

# CityMatCH CityLights

Promoting communication and collaboration to improve the health of urban women, children and families

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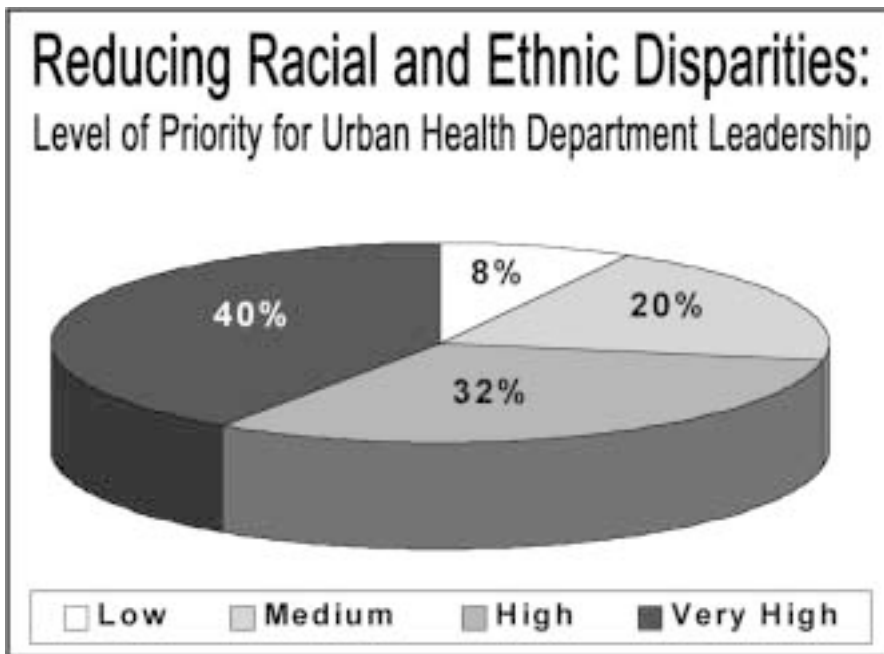


## Racial & Ethnic Disparities in Urban MCH



**E**liminating racial and ethnic disparities remains key to achieving better health outcomes for *all* who live in America's urban centers. It is one of CityMatCH's leading priorities. Our efforts in this area are threefold: stimulation of honest discourse, promotion and dissemination of science for evidence-based action, and building the capacity of urban health departments to impact disparities and strive to understand and undo generations of damage caused by racial and ethnic discrimination.

This edition of *CityLights* mirrors the CityMatCH strategy by including **Assessment**: "What we know," and "What we can do;" **Translation** of key issues into public health practice, reviewing key CityMatCH tools developed over time, highlighting selected **Practices**: such as California's Black Infant Health Project, and looking closely at how effective **Alignment** and **Integration** of initiatives and tools in cities can lead to change.



Source: 2001 NACCHO - CityMatCH Survey  
(See inside: pages 3 - 6)

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## Weeds Within

Magda Peck, ScD  
CEO, Executive Director  
of CityMatCH

There are certain stories that best lay dormant, untold for years. The very thought of them can stir embarrassment or open unhealed wounds. Sleepy stories must be ready to be told; it is time for this one to awaken. In the span it has taken for Sam to grow from babe in arms into a young man whose strong arms encircle me, I have come to better understand the

hurt and doubt I caused that day years ago.

It was a time of many firsts, and first baby loomed larger than all others. Though I had worked at the health department

for less than a year, already I was ripe to deliver. Professional and personal work were prenatally braided. I was surprised when they offered to throw me a shower, and in the office no less. Chronic staff tensions were palpable, with occasional flares. Doctor vs. nurses, RN's vs. MSW's, White vs. Black vs. Latino vs. Asian, professional vs. grass roots. Each of us was convinced that she was most right, needing for others to be mostly wrong. With belly humongous, just days to go, we gathered in the conference room for potluck potpourri. The party conversation turned from caseloads to children, from data to deliveries to childcare and then to names. We lightly swapped stories of naming our kids and how our parents named us.

When asked of the origin of my unusual name, I told a story that had oft been told in my family. There had been

two birth certificates. When my *father's father* learned that I was to be named for *his* father George, in accordance with our tradition for honoring the dead, he insisted the first be torn up. No granddaughter of his was going to bear the name of a Southern state populated by so many "blacks." The ugly Yiddish word he used was not easily repeated. "*So that is how 'Georgia' became my middle name,*" I told them. An abrupt silence followed, the festivities ended, potluck gone sour.

The following day's formal accusation of racism lodged by one of my colleagues brought stunning shame. She insisted that I be fired, for how could the City trust someone with such deep seeded racial bias to be responsible for interpreting data on racially sensitive issues like infant mortality? I was mortified and afraid, certain that my career was unjustly damaged. My liberal Jewish sensibilities were stung; defensive righteousness spewed forth. Hadn't I spent most high school weekends rebuilding inner city houses and sleeping in church basements? Hadn't I stood with my family on the steps of the Lincoln Memorial, yards from Reverend Dr. King at the March on Washington? Hadn't I gone into public health to address injustices like racial disparities?

In my family, the naming story had always been told in context: to illustrate how times have changed, to acknowledge how our ancestors could be blatantly prejudiced, how in every generation the pursuit of justice includes righting the wrongs of our elders. The naming story also had only been told *among* family. That afternoon in the conference room, I was oblivious to the boundaries I had crossed, unaware of the offense I had triggered.

In time, my colleague dropped the complaint; our staff underwent cultural competency training. But the wounds did not quickly heal; its lessons were not fully learned. New baby in arms, new

job for my spouse, we moved to the Midwest for a new beginning.

I have spoken before of the many powers of story: how every great story reveals a piece of us, reflecting in words and in endings our own possibilities. About its power to haunt us with verbal melodies that we find ourselves singing aloud. Of the power of healing that is unleashed with each telling, soothing the listener, releasing she who tells. Like mirrors and music, all stories are. But the greatest power of a really great story is its magical medicine that cleanses the soul.

In telling this old story, I hope for healing; telling it scours my soul. I have since learned that casting a dent in the thick, institutionalized underbrush of racism that entangles our communities and our nation starts with casting out seeds of racism that lie within. I may not have planted them, but I am still responsible for the weeds they bear, that can choke the breath of innocent children and hold back their mothers from safety and health.

In the 2001 NACCHO-CityMatCH survey results on addressing racial disparities included in this edition of *CityLights*, most urban public health leaders identified addressing racial disparities of high priority. At the same time, almost two-thirds said they were not adequately prepared to address "institutionalized racism."

This is a barrier we have yet to bust, that together we must, and we can. Undoing racism requires daily battle against the injustice of disparities through our collective public health work and own personal deeds. I believe

it can start with a story. What is yours? Who must you tell? And what will you do after that?



*"Casting a dent in racism . . . starts with casting out seeds of racism that lie within"*



## Undoing Racism: *Boston's Plan*

One city health department that is taking the challenge of institutionalized

racism head-on is the Boston Public Health Commission. In Boston, Black babies are much more likely to be born extremely premature than all other

babies. Technological advances are not successful at preventing high rates of death for extremely premature infants. It was determined that strategies for addressing extreme prematurity need to focus on the health of women prior to conception. Issues related to racism, economic inequality, and the distribution

of resources are cited as contributors to poor health outcomes.

In the May 2002 Perinatal Periods of Risk Practice Collaborative seminar, Deputy Director of the Public Health Commission, Barbara Ferrer recently reported on steps being taken to address Boston's problems.

In developing and implementing new strategies, the Boston Plan includes efforts  
(continued on page nine)

*Urban Health Department Efforts to Reduce Racial and Ethnic Health Disparities in MCH:*

# Results of the 2001 NACCHO and CityMatCH Survey

The National Association of County and City Health Officials (NACCHO), representing the nation's 3,000 city and county health departments, and CityMatCH joined efforts last summer to survey directors of local health departments on three national MCH priority areas: reducing racial and ethnic disparities, improving women's health, and strengthening data capacity and epidemiology.



Reported below are selected highlights on reducing disparities in MCH taken from the survey. Publication of final results for the complete survey is forthcoming. Presentations of results are planned for the CityMatCH, APHA, and national MCH Epidemiology meetings later this year.

**Methods and Response:** In May 2001, a 21-page, 54 question multiple choice and short answer questionnaire was mailed to all CityMatCH member health departments (N=149) and a stratified random sample of all other local health departments (N=677) based on three levels of jurisdiction size. The questionnaire was sent to the local health director. CityMatCH member health departments' MCH representatives were also notified. Non-responders were followed up by both mail and telephone. CityMatCH offered financial support to its national conference as an incentive for increasing the response from its members. Of the 828 surveys mailed, 313 health departments responded for a 38% overall response rate. The response rate for CityMatCH member health departments was 83%. The findings reported here are the results from the racial and ethnic disparity section of the survey of the 123 CityMatCH member health departments that responded.

## *Reducing Racial and Ethnic Health Disparities: An Urban Priority*

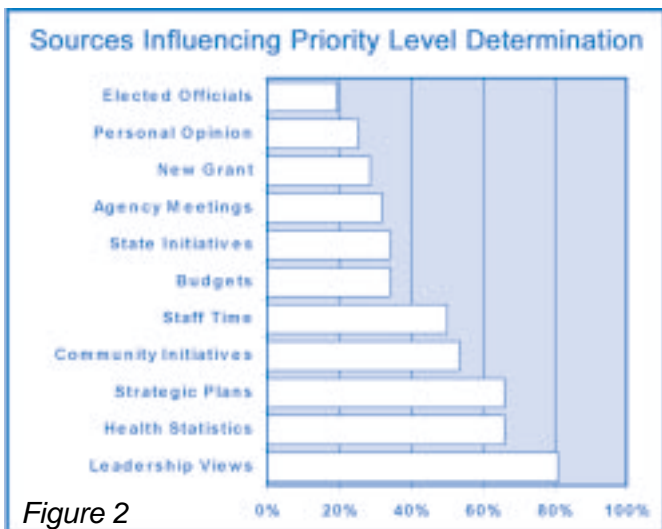
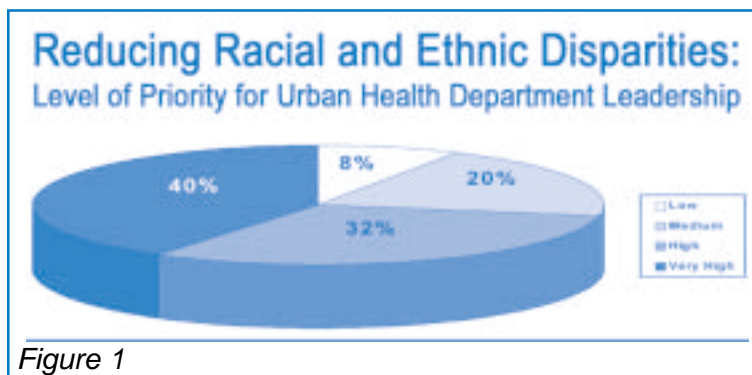
Addressing racial and ethnic health disparities is perceived to be of high priority by the leadership of a majority of the urban health departments responding to the survey. Local health officials were asked, "At this time, how much of a priority overall is reducing racial and ethnic health disparities for the executive management team or leadership of your health department?"

72% of urban health departments reported that it was a high or very high

priority for their health department. Only 8% of urban health departments reported that addressing racial and ethnic health disparities is of low priority (Figure 1).

When asked to indicate the criteria used to determine agency priority, most (81%) indicated that they relied on the views of leadership. Over half of responding health

departments also used health statistics (66%), strategic plans (66%), community initiatives that address racial and ethnic disparities (53%), and allocated staff time (50%) as means of assessing the priority level within their health department. Multiple responses were allowed (Figure 2).



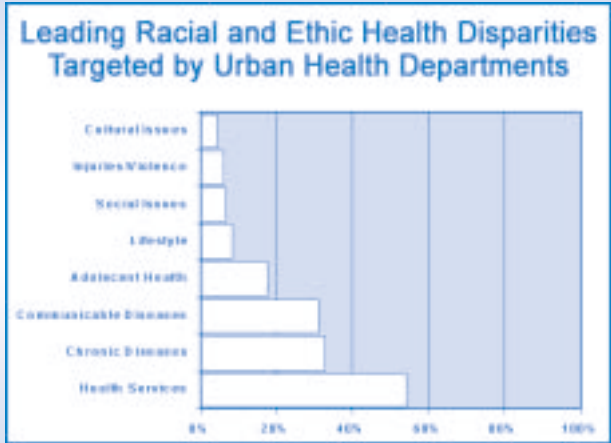
*"Before any problem is successfully addressed, it must be recognized and deemed worth confronting. One might think that initiating and sustaining a public discourse on racial disparities would be the easy part, but it is actually a formidable challenge. The most obvious aspect is the sheer number of disparities between whites and non-whites that one can plausibly highlight...the list of problems can paralyze by its very length."\**

\* **Facing Up to Racial Reality: Daunting Realities Hinder the Drive for Equality**, by Christopher H. Foreman, Jr, *Brookings Review*, Spring 2000, Volume 18, No. 2. Pages 29-30, The Brookings Institution, Washington, DC.

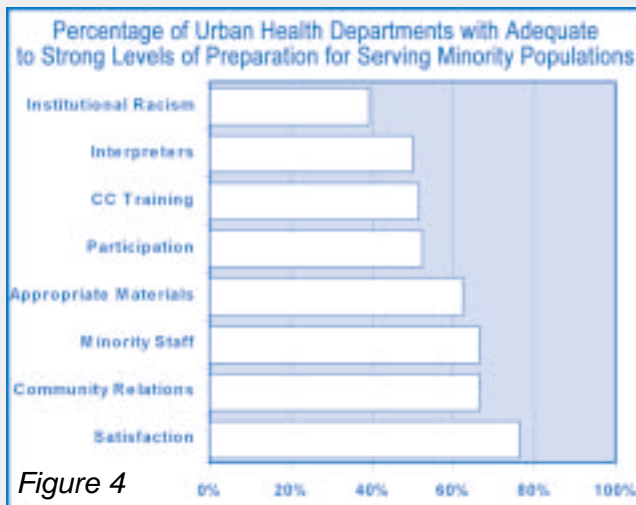
## Urban Health Department Efforts to Reduce Racial and Ethnic Health Disparities in MCH: Results of the 2001 NACCHO and CityMatCH Survey *Disparities Targeted by Urban Health Departments*

The number and range of racial and ethnic disparities in health is enough to give the most dedicated professional pause. How then do we begin the process of establishing priority areas and targeting efforts to reduce these particular disparities?

In the 2001 Survey, urban health departments were asked to list the top three racial and ethnic health disparities for women, children and families targeted by the health department. Over half (54%) responded that disparities in accessing health services were targeted by the health department, including access to prenatal care and oral health services. Disparities in chronic and communicable diseases, were the next most frequently targeted. Few health departments have chosen to take on directly larger systemic and social issues such as poverty and housing (7%) or cultural issues (4%) (Figure 3).



## *Health Department Preparedness: An Urban Challenge*



Addressing disparities in a meaningful, thoughtful way as part of a long term plan for optimizing community health is crucial to achieving the goals of initiatives such as Healthy People 2010 (see page 11). How well prepared are urban health departments?

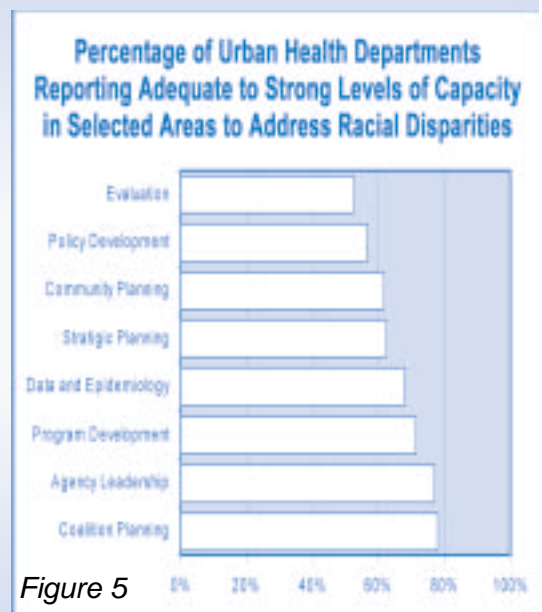
The Summer 2001 survey asked “How would you rate your health department’s preparation for serving minority populations in your jurisdiction on a scale of none, some, adequate, and strong,” more than half reported being strong or adequately prepared in the areas of customer satisfaction (76%), community relations (66%) hiring minority staff (66%), preparing culturally appropriate materials (62%), and offering cultural competency (CC) training (52%).

However, only 39% of urban health departments reported that they were adequately prepared to address institutional racism, a long standing barrier to racial equality (Figure 4).

## *Health Departments' Self-Reported Capacity to Address Health Disparities*

Local health departments were asked to rate the strength of their health department's capacity to address racial and ethnic disparities among women, children and families in certain areas. For purposes of the Survey, "capacity" was defined as having both the availability and ability to perform the functions they were asked to rate.

More than half of the responding CityMatCH member health departments reported a perception of having adequate to strong capacity in all areas addressed in the survey, including evaluation (52%), policy development (57%), community planning (61%), strategic planning (62%), data and epidemiology (68%), program development (71%), agency leadership (77%), and coalition planning (78%) (Figure 5).



## Urban Health Department Efforts to Reduce Racial and Ethnic Health Disparities in MCH: Results of the 2001 NACCHO and CityMatCH Survey

### Urban Health Department Approaches to Address Health Disparities

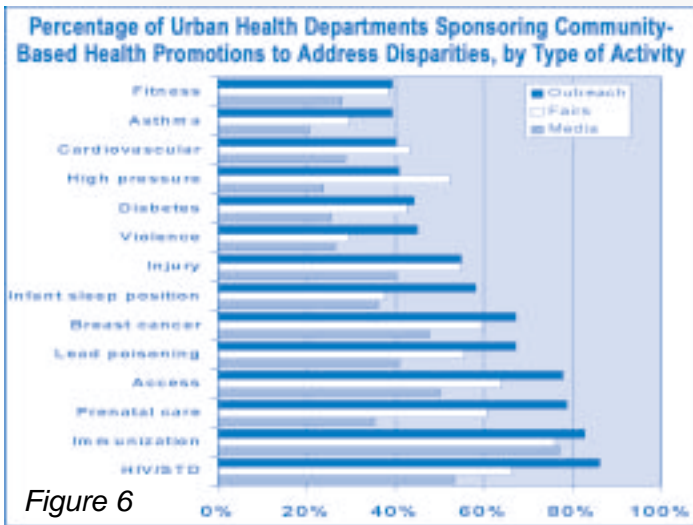


Figure 6

Health departments were asked to indicate activities in the last five years aimed at reducing racial and ethnic disparities that they were planning to do or had already done.

Most (89%) of the responding urban health departments reported planning or completing a needs assessment. Nearly three-quarters (73%) have created or are creating a strategic plan for addressing the area of racial and ethnic disparities. 53% of the respondents reported planning or completing a minority health report. Less than half of reporting health departments had received additional funding or reorganized to address the issue of racial and ethnic disparities (Figure 6).

### Health Promotion Activities to Reduce Racial and Ethnic Disparities

Surveyed health departments were given a list of MCH problems and asked, "In your jurisdiction for the past year, have any of the following community-based health promotion activities been sponsored solely by your health department or in collaboration with others to specifically reduce racial and ethnic health disparities?" For each problem, respondents were asked to indicate which type of activity they used for health promotion: media, community health fairs or outreach activities. HIV/STD education, immunization campaigns, and prenatal care were issues most commonly promoted by urban health departments. Less than half of responding health departments were promoting changes in fitness, asthma education, or issues related to cardiovascular disease by any means (Figure 7).

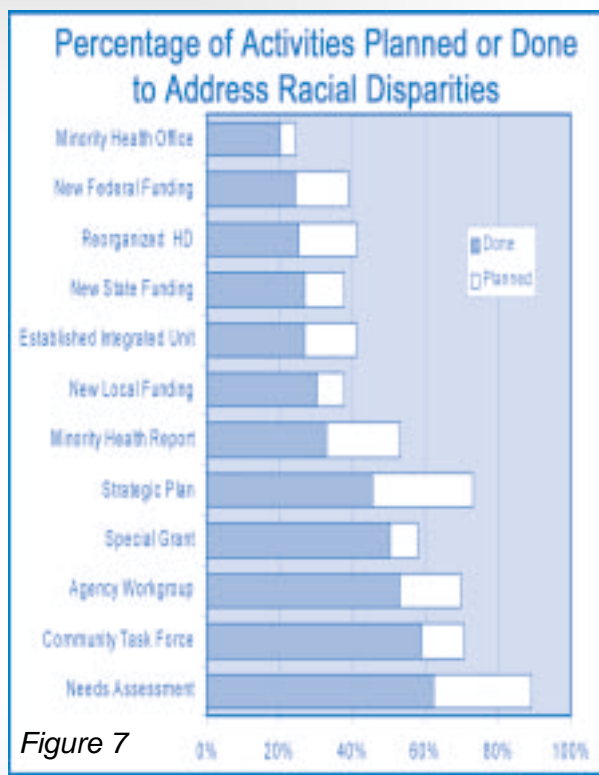


Figure 7

### Fostering Linkages Through Community Collaborations



Figure 8

Urban health departments were provided with a list of 22 organizations and asked, "What is the current level of collaboration between your health department and the following entities working to reduce racial and ethnic health disparities?" Level of collaboration was measured on a scale from "high" to "none," with "low" defined as occasional communication and/or meetings and "high" defined as a current joint initiative, activity, or other combined effort.

More than half of the health departments reported that they had medium to high collaboration with community organizations, human service agencies, community health centers and advocacy organizations. Religious organizations, substance abuse agencies and Head Start were the entities with which urban health departments were least likely to collaborate to address racial and ethnic disparities (Figure 8).

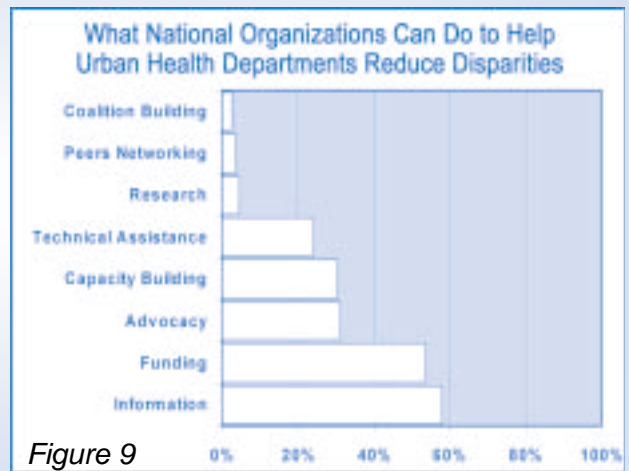
## Urban Health Department Efforts to Reduce Racial and Ethnic Health Disparities in MCH: Results of the 2001 NACCHO and CityMatCH Survey

### Can National Organizations Help?

Health departments were asked “*what three things can national organizations like NACCHO and CityMatCH do to help your health department make a substantial contribution to reducing racial and ethnic health disparities among women, children and families in your jurisdiction?*”

More than half of urban health departments responded that dissemination of pertinent information and providing financial resources are the most important functions that national organizations can provide.

Additionally, a third of the respondents or less indicated that national organizations should advocate for funding or policy changes on behalf of local health departments and continue to provide capacity-building activities and technical assistance (Figure 9).



### Next Steps: CityMatCH Responds

In a national survey that immediately predated the events of 9-11, 3 out of 4 public health leaders of local health departments that serve urban communities in the U.S. reported that reducing racial and ethnic disparities in maternal and child health was a leading priority. And as of last summer, most of the 83% of CityMatCH member health departments who responded to the 2001 NACCHO-CityMatCH survey perceived themselves to be up to the challenge.

Over half of the 123 responding health agencies say they have at least adequate capacity to carry out their core functions of data and assessment, planning, evaluation, and policy development in this critical arena. Over 75% perceived their agencies' leadership to be at least adequate for the task.

With access to health services and chronic and communicable diseases most frequently being targeted for change, most urban health departments were solely or jointly sponsoring a range of community based health promotion activities to reduce disparities in HIV/STD, immunizations, and prenatal care. Less than half of the health departments that responded to the survey received

additional funding or reorganized specifically to reduce racial and ethnic disparities. Most often health departments collaborated with community organizations, community health centers and advocacy organizations to get the job done.

These upbeat findings reflect a surprisingly high level of perceived general competence and capacity. They also beg a series of questions.

► *What are the perceptions of the other players in urban communities of their local public health agencies' preparation and capacity to reduce racial and ethnic disparities in MCH?* Less than half of the responding urban health departments report significant collaboration in this area with key partners such as religious organizations.

► *How ready are urban health departments to take on the underlying systems issues that drive disparities, such as poverty and racism?* Only 39% said they were at least adequately prepared to deal with institutional racism in their service to minority populations. And less than 10% target housing, poverty, culture, or other social issues in their efforts.

Member health departments mostly want CityMatCH and other national organization to provide information and

advocate for additional dollars so that they can stay the course. Few indicated a need for additional research or peer exchange. The challenge is that information and money may be necessary but are insufficient to ameliorate the entrenched root causes of health disparities.

CityMatCH plans to respond with more than information. We are generating new public health tools such as the Perinatal Periods of Risk Approach to mobilize urban communities for targeted action. We want to build urban communities capacity to undo racism. And we will foster urban MCH leadership that pursues collaboration with a wider range of partners in the sacred and secular domains for an all out assault on racial and ethnic disparities in the health and well being of the women, children and families who call America's cities 'home.'

Publication of the final results for the complete survey is forthcoming. Presentations of results are planned for the CityMatCH, APHA, and national MCH Epidemiology meetings later this year.

- Magda Peck.



## E-ROUNDTABLE: *Leaders Assess Local Health Department Efforts to Reduce Racial and Ethnic Health Disparities*

*In April, 2002, CityMatCH hosted an E-Roundtable of selected member MCH leaders to gather their insights, advice and lessons learned about local health department efforts to reduce racial and ethnic disparities in health. Following are edited highlights from their responses; additional comments can be found in "E-Stories" boxes throughout this issue.*

### ► What is the unique role of your health department in reducing racial and ethnic health disparities?

**Vicki Alexander:** Education, education, education at all levels is absolutely the main unique role of the Health Department. The education must be based in fact and reality; it cannot be a dream. The health department can set the standard, and needs to be well grounded in the concept that *as long as one child is left behind in this world, all children are at risk of not reaching full potential.* As a community is educated, all stakeholders have unique contributions to assist in creating interventions at all levels, from setting policies to improve housing, creating jobs that are long term, working toward improved health care and universal insurance, or as basic as insuring that all families have food.

**Kathy Carson:** Talking about racism as the cause of racial disparities, using the 'R' word, rather than just talking about disparities as if it were somehow the fault of the population that they have poorer outcomes, is the major contribution I feel public health must make. Make the connection between racism and chronic stress and how elevated hormones associated with chronic stress impact virtually every body system adversely. Talk about how the power differential of racism maintains a differential in economic status and education level that reduce both access to and quality of health care, and that disparities in health outcomes will never be eliminated until social justice is achieved.

**Violanda Grigorescu:** Reinforce the public health mission and take the lead in building partnership/collaboration among different professionals, different agencies and different programs/projects. Eliminating racial and ethnic disparities in health requires enhanced

efforts for preventing disease, promoting health and delivering appropriate care. Our unique role is to be the catalyst for partnerships among different agencies, professionals, researchers and programs, including communities identified as priority populations.

**Llamara Padro Milano:** With Syracuse Healthy Start funds, we have provided leadership in the statistical assessment of the risks that lead to disparities in maternal and infant health. We have an extensive program of inservice training, quality assurance, and computerized monitoring aimed at reducing disparities. This involves public health nursing home visiting, and enhancing the linkage of all local case management programs. We have undertaken a great deal of effort in assuring culturally competent care.

**Betty Thompson:** The Metropolitan Health Department (MHD) of Nashville, Tennessee is located in the Southeast Region of the country where disparities in health for populations of color have been a long-standing focus. The Mayor of Nashville demonstrated innovation in 1995 by hiring the first African American Director of Health. Under her leadership, the Health department established a strategic goal to hire staff who looked like the community and spoke languages other than English. The MHD has historically served in the role of facilitator in developing community coalitions to reduce and eliminate disparities in health status experienced by African Americans and other racial and ethnic minorities.

Prior to 1999, there was no collective think tank or effort to reduce and eliminate disparities. That year, the Racial Disparities in Health Coalition of Nashville was formed to reduce and eliminate disparities in health status. Founding organizations included hospitals, community health centers, NAACP, Clergy and Managed Care Organizations.

The first major initiative of the Disparities Coalition was to submit a proposal in the national competition for the REACH 2010 planning grants with a community health agency as the lead agency. The proposal was accepted and the Nashville REACH 2010 project has been working since October of 1999 to

### E-Roundtable Participants

#### Vicki Alexander, MD, MPH

MCAH Director  
Berkeley (CA) Public Health Department

#### Carolyn Burwell, MD

Medical Director, Pediatric Clinics  
City of Norfolk (VA) Department of Public Health

#### Kathy Carson, BSN

Administrator, Parent Child Health  
Public Health - Seattle & King County (WA)

#### Mildred Crear, BS, MA, MPH

MCAH Director  
San Francisco (CA) Department of Public Health

#### Violanda Grigorescu, MD

Epidemiologist  
Louisville-Jefferson County (KY) Health Department

#### Llamara R. Padro Milano, BSN, RNC

Director of Nursing  
Onondaga County (NY) Health Department

#### Betty Thompson, RN, MSN

Director of Health Access  
& Assurance  
Nashville-Davidson County (TN) Health Department

formulate a four-year plan to address disparities in health status due to diabetes and cardiovascular disease in North Nashville.

**Mildred Crear:** The San Francisco, CA, Health Department and MCAH released two reports in 1998: "*San Francisco Burden of Disease*," and "*The Health and Well Being of Children and Youth*," highlighted disparities in the African American population. The Department began the African American Health Initiative (AACHIE) in November 1999, creating a community-based coalition whose mission is to improve the quality of life of African Americans in San Francisco by integrating an African-centered and cultural approach to prevention and health promotion, by engaging and empowering community residents;

- Continued on next page

## CityIssues

### Leaders Assess Efforts to Reduce Disparities

- Continued from page 7

creating a healthy community through education, planning, training, and asset mapping.

#### ► What do you “do” first to undo racial and ethnic disparities in health?

**Vicki Alexander:** Get a firm grasp on the data specific to my community. Put the data in a format that can be understood by all. Present the data at various levels in the community.

Constantly raise the “bar of expectations” for me, coworkers and community to understand, utilize and create data from which to shape opinions,

programs and thereby decrease disparities.

**Kathy Carson:** Educate our leaders and staff about the impact of racism and sensitize them to seeing it in our everyday business. Empower communities of color with information about racism and stress. Involve communities of color in guiding priority setting and programming and assure that resources are targeting the populations most in need. Eliminating poverty should be somewhere in our vision statement and goals, and social justice on our agenda.

**Llamara Padro Milano:** We have provided a publicly disseminated community assessment that outlines the extent of these disparities. We have secured funding to further assess the root causes of disparate survival from the CDC and HRSA. We have sought to increase community awareness and involvement in addressing these root causes.

#### ► How do you measure and hold accountable the health department for making a difference in this issue?

**Betty Thompson:** Measure and hold accountable the health department for making a difference through strong epidemiological involvement and data evaluation from the start of the process. Facilitate new approaches such as, PPOR. Disseminate model programs.

**Vicki Alexander:** Short and long term measurable goals must be set and used to educate the community about changes. After all, if the city council gives you \$200,000, they want and expect to see a product, some change, some improvement. Yet sometimes it takes three or more years to see data change in the traditional sense. Therefore, intermediary goals need to be clear. Short term, intermediary measures should be presented to the community. These could be in the form of numbers of cases, or stories of individual cases.

**Violanda Grigorescu:** We should measure with honesty and commitment our work, findings and recommended changes, results and their impact, successes and failures. The findings should be continuously shared with all the other partners, and followed by recommendations for changes of strategies and activities and then the results/ impact evaluation. Efforts to expand insurance coverage, and changes in public health and health care delivery systems should reflect an understanding of effective strategies for improving

women’s health sensitive to different social and cultural needs.

#### ► What can CityMatCH do to assist in efforts to reduce racial and ethnic disparities in your jurisdiction?

**Betty Thompson:** Continue the role of sharing data designed about and for cities; expanding the role of leadership development for urban MCH leaders, specifically as it relates to data use and evidence based practice; refine the products, that CityMatCH is known for, i.e. Lessons Learned, Ask-A-Colleague, CityLights, etc.; and develop a strong voice for advocacy regarding issues that affect women and children in urban cities.

**Vicki Alexander:** Data, data, data, and how to use the data! The **Spring 1998, CityLights**, presenting data comparing low birthweight rates for cities, was the spark that ignited the fire in Berkeley to not only direct MCAH, but also to steer the entire health department towards a commitment to eliminate health disparities.

Teach us how to put data into an historical context, for example, how data might change with major policy changes. We need to draw on history and make linkages not otherwise considered.

**Mildred Crear:** Continue to share information regarding best practices. We appreciate the national connections that CityMatCH has; framing policy issues, highlighting data needs, and sharing grant opportunities.

**Violanda Grigorescu:** Continue offering support to local health departments. CityMatCH creativity, energy, support and enthusiasm is refreshing and a stimulus for local public health professionals.

Continue to be the national voice for public health professionals. Keep the communication among different local health professionals. Be the “glue” for a strong partnership among different projects/programs, agencies, professionals from local, state and national level.

Keep local health departments up to date by having regular conferences, seminars and updates.

**Ed. Note:** For a complete transcript of responses to this Roundtable, visit the CityMatCH website at [www.citymatch.org](http://www.citymatch.org) and click on “publications.” You’ll be directed to a link of our local health department leaders’ unabridged stories.



### E-Story1: *Up Close and Personal*

As an African-American woman, a minority and a health care professional, I have an “up close and personal” experience with the effects and end results of racial disparities: From grammar school, when I had to use books that were previously used by white children when they were new and then given to the black children after they were worn, ragged, with pages missing, to my present status as the only Black Director of Nursing in the State of Tennessee, and the first Black Supervisor for the Davidson County Health Department.

Those are not health issues, yet they give a picture of situations that impact the health status of people, regardless of income. Living in a society that continues to treat people differently because of the color of their skin or their ethnic origin will continue perpetuation of disparities in health.

My continued affiliation and affection with CityMatCH is based partly on the genuine desire to help all people, regardless of their color or ethnic background. This passion is evidenced by the Board, Executive Director and staff by keeping on the table the fact that our Board and membership should look like our communities (diverse).

Additionally, in my present role as an Executive Manager, I have the ability to facilitate change and introduce new concepts. My goals and objectives mirror CityMatCH in assisting to change the lives of all urban women and children for the better.

- Betty Thompson

# Mobilizing to Eliminate Racial and Ethnic Disparities

## PPOR Seminar Leads to New Insights

The February 2002 Perinatal Periods of Risk (PPOR) Practice Collaborative seminar looked at, "*Mobilizing for Eliminating Racial and Ethnic Disparities.*"

Participants comprised representatives from the fourteen cities currently taking part in this national Collaborative, along with Vijaya Hogan, Shirley Shelton (see page 12) and key CityMatCH staff. Vijaya Hogan, DrPH, MPH, has been an Epidemiologist in the Division of Reproductive Health (DRH) of the National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention (CDC). She is currently a Clinical Associate Professor in the Department of Maternal and Child Health, School of Public Health at the University of North Carolina - Chapel Hill.

Key findings from the seminar conversations are summarized here:

► The Perinatal Periods of Risk approach to monitor and investigate fetoinfant mortality is an effective tool used to improve the health of women and infants in their communities. This tool has the added benefit of helping to focus work aimed at defining and eliminating disparities. For example, when PPOR

results indicate great disparity in maternal health and prematurity, a strategic shift in focus and investment in women's health, with subsequent linkages to addressing other disparities in women's health in urban communities. When PPOR results identify great disparity in "infant health," such an "Aha!" can lead to greater emphasis on known racial disparities in that period of risk.

► Practice Collaborative cities that are involved in Federal Healthy Start are finding PPOR to be of added value, as it can be easily integrated into program planning. Linkages of the two - Federal Healthy Start, and PPOR (both data analysis and community process) - can be integrated into current continuation grant planning processes.

► Linking the PPOR with university/academic partners is another potential mechanism to bring greater knowledge and expertise to the planning process and also to gain access to evidence-based, cutting edge information. However, it is important to distinguish between the individual and the academic institution when partnering, as each brings a different cluster of assets.

One important caveat: universities

mean research, which remains a sensitive issue in the African American community, whose members may perceive that the research is historically "on them" .. and/or that enough has been done already.

► Links between hypertension, diabetes and women's health among women of color are known and relevant to the work being done in PPOR.

Interest remains high and significant progress is being made among the 14 cities participating in the PPOR Practice Collaborative to move from data to action. Continued promotion of cross-team exchange is essential to support and encourage sharing best practices.



*Disparities are caused by an "interaction of complex forces"*

*- V. Hogan*

### The Perinatal Periods of Risk (PPOR) and Practice Collaborative

PPOR is a tool that can be used by larger communities to examine their fetal and infant mortality and improve their maternal and infant health by identifying gaps in their community. The PPOR approach enables communities to target resources for prevention activities, and mobilize the community to action. Since 1998, CityMatCH has collaborated with the CDC to validate and standardize this new approach.

In December 2000, CityMatCH, with support from the CDC, and the National March of Dimes Birth Defects Foundation, launched the Perinatal Periods of Risk Practice Collaborative (PPOR-PC) to distill best practices in using the approach as a community tool for decision-making, targeting resources, and program/policy development. CityMatCH and the Practice Collaborative's 14 community teams are working together to address the PPOR approach to improve the health of women and infants; to develop easy-to-use materials and services to support other communities interested in using PPOR; and to assure the strategic linkage of the PPOR approach with related existing efforts, especially FIMR and Healthy Start.

For further information about the National Perinatal Periods Of Risk Initiative and PPOR-PC, please contact: Jennifer Skala, MEd, Managing Coordinator for Education and Training by E-mail: [jskala@unmc.edu](mailto:jskala@unmc.edu) at CityMatCH or visit the website at [www.citymatch.org](http://www.citymatch.org) and click on PPOR for an online tutorial.



### Undoing Racism: Boston's Plan

*(continued from page two)*

to undo racism, including the promotion of anti-racism training opportunities and the development and use of tools to assess "cultural competency" of health care institutions. Boston wants to join with other cities' efforts to "undo" racism. Undoing racism will be a featured topic at the upcoming INTERCHANGE 2002, (see page 15). Dr. Ferrer will present more detail on Boston's plan at the closing plenary session.

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# CityMatCH Helps Its Members Translate Infant Mortality Data Into Action

A recent infant mortality report released by the Centers for Disease Control and Prevention (CDC) underscored the need for cities to define and execute data-driven strategies to eliminate racial and ethnic differences in infant mortality.

*"Every city must be ready and able to translate its data into action to safeguard the health and well-being of its youngest residents,"* said Magda Peck, Sc.D., one of the report's co-authors and CEO/Executive Director of CityMatCH. *"That is what CityMatCH is all about."*

The report, titled *"Racial and Ethnic Disparities in Infant Mortality Rates – 60 Largest U.S. Cities,"*\* was published in CDC's Morbidity and Mortality Weekly Report, on Friday, April 19, 2002.

Of those 60 cities cited in the study, 49 are current CityMatCH member health departments. Alerted prior to publication by the CDC, CityMatCH was able to prepare its members to work with their local media. CityMatCH assisted them with a list of possible questions and suggested ways for members to seize the opportunity of the data release to highlight local issues and showcase local strategies.



The study illustrates how differences in populations and communities and documented wide variations among U.S. Cities in infant death rates overall, and specifically among urban white, black and Hispanic infants.

The report's data should be used as a starting point for each city to take stock of its infant mortality problem. CityMatCH is providing tools and training to assist cities in this process. Already, many of the 60 cities cited in this report have used CityMatCH training, including the Perinatal Periods of Risk (PPOR) and the Urban MCH Data Use Institute, to strengthen their capacity to address urban problems such as infant mortality.

*"Each city has its own set of problems and gaps that it needs to overcome in order to effectively address maternal and child health issues,"* Dr. Peck said. *"We can, and are helping cities find solutions to this very difficult problem."*

The PPOR approach helps target resources for proven prevention activities

and mobilizes the community to action. A 14-city National Practice Collaborative is developing "best practices" for using this new approach in other cities. The CityMatCH-CDC urban MCH Data Use Institute trains community leadership teams to use data effectively to improve the health of women, children and families in urban areas.

To review the MMWR report, visit the website at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5115a4.htm>

**\*Racial and Ethnic Disparities in Infant Mortality Rates – 60 Largest U.S. Cities.** V Haynatzka, PhD, M Peck, ScD, CityMatCH, University of Nebraska Medical Center, Omaha, Nebraska. W Sappenfield, MD, (formerly assigned to CityMatCH) S Iyasu, MBBS, H Atrash, MD, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion; K Schoendorf, MD, National Center for Health Statistics; S Santibanez, MD, EIS Officer, CDC, (formerly assigned to CityMatCH) ; Morbidity and Mortality Weekly Report (MMWR) April 19, 2002 / 51(15);329-332, 343.



## One America in the 21st Century: The President's Initiative on Race

describes the nation's health objectives for the 21st century. This policy initiative has fostered a renewed national interest in the undoing of racial and ethnic disparities with the Centers for Disease Control and Prevention (CDC) playing a major leadership role.

REACH 2010 is part of the Department of Health and Human Services (DHHS) response to the President's Race Initiative and Goal for 2010 to eliminate disparities in health status experienced by racial and ethnic minority populations in the following six priority areas:

### \* Infant Mortality

## "REACH" into the Twenty-first Century

- \* Deficits in Breast/Cervical Cancer Screening & Management
- \* Cardiovascular Diseases
- \* Diabetes
- \* HIV Infections/AIDS
- \* Child and Adult Immunizations

REACH 2010 is a two-phased, five-year demonstration project supporting community coalitions in the design, implementation, and evaluation of unique community-driven strategies to eliminate health disparities. Phase I was a 12-month planning cycle to support planning and development of demonstration programs. Phase II is a four-year plan for implementing and evaluating demonstration projects. Grantees will use appropriate local data to develop a Community Action Plan (CAP) to guide the work of the coalition through the

implementation and evaluation period.

CAPs target one or more specific racial or ethnic minority community groups. Coalition membership includes a community-based organization and three other organizations that must be either a local/state health department, university or research organization.

For the Fiscal year 2001, there are 36 REACH 2010 Project Sites, ranging from Seattle to Massachusetts, from Florida to Southern California.

For more information, contact:  
 CDC, National Center for Chronic Disease Prevention & Health Promotion  
 Phone: 770-488-5269  
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<http://www.cdc.gov/reach2010>

# Assessing Your Organization for Cultural Competence in Health Care

Just what does "Cultural Competence" mean? No one definition for "cultural competence" exists; in fact, there are numerous descriptions for what it can comprise. One helpful explanation:

*"Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables this system, agency or those professionals to work effectively in cross-cultural situations."*\*



Achieving cultural competence is crucial as mainstream populations shift. U.S. Census Bureau predictions suggest that within the next 50 years, nearly one half of the nation's population will be from cultures other than White, non-Hispanic.

*Within the next 50 years, nearly one-half of the nation's population will be from cultures other than White, non-Hispanic.*

Because the U.S. health system was founded on Northern European beliefs, great shifts will need to occur to optimally meet the needs of emerging populations. Primarily White employees may hold world views, communication styles, work habits and ethics different from culturally diverse staff and clients. Local public health must expand its cultural competency to achieve positive health outcomes.

**The DHHS Office of Minority Health** recently published a first draft of *"A Practical Guide for Implementing the Recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care"* on the web at <http://www.omhrc.gov/clas/guideintro.htm>. This guide explains the need for a cultural and linguistic self-audit prior to embarking upon a cultural competence initiative. Downloadable "checklists" and other forms to carry out this audit are available.

**The Managed Care Technical Assistance Center, (MCTAC)**, established in 1999 by HRSA, provides awareness and easier access to existing managed care technical assistance resources to support the local interests of the Safety Net Provider community, including health professions education and training

programs. Recently, MCTAC began training in Cultural Competence, offering a seminar entitled, *"Approaches to Cultural and Linguistic Competency in Managed Care,"* in May, 2002. MCTAC assists HRSA grantees in obtaining managed care technical assistance and training in a variety of areas. For more information on MCTAC, see their website: <http://www.jsi.com/hrsamctac/>

**The National Center for Cultural Competence (NCCC)** seeks to increase the capacity of

health care and mental health programs to design, implement and evaluate culturally and linguistically competent service delivery systems. A component of the Georgetown University Child Development Center, Center for

Child Health and Mental Health Policy, NCCC is supported in part by HRSA.

The MCH/CSHCN component of the NCCC provides the following: networking and information exchange on cultural and linguistic competence issues; fosters linkages between MCH and CSHN directors, regional consultants, and state and local program representatives to maximize resources and enhance the development of culturally competent systems of care at the state and national level; provides training, technical assistance and consultation to MCH and CSHN directors, regional consultants and MCH/CSHN programs; and develops and disseminates products and materials which promote culturally and linguistically competent systems of care.

The National Center recently released, *"A Guide to Planning and Implementing Cultural Competence."* For more information, see the website: [www.georgetown.edu/research/gucdc/nccc/](http://www.georgetown.edu/research/gucdc/nccc/)

\* Cross, T., et al, *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children who are Severely Emotionally Disturbed*, Georgetown University, 1989.

## Reducing Disparities is Key to Healthy People 2010



Healthy People 2010 offers a simple but powerful idea: provide health objectives in a format that enables diverse groups to combine their efforts and work as a team. It is a road map to better health for all and can be used by many different people, States, communities, professional organizations, and groups to improve health. The initiative has partners from all sectors.

Healthy People 2010 (HP2010) is the prevention agenda set forth for the nation. Building on the previous 1979 Surgeon General's Report, Healthy People, and Healthy People 2000: National Health Promotion and Disease Prevention Objectives, HP2010 is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats.

HP2010 is designed to achieve two overarching goals:

- ▶ **Increase Quality and Years of Healthy Life.**
- ▶ **Eliminate Health Disparities.**

The Healthy People Consortium, comprises over 400 national membership organizations, including **CityMatCH**, all State and Territorial health departments, and key national associations of State health officials working to advance health. It is envisioned that membership will expand beyond the traditional public health community and health associations to include business, labor, and other organizations which will take the message of Healthy People into every community and workplace.

HP2010 is managed by the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services.

Source, and for more information: <http://www.health.gov/healthypeople/default.htm>

## Achieving Success: California's Black Infant Health (BIH) Program

**D**esigned to improve birth outcomes in African-American Communities, the Black Infant Health Program (BIH) was initiated in 1990 by the California Department of Health Services, Maternal and Child Health Branch and coordinated by Shirley Shelton, a Health Program Specialist who has spent the past ten years as Coordinator of the statewide program. During this time, Shelton facilitated development and implementation of six best practice interventions designed to help standardize critical features necessary for improving health care and reducing infant mortality.

Supported by Federal Title V and State General Funds, the BIH Program identifies at risk pregnant and parenting African-American women and provides assistance in using appropriate health care and other family support services; and assures that appropriate pediatric care is received through the first two years of the infants' life. Current interventions include Prenatal Care Outreach, Case Management, Social Support and Empowerment, and the Role of Men.



From July 1, 1996 to June 30, 2001, 9,396 women were enrolled in BIH. Client enrollment ranged from 195 clients to 1,110 clients among the 17 BIH sites continuously operating during this time period, with a 25% drop out rate among BIH clients. There were 3,984 singleton live births to women enrolling in BIH prior to 32 weeks gestation, of which 11.9% were born with low birth weight (<2,500 grams), 2.0% with very low birth weight (<1,500 grams), and 15.4% with a preterm delivery (<37 weeks). BIH clients had a very high-risk psychosocial and obstetric clinical profile.

An evaluation of the BIH program compared birthweights among 1995 Medi-Cal funded clients in targeted BIH zip codes to BIH clients enrolled from July 1, 1996 – September 30, 1998. BIH clients had a lower percentage of very low birthweight babies (1.9% vs. 3.0%) and a higher percentage of infants born with birthweight of 1,500-2,499 grams (13.0% vs. 11.0%), than the Medi-Cal comparison group. These findings were statistically

### California's Black Infant Health Program Addresses:

- ▶ African-American infants in California are more than twice as likely to die during infancy as White children.
- ▶ In 2000, the infant mortality rate for African-Americans was 12.9 deaths per 1,000 live births, compared to 4.8 per 1,000 live births among whites.
- ▶ African-American infants in California are twice as likely to be born with low birthweight as White infants.
- ▶ Many infant deaths could be prevented if early access to comprehensive prenatal care, family support services, and case management were available to low-income women during their pregnancies and during their infants' first two years of life.

significant. These results suggest that one effect of the BIH program may be reducing the risk of infants born with very low birthweight (< 1,500 grams) successfully moving them into a higher birthweight group. A similar, although not statistically significant, reduction in the rates of very pre-term delivery, was also observed. Further evaluation of the BIH program using more recent data and a larger client base is underway.

The BIH program has been successful in serving the hardest to reach in fourteen counties and three cities where 93 percent of African-American births occur in California. These are the counties of Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano and the cities of Berkeley, Long Beach, and Pasadena.

Each local program is unique as each health jurisdiction selects models for implementation based on the identified needs of clients in local communities.

For more information on California's Black Infant Health Program, contact: Shirley Shelton  
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### Case in Point: LA County BIH

Los Angeles County's Black Infant Health Program employs two models: Prenatal Care Outcome (PCO) and Social Support and Empowerment (SSE). PCO utilizes community health outreach workers to identify potential families in the community in need of perinatal services. Intensive outreach efforts locate high-risk pregnant women, document their health and social support needs and link them to services. SSE provides high-risk women with support, advocacy and assistance, through a series of classes. The classes enable women who feel powerless in their own lives to identify and uncover inner strengths and then utilize these strengths for empowerment.

LA County's BIH seeks to reduce African-American infant mortality; reduce the rates of African-American low birthweight infants; reduce smoking, alcohol and/or non-prescription drug use during pregnancy in African-American women; reduce SIDS deaths among African-American babies; and increase breastfeeding rates in pregnant/post partum African-American women.

The health department contracts with five community-based organizations (CBO) - Great Beginnings for Black Babies, HarborUCLA REI South Los Angeles Health Projects, Mission City Community Network, Partners in Care Foundation, and Prototypes. The first two agencies have deep roots in the community and so have the trust of the populace. The latter three CBO's are new contractors in the San Fernando Valley, the Antelope Valley, and the San Gabriel Valley, respectively.

Keys to the success of LA's BIH include utilizing a uniform, coordinated approach across programs to create maximum impact. Culturally competent curriculum focusing on social support and empowerment has led to better birth outcomes. Community health outreach workers, reflective of the community, are a solid resource and a human link to connect pregnant and parenting women to appropriate services.

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## Triple Dipping in Philadelphia: 1+1+1>3

With a greater metropolitan area population of 3,849,647, Philadelphia is the fifth-largest city in the nation. And like many of the other largest U.S. cities, Philadelphia is home to multiple public health initiatives. It has three federal Healthy Start sites and is part of the REACH 2010 network (see page 10). With CityMatCH, Philly is currently the only "Triple Dip" city member, with separate health department-led teams participating in the Data Use Institute (DUI), the Perinatal HIV Urban Learning Cluster (see below), and the Perinatal Periods of Risk Practice Collaborative (PPOR-PC) (see page 9). There also are multiple local assessment, programmatic and policy initiatives underway to address maternal and child health.

Philadelphia's challenge is one of aligning disparate but related streams of effort. How does the health department "braid" related programs such that their synergy yields greater impact, while sustaining the relative autonomy of each to assure accountability to the funders and stakeholders of each? How does it cross fertilize across initiatives to assure optimal learning and application? How can they integrate the data from each initiative to tell the whole story.

According to Marjorie Angert, MD, Medical Director of the Division of Early Childhood Youth and Women's Health (DECYWH) at the Philadelphia Depart-

ment of Public Health, and a member of both the Perinatal HIV Urban Learning Cluster and the PPOR Practice Collaborative, one key is case review to gain a better understanding of the stories behind all of the data they have. Recently they used the Women's Death Review process, funded by the Department of Public Health and local Non-Profits, to look at data related to HIV. They reviewed 255 of the 1,340 women between the ages of 15 and 60 who died in 1998. Forty-six of those women had AIDS as the contributing cause of death. Of these, nine were known prostitutes and six were known substance abusers. Explained Dr. Angert, "We know that women with a history of drug abuse and prostitution are one of the "hardest to reach" groups when trying to prevent perinatal HIV transmission. With real data that now can tell the stories of real women, our Perinatal HIV team can make recommendations about the comprehensive services needed for these women, including education about the risks of HIV to themselves and their babies, and how to prevent the disease."

Department of Health Epidemiologist Kennen Gross, a member of Philadelphia's DUI team last year and a member of the PPOR-PC, has been integrating PPOR with both Healthy Start (HS) North and Healthy Start West/SW projects. PPOR analysis has been done for the geographic areas covered by each project, and findings have been shared and discussed with the

HS Community Consortia of each neighborhood. For example, in North Philadelphia HS, PPOR Phase II findings showed that chronic hypertension was contributing to their high number of very low birth weight infants. As a result, discussions have begun to consider expanding HS referrals to women of reproductive age who have been diagnosed with chronic hypertension. "The PPOR findings hopefully will help guide the members in their efforts to choose an infant mortality prevention strategy," said Gross.

Two DUI teams in two years has positioned Philadelphia's current teams to be more effective in having and using data, together. PPOR has interacted with Mortality Review and Healthy Start, and there is growing awareness that it also would be helpful to integrate the current DUI and HIV teams with Healthy Start. "Now our task is arranging organized interactions between the various CityMatCH teams so that each can learn from the others expertise," notes Dr. Angert.

To learn more about Philadelphia's "triple dip," log on to our website at [www.citymatch.org](http://www.citymatch.org) and click on HIV, DUI or PPOR-PC. And come to the first CityMatCH INTERCHANGE 2002, September 29 - October 1, in Los Angeles to see how braiding for results works in places like Philadelphia.

### HIV Urban Learning Cluster Looks at "Hardest To Reach" Populations



CityMatCH Urban Learning Clusters foster strategic interchange among scientists and other content experts and action-oriented teams of policy-makers and practitioners from targeted communities. The National

Perinatal HIV Urban Learning Cluster, organized by CityMatCH and launched in Spring 2000, currently includes nine urban health department-led community action teams, joined by CDC and other national HIV and Maternal and Child Health (MCH) experts. CityMatCH serves as convener, broker and facilitator to promote team-based and cross-city learning and problem solving for

intended, measurable results.

A crosscutting theme in the Urban Learning Cluster (ULC) has been the challenge of how to draw in and aid the "hardest to reach" women in the prevention of perinatal HIV transmission. Perinatal HIV ULC Colleagues came together for conference calls in March 2002 to find a collective voice in addressing the "hardest to reach" women.

Teams have discussed the first drafts of a background paper, "Within Reach: Preventing Perinatal Transmission of HIV/AIDS among the "Hardest to Reach" Women," whose purpose is to provide a universal definition and common framework for "hardest to reach" women in urban communities. Discussion has included defining "hardest to reach" women. Given the diversity of women in the ULC

communities, the question of which women should be given primary focus was significant. Definitions of "hardest to reach" women included imprisoned women, women with mental health concerns, HIV positive women who for various reasons are not receiving care, IV drug and other substance abusers, homeless women, women who attend anonymous test sites, recent immigrants, and uninsured women.

As the ULC concludes its first phase, the nine cities are planning for community consensus and strategic activities to reach these women for effective perinatal HIV prevention.

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## E-Story2: *Integrating Healthy Start, FIMR and PPOR*



**Violanda Grigorescu, miologist and CityMatCH ber Representative in ville, Kentucky** partici-

participated in the E-Roundtable. Asked to describe local health departments efforts to undo racial and ethnic disparities, she related the following about Louisville's effort to integrate Federal Healthy Start, the Perinatal Periods of Risk approach (PPOR) and Fetal and Infant Mortality Review (FIMR).

*Excerpts of her story follow:*

**Grigorescu:** Healthy Start, PPOR and FIMR are independent initiatives, yet have common themes:

- ▶ Reducing infant mortality and improving pregnancy outcomes by improving the perinatal system;
- ▶ Community-supported processes with partnerships and collaboration between public and private sectors;
- ▶ Focus on reducing/eliminating racial disparities even though it may not be clearly articulated.

However, in Louisville, each has different funding sources and targeted areas: PPOR and FIMR touch all of Jefferson County, while Healthy Start serves a small area with a high percentage of African Americans.

Healthy Start strategies, activities and services delivery used to be developed based on existing knowledge about

maternal and child health (MCH) issues, on the guidelines received but not necessarily adapted to local findings. Outcomes were sometimes not as expected, though there were improvements. Louisville's new Healthy Start funding cycle has two major models: eliminating racial disparities and interconceptional care.

Before developing any assessment tools and services delivery, it was necessary to understand what the major causes, major problems are that caused the existing racial disparities. It is hard to find enough data.

PPOR helped us to understand a little bit more by mapping the Phase One findings to action and by performing Phase Two analysis with the available data.

For example, we reviewed marital status: as a surrogate for socio-economic status, being unmarried was considered to be a risk factor for having poor pregnancy outcomes in both White and African Americans. PPOR found that it is a risk for Whites, but not for African Americans.

FIMR, with home interviews and medical records abstraction, can bring more insights to the problems but a lack of resources, money and staff tend to make the FIMR process slower. This is when a new idea arose: to link these three

projects, to develop the Healthy Start strategies and services based on the PPOR and FIMR findings, to make evidence-based decision.

How it will work? PPOR will be the "first step" in order to identify gaps, to map actions and to perform a more detailed analysis of the risk factor exposures. That requires access to data and therefore strong collaboration/partnership with different agencies. At that point, FIMR can step in with medical records reviews and home visitation targeted to the groups with gaps, to supplement the existing data. Resulting PPOR/FIMR findings and analysis will be used to re-shape Healthy Start services to fit with the new findings.

The roles CityMatCH, CDC, HRSA, MOD play in this partnership initiative are very important. We cannot be fully successful without strong supports.

For more information about the ongoing integration efforts in Louisville, contact:

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## *National Healthy Start Association Focuses on Reducing Racial Disparities in Perinatal Outcomes*



The National Healthy Start Association (NHSA) was formally established in the spring of 1998 as a 501(c)(3) non-profit organization for the purpose of promoting community-based maternal and child health and the reduction of infant mortality, low birthweight and racial disparities in perinatal outcomes.

The NHSA represents a majority of the 96 federally funded Healthy Start projects in the United States, seeks to promote community-based maternal and child health programs. Of particular interest are those programs that strive to reduce infant mortality, low birthweight and racial disparities in perinatal outcomes. Racial disparities occur both in health status and health care throughout

the country. The goal of Healthy Start is to reduce these disparities, especially among pregnant and postpartum women and their infants.

Each Healthy Start project is mandated to develop a local consortium composed of neighborhood residents, medical providers, social service agencies, faith-based representatives and the business community. This consortium guides and oversees the design and implementation of the local Healthy Start project. The Association has a mandate to ensure that these key features of the Healthy Start model are strengthened and promoted among all Healthy Start projects and is available to provide technical assistance, when requested.

CityMatCH member representative Bobbie W. Brown, Director, MCH/Child Health Department, Marion County Health Department, Indianapolis, IN currently serves on the Board of Directors of the NHSA, representing the Indianapolis Healthy Start program.

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\*This information was derived from the National Healthy Start Association website located at:  
<www.healthystartassoc.org>



