- Carolee Douglas, Chief, Community Health Services Division, Lincoln-Lancaster County (NE) Health Department
- Michael Fraser, Senior Advisor, National Association of County and City Health Officials, Washington, DC
- Lawrence Sands, Director, Bio Defense, Maricopa County Department of Public Health, Phoenix, AZ

**WANT TO KNOW MORE?**

Head to the CityMatCH website at http://www.citymatch.org. Click on Urban MCH Conferences & CHANGE, and on CityMatCH and CHANGE Follow-up. You’ll be led to Dr. Sands’ full presentation. Also, check out the NACCHO site at www.naccho.org for Dr. Fraser’s full presentation.
Managing Organizational Change

LAURA PECK:
Organizational Strategist, Claris Consulting, Albany, GA

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R. ELLIOTT CHURCHILL:
Senior Communications Officer, Epidemiology Program Office - DOH, Centers for Disease Control and Prevention, Atlanta, GA

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R. ELLIOTT CHURCHILL:
Senior Communications Officer, Epidemiology Program Office - DOH, Centers for Disease Control and Prevention, Atlanta, GA

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Writing and Publishing “Best MCH Practices”

MILTON KOTELUCH: Editor, Maternal and Child Health Journal, Boston University School of Public Health, Boston, MA

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- What are the five key areas of focus of the Maternal and Child Health Journal: MCH epidemiology, demography and health status assessment, innovative MCH service initiatives, implementation of MCH programs, MCH policy analysis and advocacy, MCH professional development.
- Professors and journals should be only one part of a project’s Dissemination Strategy: A good dissemination strategy should define specific audiences and target them with specific messages, there are multiple venues for dissemination: brochures, websites, NCEMCH newsletters, conference presentations, and others.

Balancing Competing Priorities: Bioterrorism & MCH

LAWRENCE SANDS, Carole Douglas, Michael Frase, Betty Thompson

Balancing Competing Priorities: Bioterrorism & MCH

What are the risks and opportunities for women and children and four public health programs’ capacity to serve them in an era of bioterrorism? Roundtable discussion led by Betty Thompson, Director, Health Access and Assurance Nashville-Davidson County (TN) Health Department, described how other urban health departments are balancing their MCH agendas amid the continuing shifts from prevention and safety to security. Excerpts from each panelist follow:

Carole Douglas: Look at what you have in terms of being an MCH leader or a person with a particular interest in MCH and then look at what you might have to sell to this wildly diverse and multidisciplinary group, sometimes people that either have not interacted with or maybe have interacted with on an entirely different level for emergency response.

I can see the benefits in particular, of bioterrorism preparedness being more closely connected to maternal and child health. We have a lot to bring to the table.

The very first priority was to determine the most important existing MCH services and programming and rank that with priority, because it was clear that you weren’t going to have the energy to take on new activities and at the same time, grieve and moan over what couldn’t be done during this time of preparing and gearing up. That was very important in terms of leadership. If we have it clear, it will be easier to help our staff realign and do the new priorities.

Lawrence Sands: It makes no sense to develop a separate system or process in public health separate from the other emergency management system. You need to develop a system in public health that integrates smoothly and seamlessly with your community’s emergency management system.

When your agency goes into emergency response mode, you’re a new agency; a whole different organization. You are no longer the organization you were the day before when you were doing your routine activities, you now reorganized into two systems; one that allows for emergency response.

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When your agency goes into emergency response mode, you’re a new agency; a whole different organization. You are no longer the organization you were the day before when you were doing your routine activities, you now reorganized into two systems; one that allows for emergency response.

Mike Fraser: NACCHO has been working on bioterrorism preparedness at the local level since about 1999, when the first bioterrorism grants were released to states. We have a little bit of experience and certainly learned a lot more since then, as of September 11, 2001.

For those not directly involved with the smallpox vaccination policy in your jurisdiction, consider asking about this. As I understand MCH, one of the core functions is immunization or at least assuring immunizations are taking place. To have the folks working on bioterrorism in one place and the folks doing the immunizations in the other places involved in any way? Do the immunizations in the clinics in another and not making that link is a real problem.

With 3,000 plus counties in the country, the federal government, and certainly your state public health agencies do not have the work force to fly in and do a mass vaccination in your jurisdiction.

Whether you like it or not, this is going to get dropped on the local lap and certainly you need to think about how you would do that in addition to your routine functions.

Build on the successes you’ve had dealing with MCH issues, your community involvement is really important in all your programs. Bioterrorism is just another one of those on which to build. We all need to sit at the table to work this out, whether we’re in MCH, whether in environmental health, whether in any of the other program areas in your agency.

It’s going to take all of us. We need everybody at the table and the success we’ve had dealing with MCH is only going to make your BT preparedness that much more successful.

RONDOUT PARTICIPANTS

- Carole Douglas, Chief, Community Health Services Division, Lincoln-Lancaster County (NE) Health Department
- Michael Fraser, Senior Advisor, National Association of County and City Health Officials, Washington, DC
- Lawrence Sands, Director, Bio Defense, Maricopa County Department of Public Health, Phoenix, AZ

WANT MORE TO KNOW?

Head to the CityMatch website at http://www.citymatch.org. Click on Urban MCH Conferences & CHANGE, and on CityMCH and CHANGE. Follow-up. You’ll be led to Dr. Sand’s full presentation. Also, check out the NACHO website at http://www.nacho.org for Dr. Fraser’s full presentation.
There are many contributors to health disparities, including intergenerational exposures that include social, cultural, and environmental factors; socioeconomic status or social environment, health behaviors; health care differences and access; accumulative history, and racism. Different combinations of these factors may contribute to adverse health outcomes.

Many of these factors contribute, but don’t entirely explain gaps between African Americans and Whites in rates of pre-term delivery. Racism is an independent contributor, acting as both an independent stressor and interacting with other factors.

Camara Jones’ article, “The Gardener’s Tale,” (see page nine) is a good example for how racism plays out over time and impacts individuals, communities and institutions. Social factors that occurred many years ago set the stage for health disparities today. Population-risk accumulation is defined as experiences that build inter-generationally. Historical experiences of slavery, segregation, and discrimination, created the original disparities that continue to impact health.

Medium income for black families in the US is less than $28,000; for whites and Asians it is more than $45,000. The average net wealth (often gained by home-ownership) of blacks is about one-tenth of whites. African Americans are more likely to live in low income and/or segregated areas with higher concentration of risk with less access to affordable, healthy foods at grocery stores located within the community. Solid waste dumps are more often located nearby.

On nearly every block in the African American communities in Los Angeles, you will see liquor stores, tobacco ads and liquor billboards strategically targeted.

Another contributor to health disparities is health behavior. You might ask, “How is this related to racism?” Consider the “Circle of Influence.” Individuals are in the center; everything they do is influenced by these other rings that include family, social network, social environment, provider in health care system in state and local and national policy. Individual actions are affected by experiences in the surrounding rings. Good behavior is not always under total individual control. Unless the social-environmental factors are altered, changes in individual behavior are unlikely.

The recent Institute of Medicine report (see page three) uncovered extensive evidence of racial and ethnic differences in the provision of health care, differences that crossed diagnostic tests and procedures, therapeutic procedures, the intensity of care, pain control and preventive services. These differences contribute to differences in health outcomes.

By doing nothing, you contribute to the problem. Left unaddressed, problems compound like a snowball rolling downhill, gathering strength, getting larger, and harder to deal with. Overt racism consciously perpetrated by decision-makers, and acts of omission, inaction or inadvertent action help to sustain and exacerbate the effects of historical racism.

MichaeLiLiu:
Associate Professor
Community Health Sciences,
University of California Los Angeles

Michael LiU:
Associate Professor
Community Health Sciences,
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to the accumulative impact: wear and tear on the body’s adaptive systems, programmed with a response to mistreatment. If a woman is pregnant and subjected to racial discrimination, her placenta puts out stress hormones that cross the placenta. The baby is bathed in these stress hormones while its own system is developing, which may lead to higher stress reactivity in the baby later in life. When the baby is later exposed to stress, it may not have the same stress responses as older individuals. When that baby later becomes a mother herself, maybe the previous exposure was one that mother to program her baby have higher stress reactivity.

Racism acts in a single point in time, but really across the life course and across generations. If you really want to do something about health disparities, you have to work on all the factors that got them there in the first place. For many women of color, racism is one of the most important factors.

RACE AND ETHNICITY

Race and ethnicity are not equivalent: race, a classification system set up to perpetuate and create white privilege and oppress people of color, is a political concept; ethnicity is a cultural concept.

To undo institutional racism within the health care system, one has to dismantle current systems of organization and move to participatory structures and strategies that allow people served to be leaders and decision makers. We must “clean up our own shop,” and promote an “anti-racist” work environment; develop a mission, goals and objectives and an institutional commitment to undoing racism, with performance measures so that we can be held accountable.

We must build and support community partnerships as a way of hearing many voices, work to increase diversity at all levels, create tools that look at institutional racism, and measure and review progress over time. We are creating learning circles and work teams that enable people to set goals and objectives, do their own measures and work in non-hierarchical settings.

We are creating a grievance process to address racism and are reviewing sick leave, bereavement and family leave policies, mechanisms for better recruitment and retention of people of color and uniform standards for collecting information on race and ethnicity.

Sponsoring “Unpacking Racism” training for others including contracted providers is a key part of this process. We are working across other city departments such as schools, police, housing, prisons and human services. We link contract funding to efforts that reduce disparately adverse language and terms in contracts requiring collection of race and ethnicity data, annual reports with information on health outcomes by ethnicity, projects to reduce documented disparities (we are providing funding to support those projects) and assessment and foster institutional cultural competency.

Public Health must shift focus from personal health behaviors to institutions and systems, retaining and retooling staff, and must work with existing coalitions and leaders who are already addressing racism, and shift resources.

Levels of Racism: A Gardener’s Tale

The following allegory was used by Camara Jones in her video presentation to participants at recent CHANGE: “A gardener has two kinds of seed, red and pink, and two flower boxes. One contains rich soil and one has poor, rocky soil. The gardener favors red flowers over pink, so she plants the red seed in the rich soil and the pink seed in the poor soil. Year after year, the rains water, the sun shines, and the gardener harrests the flowers. But she never changes the soil. The red flowers flourish in the rich soil. But the pink flower languishes—the strongest make it to middling height, the weakest die. The gardener notices the difference, but soon forgets her original decision to put poor soil in one flower box and rich soil in the other. ‘It’s really good that I liked red flowers because they’re much prettier,’ she thinks.

The analogy to institutional racism arises from the flowers being contained in separate boxes, and is perpetuated by the gardener failing to fertilize or mix the soil. An example of personally mediated racism would be if she purposefully removed a stray pink seed that found its way into the red flower box. Internalized racism results when the pink flowers, realizing they are all scraggly, say to the bee, ‘Don’t bring me any of that substandard pink pollen, bring me the high-quality red pollen,’ believing that there is something inherently inferior about their own kind.

It all goes back to institutionalized racism,” says Jones. She suggests that if society would address institutionalized forms of racism: mix up the soil, mix up the seed, fertilize, then the personally mediated and the internalized forms would also disappear.

Head to the CityMatch website at http://www.citymatch.org, Click on Urban MCH Conferences & Event CHANGE. MCHC is a follow-up. You’ll need to lead more detailed information and posters from selected emerging best practice profiles, or call the Central Office at 402-961-7500.

Emerging MCH Best Practice Profiles

Each year CityMatCH members have been asked to profile a successful MCH effort in their communities. As part of the unique dissemination model that is “TermsCHANGE,” current PPOR, HIV, and UIE teams were asked to submit “Best Practice Profiles.” Each team submitted a profile of a recent innovative activity, strategy or lesson learned that strengthened their capacity to serve women, children and families. Selected submissions were presented during the “Emerging MCH Practices” sessions at CityMatch 2002.

Additionally, all teams were instructed to craft posters to communicate findings and summarize results, and some were recognized with awards. Phoenix PPOR received an award for “Effective Communication” for outstanding development and use of effective tools to communicate and promote PPOR locally. The STAR Award was given to the Philadelphia PPOR Team for using PPOR data to focus and promote effective fetal-infant mortality prevention strategies. (See profile for more details).

Great thanks to the March of Dimes for hosting the poster reception and being a great partner in Saving Babies, Together.

~ Translating Evidence into Effective Practice ~

Claude Earl Fox, Director of the Urban Health Institute, at the Johns Hopkins University, Baltimore, MD, and William M. Sappenfield, Medical Epidemiologist and MCH EPI Team Leader, Dir. of Reproductive Health/NCDDPHF, Centers for Disease Control and Prevention, Atlanta, GA met outages in a restaurant-style table before ISTECHANGE 2002. Participants and Sappenfield shared their thoughts in a conversation about the importance of going beyond what is known from the literature and published reports into evidence-based practice and data-driven policies in public health. A systematic approach to ask the right questions, get the complete information we need to effectively and appropriately answer, thoughtfully evaluates the new information gained, and uses the findings to create, change and enhance policy and programs is ideal, but seldom practiced. What will it take to change how we do business?

Barbara FERRER:
Deputy Director, Boston Public Health Commission

Participant Pearl:
This conference exceeded my expectations. Each day offered new and different topics and ways to share. The final plenary was excellent - hopefully we will spur us on to address some of the important issues.
Woven throughout the National Change Center’s (CATC) review of literature by L. Jackson and L. Williams, we see that the public’s perception of the rights of children has evolved significantly over the past few decades. CATC was established in 1989 to provide a forum for the exchange of ideas and best practices in the field of children’s rights. This year, CATC has published a comprehensive review of the literature on children’s rights, including a section on the rights of children in health care. The review includes an analysis of the literature on children’s rights in health care, as well as a discussion of the implications of these findings for policy and practice.

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A kickoff event afforded opportunities to learn about leadership, team navigation, and strategy to get measurable and intended results for improving urban women and children’s health.

Kay Johnson, President, Johnson Consulting Group, and Magda Peck, CityMatCH CEO, served as Navigation guides through a series of exercises:

1. **Really Unusual Treatment!** At the start of the Conference, teams were given materials needed to crack the first “case,” based on a scenario about using the results of the recent Institute of Medicine (IOM) report, “Unhealthy Cities: Confronting Risk and Equity: Disparities in Health Care.” All of the thirty teams met the deadline for handing in a unified response.

2. **True Confessions.** Team conversation about systems building was the warmup needed for the “Confession” plenary session. Amos Smith, Director of Health Grantmaking for the Community Foundation for Greater New Haven (CT) and Aramada Ayala, Section Manager of Special Studies for the County of Los Angeles (CA) Office of AIDS Programs and Policy at the County of Los Angeles’ Department of Health Services shared their views on what it takes to overcome bureaucratic troubles that can plague local public health systems. Participants heard their “true confessions” of how better, more integrated systems for women, children and families can emerge from persistence and teamwork.

3. **Aha! Roundup.** The final morning of switchCHANGE, each Navigation Team generated its “Top Ten” list of concepts learned that would be most useful in their work back home. (Selected “Ahas!” listed below) This exercise encouraged cross-fertilization of ideas and fostered sythesis of the three-day event.

**Building Urban MCH Capacity** has been funded by the Centers for Disease Control and Prevention (CDC) to assist urban public health leaders with new assessment and surveillance tools and methodologies. One of two focus areas in this cooperative agreement is the Perinatal Periods of Risk (PPOR) Approach to Reducing Infant Mortality in U.S. Cities. This joint initiative of CityMatCH at the University of Nebraska Medical Center, the CDC, the National March of Dimes Birth Defects Foundation and HRSA/ MCHB to monitor and investigate fetal-infant mortality.

CityMatCH is in partnership with the CDC and the March of Dines, launched the PPOR Practice Collaborative to generate evidence-based PPOR practice in U.S. cities. Over the next two years, CityMatCH will continue to disseminate the information, utilization and integration of the PPOR Approach in U.S. urban areas. Intensity strategies are grouped into three levels:

Level One: General Communications, offers general information about the PPOR approach, dissemination of best practices and enhanced peer exchange.

Level Two: Learning Network is for communities using or planning to use the PPOR approach. Level Two will increase knowledge, awareness, understanding and integration of systems among urban health departments and community partners who are using the Perinatal Periods of Risk. Members will have access to information about emerging best practices using proven communications vehicles and tools. Registered CityMatCH member health departments and their partners will want to implement the full PPOR approach, attend one of the CityMatCH on-site training workshops, and submit their partnership to CityMatCH about their experience are eligible.

Level Three: PPOR-Practice Collaborative Adancement Collaborative (PAC). From December 2002 to December 2004, selected members, urban health department representatives, and partner organization partners who work with CityMatCH and our national partners to institutionalize the PPOR approach across the U.S. The Practice Adancement Collaborative will assist the PPOR initiatives implemented in these cities to improve health of women and infant’s health. The ultimate goal of the PPOR-PAC is to improve the health of women and infants participating in urban communities through effective use of the PPOR framework in the broader public health systems change.

**Eliminating Perinatal HIV Transmission: An Urban Strategy** was funded by CDC to strengthen prevention of AIDS-related disease and disability among women and children in U.S. cities. This partnership builds upon the previous cooperative agreement, “Preventing Perinatal Transmission of HIV in U.S. Cities.” CityMatCH will continue to disseminate information on the epidemiology, new science and best practices of perinatal HIV prevention to urban MCH and HIV communities, work with local partners, foster collaborative cross-city learning, targeting selected urban communities, and involve additional communities to become involved in a learning network. Strategies, models and tools to address issues and better understand individual cases of perinatal HIV mortality and morbidity will be enhanced and adopted. Intensity strategies are grouped into three levels:

Level One: General Communications will disseminate information about perinatal HIV prevention to and among the most affected urban areas. Participants will receive city-specific HIV/AIDS rates, related surveillance data and emerging prevention strategies, engage in electronic discussions, and have opportunities to partner with original Urban Learning Cluster cities and attend workshops and/or skill-building sessions at the annual CityMatCH Conference.

Level Two: Urban Learning Network will increase information and communication about perinatal HIV prevention to and among the most affected urban areas. Participants will receive city-specific HIV/AIDS rates, related surveillance data and emerging prevention strategies, engage in electronic discussions, and have opportunities to partner with original Urban Learning Cluster cities and attend workshops and/or skill-building sessions at the annual CityMatCH Conference.

Level Three: Urban Prevention Collaborative (UPC) builds upon the current Learning Cluster to further strengthen capacity, foster team-based shared leadership and promote greater systems integration between MCH and HIV/UPC Working groups will conduct feasibility studies on select issues and report findings and recommendations to the CDC and other national partners.

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CityMatCH Presents First “How-to-Do” PPOR Workshop at MCH Epi Conference

Since 1997, in partnership with CDC, the March of Dimes and several major cities, CityMatCH has led national efforts to validate, enhance and adapt the PPOR approach for greater use in mobilizing U.S. cities to reduce fetofetal mortality.

In conjunction with the annual Maternal and Child Health Epidemiology Conference held in Clearwater Beach, Florida on December 13th-14th, 2002, CityMatCH staff and national faculty shared concepts about PPOR by offering approximately forty workshop participants the opportunity to:

- Recognize and understand all components of the PPOR Approach;
- Learn how to assess “community readiness;”
- Achieve a common understanding of what it takes to conduct the first phase of analysis;
- Learn how to shift focus from PPOR data to using the PPOR approach for systems change; and
- Obtain certification to participate in upcoming CityMatCH PPOR Level 2 activities.

For more information about the Perinatal Periods of Risk Approach and CityMatCH efforts to reduce infant mortality in U.S. cities, see the related article on page 11, “Building Urban MCH Capacity.”

The next “How-To-Do” PPOR Training will be held during the 2003 AMCHP Annual Conference, “Mobilizing to Eliminate Health Disparities” March 8 - 12 at the Crystal Gateway Marriott in Arlington, VA. “How-To-Do” PPOR Training will be part of the Pre-Conference Skills-Building Workshops taking place on March 8. If you are interested in attending, please contact LaToya Williams at CityMatCH, 402-561-7500.

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