Building State Partnerships to Improve Birth Outcomes

AMCHP Perinatal Disparities Action Learning Lab Report

January 2005

Background

Recent progress has been made in health care and medical technology that has contributed to steady overall declines in low birth weight, premature births and infant mortality in the United States.[1] In spite of these accomplishments, however, perinatal disparities not only persist but are widening for black Americans.[2] The latest available data show infant mortality rates of 14.0 per 1000 births for blacks as compared to 5.7 per 1000 births for whites.[3] Black infants also have the highest preterm birth rate (17.6 percent versus 10.7 percent for whites), and are more likely than all other racial and ethnic groups in the U.S. to be born low birth weight (13.2 percent versus 6.8 percent for whites) – conditions that place them at higher risk for multiple health problems, disability and death.[4]

A public health approach to this dilemma stands a promising chance of reducing these very serious and unacceptable gaps.[5] Such an approach would incorporate early prevention, cross-disciplinary and community collaborations, a comprehensive view of the social and environmental factors that impact health, and a focus on population well-being. In particular, the nation's public maternal and child health (MCH) system, with its federal mandate to assure the health of all women and children, has a unique responsibility and opportunity to make a real and lasting difference in this area.[6] The MCH system serves over 27 million women and children each year, or roughly 80 percent of infants born in the U.S. and 50 percent of pregnant women.

In 2004, with support from the W. K. Kellogg Foundation and Centers for Disease Control and Prevention, the Association of Maternal and Child Health Programs (AMCHP)[7] planned and convened a two-part Action Learning Lab (ALL) to help state MCH professionals and their local partners increase their knowledge of perinatal disparities and their contributing factors and to assist them in creating and implementing year-long action plans for reducing these gaps in their states and territories. The project was initiated in response to research linking the higher rates of poor birth outcomes among black American women to social and environmental factors such as chronic stress and racial discrimination.[8]

This report provides a brief overview of the ALL participants' planning process, essential elements of their collaborative activities, preliminary outcomes and lessons learned. It is *not* meant to be a comprehensive or "best practice" guide for addressing racial perinatal disparities. Confronting an issue this pervasive and complex requires a long-term commitment to systems change, and AMCHP and the ALL participants readily acknowledge that our work in this area has just barely begun. Nevertheless, we hope that our efforts and reflections so far will encourage others who are contemplating similar fundamental steps toward improving pregnancy and birth outcomes of minorities.

Methods

ALL Process Overview

AMCHP has conducted ALLs with its state and territorial MCH members since 1996 on a range of topics, including Medicaid and child health insurance reforms, smoking cessation, and mother-to-child HIV transmission. The ALL brings diverse teams together to work on emerging issues in MCH, to create new approaches to ongoing issues, to build knowledge and use of promising practices, and to establish partnerships that may result in more enduring positive health outcomes for families (*see Appendix: ALL Logic Model*). The ALL is based on continuous quality improvement methodology, a planning and improvement process that has proven effective in making systems-level changes.[9]

In January and May 2004, AMCHP convened teams of MCH professionals and their local partners from five states — Florida, Georgia, Indiana, Maryland and Massachusetts — to help them develop strategies to reduce racial and ethnic perinatal disparities. An advisory committee[10] selected the states based on several factors, including team composition and organization (i.e., MCH leadership, consumer participation, organizational diversity); rationale for participation (i.e., high level of disparities, realistic expectations of the ALL process); commitment and enthusiasm (i.e., adequate organizational support, recent or past efforts); and overall capacity to effect change at a systems level. Each team consisted of 5-8 "travel team" members who attended AMCHP's ALL meetings and provided leadership for a larger "home team." Team members represented state, county and city departments of health and MCH programs, Healthy Start, private providers, consumers, March of Dimes, and other agencies and programs.

A public health consultant familiar with MCH and racial disparities issues facilitated both meetings. AMCHP staff and advisory committee members guided team breakout activities. Teams were provided additional technical assistance along the way to increase their knowledge of perinatal disparities and contributing factors, explore promising approaches for effective action, and use tools to create and implement year-long action plans for reducing disparities in their states. During both phases of the ALL, nationally known researchers and others presented information on various aspects of perinatal disparities. ALL participants, as experts on MCH and perinatal disparities in their respective states, also contributed their insight and firsthand knowledge on the issue.

Conceptual Foundations

Several theoretical frameworks were used to develop the ALL content and provide teams with some grounding for their planning. An overarching assumption was the critical need, and professional responsibility, to effect change and collaborate across multiple arenas — biomedical/health care, social/environmental, public health/MCH, and within the community — to optimize well-being and reduce gaps in health.

The ALL teams first examined disparities from a health care perspective using the Institute of Medicine (IOM) study, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.*[11] This study found that racial and ethnic minorities in the U.S. receive a lower quality and intensity of health care than whites. The IOM report concluded that eliminating health disparities requires intensive and comprehensive strategies that address such things as socioeconomic inequality, concentrated poverty, and inequitable and

segregated housing and educational facilities, as well as individual health behaviors and care.[12]

State teams also explored the effects of certain social and environmental factors (i.e., socioeconomic status, chronic stress, racism and culture) on health and health disparities. In particular, they examined the life course perspective model championed by Lu and Halfon,[13] which proposes that perinatal disparities result from differential exposure to both risk and protective factors over the entire course of a woman's life and not simply during pregnancy. The life course model also underscores the need for health programs and policies that are more long-term and comprehensive in their scope to impact racial and ethnic gaps in birth outcomes.

Finally, participants discussed community-based, comprehensive approaches to decreasing racial and ethnic disparities in health, as well as practical methods for MCH to help build healthy communities in which disparities can be effectively addressed.[14] Community leadership, capacity and resiliency, family-centered care, outreach, cultural competence, and community engagement were some of the components viewed as essential to MCH efforts to maximize the health of all families.[15] Teams also discussed the need for public health professionals to closely examine *how well* we work with community in addition to focusing on *how often* we make the attempt.[16] In other words, MCH and public health in general must engage responsibly, equitably and constructively with those whom we serve to see lasting improvements in the health of moms and babies.

Findings

Baseline Assessment

To gain familiarity with each other and an understanding of their respective starting points in the ALL, each state team shared the results of a pre-lab assessment identifying: key data on disparities; priority areas and tentative approaches to address them; and assets states felt would assist them in their efforts. Commonalities were then identified across teams. ***Table 1*** reflects characteristics that were expressed and shared by the majority of state teams at the outset of the ALL.

Table 1: Common Ground Among State Teams (Lab 1)

Data • Minimum 2:1 ratio of poor birth outcomes (infant mortality, low birth weight and preterm birth) among black women compared to white women.
Priorities • Focus on disparities among black Americans. • Geographic targeting (pilot counties or statewide initiative).
Approaches • Community engagement (w/variations on methods and what "community" means). • Assess and address impact of racism/chronic stressors/social context on pregnancy outcomes. • Focus on periods before and beyond pregnancy (i.e., pre- or interconception care, early prenatal care). • Enhanced perinatal surveillance (e.g., use of focus groups to get community input).
Assets • Building on existing collaborations/community connections and efforts (e.g., Healthy Start programs). • Completed perinatal needs assessment or surveillance data (e.g., PPOR, PRAMS, FIMR). • Existing programs in state health department focused on eliminating disparities. • Currently working w/local/county/community counterparts on perinatal issues (e.g., March of Dimes, county MCH, Healthy Mothers/Healthy Babies). • Involvement in March of Dimes Prematurity Campaign.
Obstacles • Lack of political will (i.e., to confront racism as key contributor to MCH disparities). • Diversion of attention and funds from MCH to other issues (e.g., bioterrorism); overall state funding cuts. • Meta/institutional racism (i.e., pervasive and powerful, how to discuss and invigorate/support communities to advocate for change). • Changes in healthcare system (i.e., diminishing Medicaid services and reimbursement; HMO coverage limitations on preventive care; practitioners leaving out of frustration and malpractice costs). • Education and communication challenges (i.e., need to get reproductive health messages out earlier, make more appropriate and appealing for youth, different cultures).
Expected benefits (of lab participation) • Share w/ and learn from other states. • Assess opportunities and evaluate outcomes of efforts. • Strengthen existing efforts/partnerships. • Enhance statewide focus and plans on disparities.

Action Plans

Building on pre-lab discussions, state teams worked with facilitators to define their vision and refine their priority areas for reducing perinatal disparities. They then assessed their strengths, obstacles and opportunities for doing so. By the end of the first lab, teams had developed preliminary one-year action plans that included activities they felt uniquely qualified to implement to impact disparities in their states.

A sampling of the teams' planned approaches and activities is provided in ***Table 2*** State activities fell into several broad categories: *community development/coalition building; data collection and dissemination; public/professional awareness; and care delivery/quality assurance*. Many teams chose a combination of approaches that crossed several of these categories. All of the teams completed these draft action plans in a more inclusive way with their home team members over the weeks to follow.

Table 2: State Team Action Plans - Approaches and Activities

Community development and coalition building

- Work with statewide Healthy Start coalitions to establish standards and guidelines for health departments on community development and disparities.
- Create community development track at annual statewide MCH conference.
- Work with 5 community teams (building on Healthy Start coalitions) to develop statewide disparities plan.

Data collection and dissemination

- Create county-level data books (including local mortality, natality, GIS, demographic and systems data) to increase community access to information and also make available online.
- Conduct focus groups w/200 women in 5 counties to assess perceptions of pregnancy, racism and effects on access and quality of care.
- Incorporate perinatal data and information into broader department of health (DOH) health disparities initiative and website.
- Incorporate perinatal disparities surveillance and related work into MCH/Title V needs assessment.
- Train community partners in use of data and analytic tools (e.g., PPOR, focus groups) for understanding perinatal disparities at local level.
- Integrate ALL efforts into participation in online analytic training program to translate data to policy.

Public/professional awareness

- Develop statewide public awareness campaign on perinatal disparities w/March of Dimes as major partner.
- Hold statewide town meetings and press conference on disparities.
- Work w/academic and community partners on statewide campaign to increase provider awareness of perinatal disparities, institutional racism and provider bias in state health care system.
- Organize state's perinatal disparities component of APHA National Public Health Week.
- Create document on disparities statistics and overall issue for the DOH and general public, including environmental and social factors that affect community health, maternal health and birth outcomes.
- Publish article on disparities in statewide perinatal newsletter.
- Present on disparities at state Infant Mortality Commission.
- Poster presentation at statewide perinatal prevention conference for consumers and providers.
- Follow up on state "Closing the Gap" efforts, including town hall meeting, EMS training and media campaign.

Care delivery and quality assurance

- Implement early [prenatal care] entry pilot project in collaboration with Medicaid managed care and DOH with a focus on care coordination and outreach.
- Begin work to interface and better coordinate state and regional perinatal plans.
- Secure contract w/state Medicaid office to continuethis work.
- Revise state perinatal regulations (mandating training on racism and perinatal disparities for health professionals and state contractors) as way of assuring equitable quality of care.

Successes & Challenges

When AMCHP brought the five state teams together again several months later, teams discussed their action plan successes and challenges to date. These were assessed from an overall process perspective as well as in six key focus areas that the advisory committee and team leaders wanted addressed within the context of the ALL, including *racism and discrimination, data and evidence, community engagement, health care and social service interventions, advocacy and education, and evaluation.* Several themes emerged from these facilitated group discussions and from a pre-meeting questionnaire assessing teams' progress and obstacles in each of these areas. Examples of state-reported successes and challenges are listed in ***Table 3***

> **"A major obstacle is history - whether this is really going to make a difference this time, whether this really is going to be something that's going to be followed through, or is this just another political discussion?"**
> **-ALL participant**

Overall, teams described a shared tension between the need to take action, and the importance of careful and inclusive planning to help prevent or overcome the many anticipated challenges along the way. The process of building or rebuilding relationships with other partners (e.g., academic institutions, Medicaid), and with communities in particular, emerged as a difficult yet key aspect of the teams' efforts. Insufficient time and resources (e.g., funding and staffing) were also reported as significant challenges to moving ahead with planned activities. Other common obstacles reported by the state teams included lack of professional awareness of the extent of perinatal disparities and lack of political will to address the issue.

In spite of these various challenges, state teams had already made impressive progress in refining and implementing their action plans at that point. Specifically, teams reported successes in their preliminary efforts to build or join broader (e.g., statewide) coalitions, to incorporate discussion of racism and disparities into multiple existing forums (e.g., MCH conferences, focus groups, town meetings), and to use and share data to begin to address disparities at a local level.

Table 3: Summary of State Team Successes and Challenges

	Successes	Challenges
Racism & Discrimination	• Meetings throughout major counties to discuss these issues • Agencies collaborating/contributing collective resources and efforts to addressing issue • Home team consensus on racism as primary concern • Frank, open and ongoing dialogue on issue among team members	• Racism tough to discuss/address • Lack of political will to confront racism as a root cause of MCH disparities • Difficult to find/develop effective strategies and tools to tackle this issue.
Data & Evidence	• County data are current and accessible • Incorporating disparities performance measures into Title V/MCHB needs assessment • Sharing data w/communities • Building relationships w/communities, data experts, other health departments and divisions to facilitate data access	• State data not as current as county-level • Need more specific measures of racism and chronic stress • Providing timely feedback to communities on data collected • Methods for local/community-level data collection
Community Engagement	• Building on strong Healthy Start foundation and other established coalitions in this area • Focus groups underway to get community perspective on issues • Good consumer representation on planning team	• Reaching remote areas of the state • Getting local consensus/buy-in on disparities issues
Health & Social Service Interventions	• Commitment to expanding continuum of MCH services thru pre- and interconception care • Collaboration w/managed care organizations to improve care coordination • Increased discussion of quality of health care systems and delivery • Developing guidelines for coordination of services in and with communities • Incorporating disparities training for health professionals in state perinatal regulations and professional development activities	• Turf issues between hospitals • Involving providers • Fragmented pre- and postnatal care and coverage • Less discussion of social service interventions (versus clinical care)
Advocacy & Education	• Statewide conference on disparities • Working w/Healthy Start as foundation for community-based advocacy • Community advocates on planning team • Participation in local events and meetings to increase professional and public awareness • Using existing consumer education campaign and statewide professional education network to get word out	• Developing effective strategies for educating/communicating with adults and teens • Connecting w/medical schools and other professional training institutions
Evaluation	• Completion of timeline of target dates for activities • Incorporating process measures and impact objectives • Establishing baseline data	• Evaluation not seen by DOH as priority relative to service delivery • Deciding what needs to be evaluated most and best methods for doing so • Assessing impact at neighborhood level

Technical Assistance
In general, AMCHP provides technical assistance during Action Learning Labs in the form of facilitated group discussions and planning activities, speaker presentations, resource materials, expert feedback, cross-state sharing and evaluation tools. Follow-up assistance is tailored to the priority needs that each state team identifies and may include informational calls, research bibliographies, webcasts, resource referrals, participant listserv, online toolkits and communications consulting.

> **"When you say 'racism,' it immediately becomes a very personal thing that people begin to question and feel they have to respond to or defend or deny…What we're doing is focusing on making sure we don't use that word standing alone, that it's really attached to institutional racism – to the system and the organization rather than individual racism or discrimination…It frees people up to at least have a conversation outside of their own personal realm."** *-ALL participant*

Disparities ALL teams were asked to assess technical assistance needs during both meetings and were invited to contact AMCHP or any of the collaborating organizations with assistance requests as they emerged throughout the project period. Common technical assistance requests from the perinatal disparities ALL teams included facilitation of home planning meetings; techniques for conducting public and provider awareness campaigns; survey design and qualitative research methods (e.g., focus groups); ways to engage community *and* systems-level partners (e.g., managed care); funding sources for local-level work; evaluation design; methods to discuss and address institutional racism; and mechanisms to network and sustain relationships with other states attempting similar work.

> **"There is great value in both qualitative and quantitative data, and we need to work to develop a better system for sharing data between the state and communities…Data should be collected from varying representation throughout the state, crossing all social demographic boundaries.** *-ALL participant*

Evaluation
AMCHP monitored state team progress during the ALL through verbal status reports at the second meeting (six months out) as well as team leader conference calls at three and nine months into the process. State teams also completed formal process evaluations of their efforts after six months and created draft logic models to document major components of their refined action plans. The logic models served as a basis for the creation of team evaluation plans to measure desired short- and long-term outcomes. To date, most teams are still completing the logic models and evaluation plans with their home team members.

Because this report is being written within the first year of the disparities ALL project, we anticipate that desired outcomes (i.e., changes in knowledge, skills and behavior) resulting from state team action plans will not be evident for several more months, and that systems or population-level impacts could in fact take many years. Given the immense task at hand, however, and the challenges that all of the state teams have faced, it is remarkable how much they have already accomplished. Though one team has suffered an unfortunate setback due to unexpected turnover of their travel team members, the others are forging ahead to build upon existing efforts and strengthen their collaborations to reduce perinatal disparities. AMCHP will report further on the teams' ongoing successes and longer-term outcomes as they continue to make progress toward their goals.

> **"We're revising the perinatal regulations…One of the [ALL] subgroups is looking at cultural competence – what that would mean and how can you regulate it? The other aspect is establishing what we expect to be the standard quality of care, and that if you don't provide that, you're in violation of the law."** *- ALL participant*

Lessons Learned
State teams reported several lessons learned during their second AMCHP ALL meeting, on team leader calls, and in the 6-month team progress survey (see ***Table 4***). As with their successes and challenges, these lessons covered operational and process issues, as well as the six key areas (*racism and discrimination; data and evidence; community engagement; health care and social service interventions; advocacy and education; and evaluation*).

Teams stated that acknowledging racism, especially institutional racism, as a contributor to MCH disparities was critical to their efforts. They recommended that the state (DOH or corresponding agency) take the lead in addressing this area to facilitate county or local-level efforts and that there must be collaboration at multiple levels and with existing coalitions to make progress. In addition, teams suggested using current evidence linking racism and chronic stress to poor birth outcomes, as well as a skilled facilitator to help guide discussion on the issue.

> **"Don't get locked into [the idea] that only community people can reach community… sometimes community likes to hear from representatives of institutions, talking about things that no one else will touch… When it comes from some[one] that is not normally seen as an ally, it makes a major difference."** *- ALL participant*

In addition, states recommended the use of existing and multiple data sources on various population groups to assess perinatal disparities, identify opportunities for action, and begin the dialogue on disparities. They reported that partnership with the state DOH can assure greater access to key data sources and that ongoing work on disparities, including data collection, should be incorporated into the state Title V plan (e.g., using state negotiated performance measures). They also stressed the importance of building data capacity at the local level.

Teams considered community engagement essential for sustained and effective action on perinatal disparities. They strongly recommended exploring ways to enhance related efforts of existing community coalitions and emphasized that agency (i.e., non-community) representatives themselves can have a large impact at the community level. Good preparation, facilitation and follow-up were also identified as key to working with communities and keeping them engaged over the long term.

"Partner with every group who has a direct or peripheral interest in MCH. Collaboration with other entities such as the March of Dimes, Healthy Start and others has worked well. Pooling resources has been the solution to budget concerns." - ALL participant

State participants advised that health care and social service interventions designed to address disparities should involve commitment from many partners. Efforts to improve care and service coordination should start internally and include an ongoing assessment of ways to adjust existing programs to meet current needs. Some specific suggestions for enhancing access to and quality of care and services included use of Medicaid waivers to extend family planning coverage, revision of state perinatal regulations to assure equitable quality of care, and closer collaboration between the MCH and family planning programs.

"We need some help on how to evaluate what's happening in the community, at the neighborhood level…We do want to look at how many women had gotten care, but we also want to look at how did their lives change…" - ALL participant

In the area of advocacy and education, state teams suggested that detailed action planning may help to identify needs or opportunities to build awareness or legislative change. Pooling organizational resources and including advocacy groups in planning and implementation were recommended means to enhancing teams' abilities to provide information to the general public. Teams also advised participation in relevant public events and professional meetings to get educational messages out to these target audiences.

"Shrinking budgets and changing priorities require a lot of advocacy - it is hard putting out all the fires! This session, the legislature tried to roll back Medicaid eligibility for pregnant women. We have a lot of work ahead!" - ALL participant

When monitoring progress on their action plans, state teams reported that process and implementation (fidelity) evaluation should not be overlooked. They also emphasized the value of including a consumer-oriented perspective in determining desired outcomes and measures of success, as well as the importance of gathering baseline data against which to assess their progress. Finally, ALL participants shared that, although funding to support evaluation is helpful, adequate evaluation can often be accomplished using minimal existing resources.

By way of general process, teams recommended the following to develop an effective plan and partnership to address perinatal disparities: selecting team members who share passion and commitment for the work; assuring diverse team representation (e.g., racial/ethnic, providers and consumers); and establishing multiple methods of regular team communication to maintain focus on common team vision and goals. Teams also noted the importance of clearly defining "community," crafting tasks such that responsibilities can be shared across team members and obtaining strong support from represented organizations. Most importantly, teams emphasized that addressing perinatal disparities takes time and patience; setbacks will always take place, but teams should not give up this important work.

Table 4: Summary of State Team Lessons Learned

Operational/ Team Process	• Establish regular team communication/meetings w/flexible or multiple methods (e.g., conference calls, e-mails) • Assure diverse team membership (organizational/professional, geographic, racial/ethnic) • Recruit partners w/common goals, passion for issues, strong organizational support • Clarify shared definition of "community/consumer" • Share work evenly across team members (when possible) • Be patient – results won't take place overnight
Racism & Discrimination	• Address role of institutional racism in disparities • Have state take the lead (can make efforts easier at county level) • Work to get buy-in on multiple levels to move forward • Build on existing efforts, join existing coalitions • Use research/evidence linking racism/chronic stress to disparities to facilitate discussion • Have a skilled facilitator guide difficult discussions on racism
Data & Evidence	• Use existing and multiple data sources • Acquire strong support from DOH to facilitate data access • Don't make assumptions based on data from just one population • Use data to start dialogue and define direction • Create local data capacity (not just at state level) • Link efforts to Title V needs assessment and ongoing MCH work
Community Engagement	• Involve community to sustain efforts and optimize outcomes • Build on existing community networks and coalitions • Remember that DOH/agency reps can have big impact in communities • Make sure have good facilitator/preparation • Follow-up as promised and necessary to keep community engaged
Health & SocialService Interventions	• Acquire commitment from diverse partners to integrate services • Increase internal dialogue and efforts to improve care coordination • Reconfigure existing resources to meet new needs in health • Secure Medicaid waiver to effectively extend coverage • Use state perinatal regulations as a tool for assuring equitable care • Marry work of Title V and Title X programs to help ensure continuum of care
Advocacy & Education	• Conduct strategic planning to uncover opportunities for longer-term legislative intervention and education • Partner and organize together; pool resources to enhance statewide reach • Include advocacy groups in planning to increase ability to inform the public • Participate in public events and meetings to get information out
Evaluation	• Plan for and conduct process and implementation (fidelity) evaluation (as well as outcome/impact) • Consider and involve consumer/client perspective when defining desired outcomes to measure and how to define success • Establish good baseline data against which to assess progress on objectives • Funding for evaluation helps but is not necessary

Next Steps

AMCHP has committed to providing the ALL teams with ongoing technical assistance through 2005 by way of conference calls, a participant listserv, an informational call series or webcast, enhanced online resources, and evaluation guidance. In addition, AMCHP will bring the teams together once more at our 2005 annual meeting — *Delivering Results: Improving Pregnancy and Birth* — to help to reinforce their efforts one year out, and enable them to gather new information and disseminate their findings to 600 meeting participants.

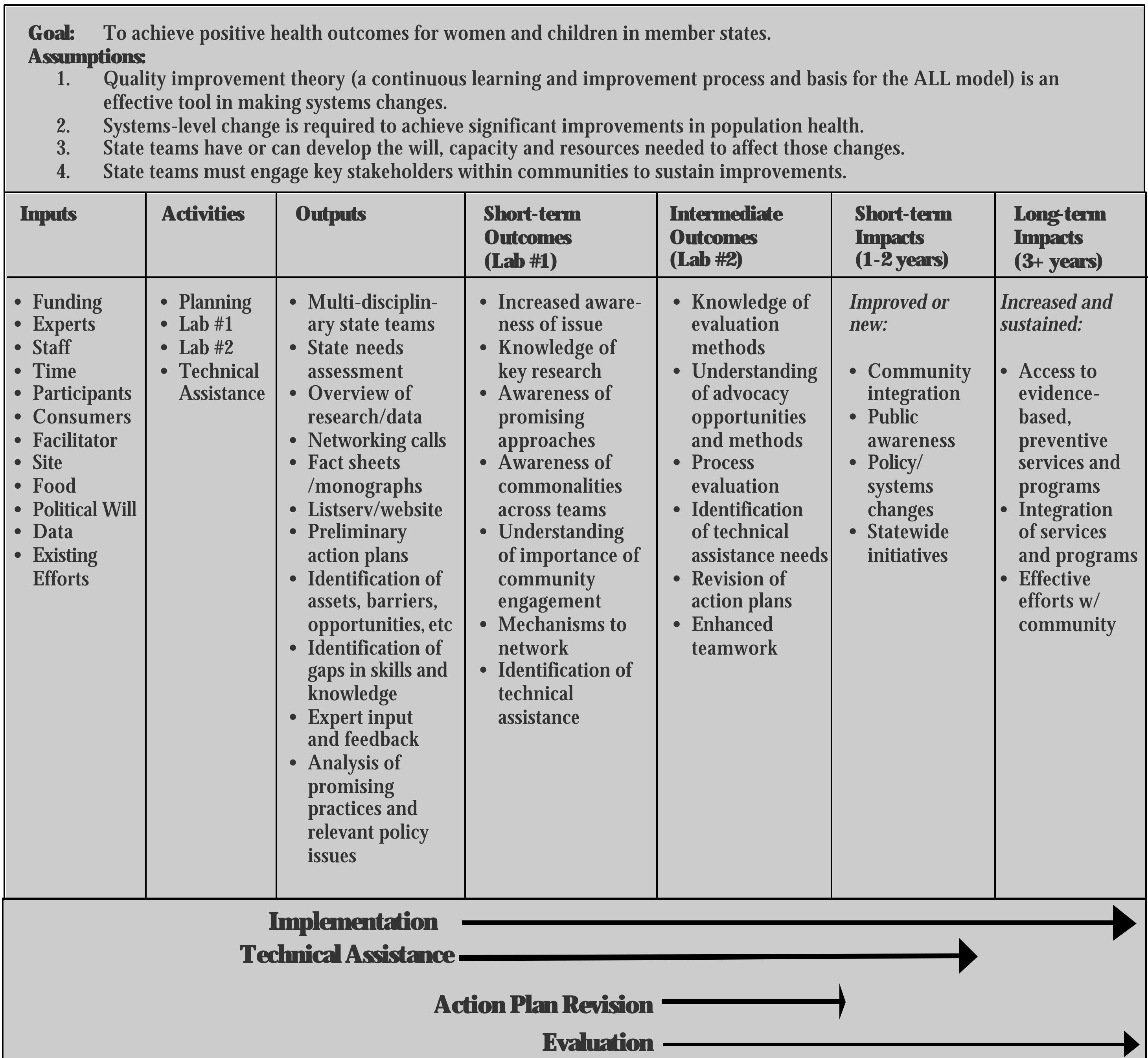
Conclusions

To date, AMCHP's perinatal disparities ALL fulfilled its two main objectives: 1) to help the selected state teams increase their knowledge of perinatal disparities and their contributing factors, and 2) to assist them in creating and implementing year-long action plans for reducing disparities at home. The larger common goal - to reduce and ultimately eliminate the gap in birth outcomes between blacks and whites — will require far greater investment of time, resources, creativity, courage, political will and collaboration. The evidence is clear that this is work we must do, because it is critical to the overall well being of our nation and all of our populations.

As the ALL participants have demonstrated, state MCH agencies and their agency and community-level partners have not only a unique role to play in reducing racially based perinatal disparities, but also an inherent professional obligation to speak out and act upon these issues. There are many health organizations already involved in this important work (e.g., American Public Health Association, Boston Public Health Commission, Centers for Disease Control and Prevention, CityMatCH, Healthy African American Families, HRSA's Maternal and Child Health Bureau, National Healthy Start Association, March of Dimes, the National Association of City and County Health Officials) with whom we must actively learn and collaborate, because this is not work we can accomplish in isolation. We also need to reach out to non-traditional and community-level partners in education, housing, human rights, economic and community development, and other "non-health" (yet vitally health-related) fields to build on their efforts.

AMCHP is committed to continued exploration of effective ways to focus on racial and ethnic disparities throughout all of our programs, not just in disease-specific or short-term projects. We believe that it is incumbent upon MCH programs to advocate for and assure equitable access to high quality, preventive care and comprehensive services for all, especially women, throughout the life course. In addition, we recognize that MCH must make a sincere and sustained commitment to take on one of the most entrenched determinants of poor health outcomes in the United States — institutional racism. The ALL process described here has taken us only a small step in the direction the larger public health community must travel to improve health for women and babies, but we're on our way.

Appendix 1: AMCHP Action Learning Lab Logic Model



Goal: To achieve positive health outcomes for women and children in member states.

Assumptions:

1. Quality improvement theory (a continuous learning and improvement process and basis for the ALL model) is an effective tool in making systems changes.
2. Systems-level change is required to achieve significant improvements in population health.
3. State teams have or can develop the will, capacity and resources needed to affect those changes.
4. State teams must engage key stakeholders within communities to sustain improvements.

Inputs	**Activities**	**Outputs**	**Short-term Outcomes (Lab #1)**	**Intermediate Outcomes (Lab #2)**	**Short-term Impacts (1-2 years)**	**Long-term Impacts (3+ years)**
• Funding • Experts • Staff • Time • Participants • Consumers • Facilitator • Site • Food • Political Will • Data • Existing Efforts	• Planning • Lab #1 • Lab #2 • Technical Assistance	• Multi-disciplinary state teams • State needs assessment • Overview of research/data • Networking calls • Fact sheets /monographs • Listserv/website • Preliminary action plans • Identification of assets, barriers, opportunities, etc • Identification of gaps in skills and knowledge • Expert input and feedback • Analysis of promising practices and relevant policy issues	• Increased awareness of issue • Knowledge of key research • Awareness of promising approaches • Awareness of commonalities across teams • Understanding of importance of community engagement • Mechanisms to network • Identification of technical assistance	• Knowledge of evaluation methods • Understanding of advocacy opportunities and methods • Process evaluation • Identification of technical assistance needs • Revision of action plans • Enhanced teamwork	*Improved or new:* • Community integration • Public awareness • Policy/ systems changes • Statewide initiatives	*Increased and sustained:* • Access to evidence-based, preventive services and programs • Integration of services and programs • Effective efforts w/ community

Appendix 2: AMCHP Perinatal Disparities Project Planning & Advisory Committee 2003-2004

Maribeth Badura
MCHB Parklawn Rm. 10C-16
5600 Fishers Lane
Rockville, MD 20857
Ph: 301-443-0543
Email: mbadura@hrsa.gov

Marsha Broussard
LSUHSC, Dept PH & Prev Med
1600 Canal Street, 8th Floor
New Orleans, LA 70112
Ph: 504-568-6893
Email: mbrous5@lsuhsc.edu

Justine Desmarais
AMCHP
1220 19th St, NW, Ste 801
Washington, DC 20036
Ph: 202-775-0436 ext 115
Email: jdesmarais@amchp.org

Cynthia D. Ferre
DRH/CDC MS K-23
4770 Buford Highway NE
Atlanta, GA 30341
Ph: 770-488-6268
Email: cferre@cdc.gov

Barbara Ferrer
Boston PH Commission
1010 Massachusetts Ave, 6th Fl
Boston, MA 02118
Ph: 617- 534-5264
E-mail: barbara_ferrer@bphc.org

Loretta Jones
Healthy African American Families II
3856 MLK Blvd., Suite 209
Los Angeles, CA 90008
Ph: 323-292-2002
Email: ljoneshaaf@aol.com

Stephanie McDaniel
AMCHP
1220 19th St, NW, Ste 801
Washington, DC 20036
Ph: 202-775-0436 ext 109
Email: smcdaniel@amchp.org

Belinda Pettiford
National Healthy Start Association
c/o 1929 Mail Service Center
Raleigh, NC 27699-1929
Ph: 919-715-3399
Email: belinda.pettiford@ncmail.net

Diane Rowley
Morehouse College
830 Westview Drive SW
Atlanta, GA 30314
Ph: 404-215-2733
Email: drowley@morehouse.edu

Patrick Simpson
CityMatCH
982170 Nebraska Medical Center
Omaha, NE 68198-2170
Ph: 402-595-1700
Email: psimpso1@unmc.edu

Nan Streeter
Utah Department of Health
PO Box 142001
Salt Lake City, UT 84114-2001
Ph: 801-538-6869
Email: nanstreeter@utah.gov

Terri Wright
W.K.Kellogg Foundation
One Michigan Ave East
Battle Creek, MI 49017
Ph: 269-969-2690
Email: tdw@wkkf.org

Appendix 3: References

[1] 2002 data from the CDC National Center for Health Statistics show the first rise in the overall infant mortality rate in the U.S. in the last 45 years (from 6.8 to 7.0 infant deaths per 1,000 live births).

[2] Centers for Disease Control and Prevention. *Achievements in Public Health 1900-1999: Healthier Mothers and Babies.* MMWR. 2000; 48: 849-858.

[3] Note: infant mortality is defined as number of deaths under 1 year old per 1000 live births.
Source: CDC National Center for Health Statistics. *National Vital Statistics Reports.* Vol 52: No 3, Table 31. 9/18/2003.

[4] Note: preterm birth defined as births occurring before the 37th week of pregnancy; low birth weight defined as less than 5.5 pounds. Source: March of Dimes. *Born Too Small and Too Soon in the United States.* June 2004. From MOD website: http://www.marchofdimes.com/peristats/prematurity.aspx?reg=99.

[5] Hogan, VK et al. *A Public Health Framework for Addressing Black and White Disparities in Preterm Delivery.* JAMWA. Fall 2001: 177-181.

[6] Authorized by Title V of the 1935 Social Security Act, the Maternal and Child Health Block Grant provides federal support to state public health systems to improve health for all women, children, youth, and families.

[7] AMCHP is a national non-profit membership organization representing state maternal and child health (MCH) leaders and others working to improve the health and well being of women, children, youth and families, including those with special health care needs.

[8] See research in: Maternal and Child Health Journal. 5(2) June 2001; Journal of American Medical Women's Association. 56. Fall 2001; Institute of Medicine report Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. 2001.

[9] Center for Continuous Quality Improvement: http://www.matc.edu/documents/strategic_plan_owner_guidebook.pdf.

[10] Committee members included representatives from AMCHP, Boston Public Health Commission, CDC's Division of Reproductive Health, CityMatCH, Healthy African American Families, HRSA's Maternal and Child Health Bureau, the Kellogg Foundation, Louisiana State University Health Sciences Center, Morehouse College, National Healthy Start Association, and the Utah Department of Health.

[11] Smedley, B. et al. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Institute of Medicine. National Academy Press: Washington, DC. 2002. www.nap.edu.

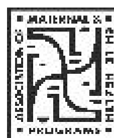
[12] Rowley, D. "Social Determinants of Reproductive Health Disparities." Presentation at AMCHP Disparities Learning Lab, January 2004, Atlanta, GA.

[13] Lu, M. and Halfon, N. *Racial and Ethnic Disparities in Birth Outcomes: A Life Course Perspective.* Maternal and Child Health Journal. Vol 7: No 1. March 2003: 13-30.

[14] Aronson, R. *The Use of Guiding Principles to Transform State Maternal and Child Health Leadership.* March 2002. http://www.amchp.org/policy/women-guiding.pdf.

[15] The Wisconsin Maternal and Child Health (MCH) Program established these Five Guiding Principles for MCH in 1994, and have made them the basis for all MCH efforts in the state.

[16] Jones, L. "Engaging Communities." Presentation at AMCHP Disparities Learning Lab, January 2004, Atlanta, GA.



This report was prepared by consultant **Amy Fine, MPH, BSN**, and **Justine Desmarais, MPH**, AMCHP program director. Development of this document was supported by funding from the W.K. Kellogg Foundation and the Centers for Disease Control and Prevention, Division of Reproductive Health. For more information contact AMCHP at (202)775-0436.

Building State Partnerships to Improve Birth Outcomes

AMCHP Perinatal Disparities Action Learning Lab Report

January 2005