

FINAL REPORT FROM THE SUMMIT

REDUCING INFANT MORTALITY IN MICHIGAN:

LESSONS FROM THE FIELD

Monday, May 5, 2008
Lansing, Michigan

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INTRODUCTION

On May 5, 2008, a summit meeting of stakeholders was held in Lansing on infant mortality in Michigan and the disparity in infant mortality rates. The summit, entitled *Reducing Infant Mortality in Michigan: Lessons Learned From the Field*, was sponsored by the Michigan Department of Community Health, Blue Cross Blue Shield of Michigan, Maternal and Child Health Bureau/Health Resources and Services Administration/US Dept of Health and Human Services, Genesee County REACH US, Michigan Council for Maternal and Child Health, W.K. Kellogg Foundation and the Prevention Research Center of Michigan. The objectives of the summit were:

- To summarize progress on priority issues and recommendations identified by the 2001 and 2004 Summits;
- To share the MDCH Infant Mortality Reduction Strategic Plan so stakeholders can understand the relationship of the many different activities involved to the overall objectives;
- To understand the outcomes to date of the current strategies being implemented at the state and local levels to address infant mortality; and
- To identify additional key resources and strategies, commitments and next steps to continue infant mortality reduction in Michigan, particularly by continuing to narrow the disparity that exists between the black and white infant death rates.

"Infant mortality is an extremely important issue in our state," said MDCH Director Janet Olszewski. "We must work hard to eliminate the ethnic disparity and decrease the overall rate in our state. This summit is an invaluable tool for our experts to gather and share ideas and strategies that could help reduce our overall rates."

In 2005, with a rate of 7.9 per 1,000 live births, Michigan ranked 40th in the nation in overall infant mortality. In 2006, Michigan's overall infant mortality rate dropped to 7.4 per 1,000 live births, with a significant drop in the African-American infant mortality rate from 17.9 in 2005 to 14.8 in 2006.

There is a significant racial/ethnic disparity in infant mortality in Michigan. Rates of infant death are much higher in African American and Native American babies when compared to white babies. The Michigan Hispanic infant mortality rate increased from 6.6/1,000 in 2000 to 11.3/1,000 in 2006. The smaller numbers of live births in racial/ethnic minorities provides a challenge for data interpretation. Intervention strategies must be culturally relevant and appropriate.

Success in reducing infant mortality in Michigan will come from improving the precursors and risk factors for infant mortality: low birth weight, preterm birth, smoking, unintended pregnancy, safe sleep, etc. Women who enter pregnancy prepared and in the best health will have better outcomes. Prenatal care accessed early with excellent chronic disease management and delivery in appropriate facilities to manage high risk pregnancies will promote better outcomes. Parents who partner with a primary provider to provide good nutrition, recognize newborn and infant development and health problems early, and adopt safe sleep habits will have better outcomes. Success means that all citizens of the state share equally in the anticipation of good pregnancy outcomes.

Reducing infant mortality in Michigan and eliminating the racial disparity in infant births is a priority goal for the Michigan Department of Community Health.

GENERAL SESSION

Lessons from the Field Barbara Sabol, Program Director, Health, W.K. Kellogg Foundation

The mission of the W.K. Kellogg Foundation is to support “children, families, and communities as they strengthen and create conditions that propel vulnerable children to achieve success as individuals and as contributors to the larger community and society.”

Data on the ranking of the U.S. and other industrialized countries for infant mortality rates was given as well as recognition of the racial disparity in infant mortality and the importance of addressing health disparities and improving infant mortality. Recommendations to the field include: public policy should include a “relational impact statement;” and there should be federal, state and local level measures of economic progress to assess the degree of income inequality, the degree of progress in health, education and purchasing power, and the ratio of disparity in economic and political development between men and women. Women should receive high standards of care including maternity care, promoting and supporting breast feeding, and Baby-Friendly Hospital status as a quality indicator for hospitals with obstetric and pediatric care services. Participatory ethnographic research methods are needed when conducting research in politically disaffected and economically disadvantaged communities. There should also be periodic quality assurance oversight of research efforts to assure compliance with requirements for including the voices of “study subjects.”

Racial and Ethnic Disparities in Birth Outcomes: A Life-Course Perspective

Michael Lu, MD, MPH, UCLA School of Public Health

Dr. Lu spoke about the racial and ethnic disparities in infant mortality and birth outcomes. A variety of popular explanations for disparities include smoking, prenatal care, socioeconomic disparities, stress, and infections. However, many of these factors alone do not explain the disparities. Even multiple risk factors explain less than ten percent of disparities in birth weight. The life-course perspective is a way of looking at life not as disconnected stages, but as an interconnected continuum. Dr. Lu challenges people to rethink preterm birth prevention and notes that the vulnerability to preterm delivery may be traced to not only exposure to stress and infection during pregnancy, but host response to stress and infection patterned over a person's life. A 12-point plan was discussed to close the Black-White gap in birth outcomes:*

1. Provide interconception care to women with prior adverse pregnancy outcomes
2. Increase access to preconception care for African American women
3. Improve the quality of prenatal care
4. Expand healthcare access over the life course
5. Strengthen father involvement in African American families
6. Enhance service coordination and systems integration
7. Create reproductive social capital in African American communities
8. Invest community building and urban renewal
9. Close the education gap
10. Reduce poverty among Black families
11. Support working mothers and families
12. Undo racism

**(Lu MC, Kotelchuck M, Hogan V, Jones L, Jones C, Halfon N. Closing the Black-White gap in birth outcomes: A life-course approach. Ethnicity and Disease forthcoming in 2008).*

BREAKOUT SESSIONS

#101 Addressing Racism in Infant Mortality Disparities

Facilitator: Barbara Sabol, W.K. Kellogg Foundation

Speakers: Renee Canady, Ph.D., MPA, Ingham County Health Department
Shannon Brownlee, Genesee County Health Department
Teresa Branson, Kent County Health Department

This session reviewed the health disparities that currently exist in Michigan based on available data and reviewed efforts that are specifically targeted to address the noted health gaps. Evidence was shared to identify actions by their agencies to address the defined issues and commit to ongoing work to improve service delivery that supports healthy lives for groups with poorer health outcomes.

The purpose of this initiative (How Race and Pregnancy Are Lived: An Analysis of Focus Group Discussions with African American Mothers) is to keep more African American babies alive and healthy in eleven counties identified as at-risk by the Michigan Department of Community Health (MDCH). This initiative looked at constructing race and racism with the goal of seeing whether or not the experiences of women in Michigan affirm what we see in larger research studies nationally, and if not, what are the patterns of concern? Racism as neglect, racism as disrespect, racism as mistrust and racism as economics was discussed. Racism as economics was the most consistent theme across the state. Next steps and challenges include further clarification of the relationship between women's perceptions and health institution goals, understanding our role in advocacy, validating women's experiences and cultural accommodation.

Two initiatives in Kent County were described: *Kent County Task Force on Health Care for People of Color* (2001-2005) and the *Kent County Infant Health Initiative: Racial Encounters in Health Care Project* (2005-2008). In one community summit, participants identified a need for a mechanism to report poor quality care and racial encounters in health care, as well as procedures to lodge complaints about negative health care experiences. To address this, the Committee on Reporting Racial Encounters in Health Care was formed.

The REACH 2010 project was conducted in Genesee County between 2000 and 2007. The aim focused on addressing infant mortality and the disparity between African American and European American deaths. A Community Action Plan (CAP) was derived from two points of view—bench (science) and trench (community) view. The trench and bench knowledge was combined to develop the CAP's three themes (enhancing the baby care system, fostering community mobilization and reducing racism). A Racism and Health Disparities Survey was conducted with REACH 2010 participants, Genesee County non-REACH 2010 participants and Saginaw County with demographically-similar zip codes.

During the breakout session participants discussed the following issues with the presenters:

A participant spoke of the need to look at ways to reduce barriers and bridge the divide. The panelists' intent is to address this divide through the programs they have created. They want to make sure that the stories of these women are not only told but heard. Also, there is a need to make the community aware of what is right and deserved by standards of care. For example, women may feel like they are getting adequate care, but compared to middle class with private insurance they may not be getting good care.

What types of trainings/workshops do the staff on these projects get before going into the community? Though not mandated, the trainings and workshops developed through the projects were offered to the staff. There were cultural competency trainings for staff and some of the staff worked with hospital CEOs as well. The panelists have found that often there is peer pressure to attend the trainings. Also, one hospital is requiring its medical residents to attend these trainings.

Is there any information from the cultural competency trainings about subcultures? And, do your trainings include any low-income women? The panelist commented that there is no solid data for the various subcultures so we cannot do specific trainings for them yet.

Have there been any attempts to sort out what people think about health care depending on their race (e.g., what do low-income white women think)? The panelists have learned that low income white women do identify themselves as being discriminated against, but the economic issue does not explain the racial differences.

How soon will the racism tools be available? The panelists said there is a lot of work to do before the tools will be done.

Some of the issues raised by participants in the discussion included the need to make connections with people outside of their circles in order to make the needed improvements, and to examine ourselves and how we contribute to the problem. One way to do this is to recognize our biases and keep our awareness about them. Also, there is a need to combine bench knowledge with trench knowledge. One participant mentioned that "simple is not simplistic." If we make straightforward statements it does not mean a simplistic idea. Also, data can impede our progress unless we use it appropriately.

A nurse shared a story about a Medicaid patient who had a baby under very poor care. She helped the woman as much as she could, but the baby may have permanent problems. The nurse recommended a lawsuit. The panelists commented about the way she handled it, and how it may be a middle class solution since a lawsuit might not be an option for a low-income woman. They felt that the real solution is to teach these women what "real" care looks like and learn to demand that care. Someone also suggested writing up a summary of this and giving it to the ethics committee of the hospital.

Some next steps were identified:

We need to emphasize relationships since they are primary. Then, we can use these relationships to solve problems. We need additional data on different classes and we must act on the data that we have. We must find ways to give ourselves voices and give others voices and cannot "afford to remain silent witnesses" as one participant said.

#102 Healthy Start – Lessons from the Field

Facilitator: Leseliey Welch, Detroit Head Start
Panel Members: Elizabeth Kushman, Inter-Tribal Council of MI
Dawn Scharer, Genesee County Health Department
Dawn Shanafelt, Saginaw County Department of Public Health
Carmen Sweezy, Kalamazoo Healthy Start Project
Marjorie Thomas, Detroit Healthy Start Project
Peggy Vander Meulen, Strong Beginnings

In this session the Healthy Start projects in Michigan were described briefly, including information on eligibility, overall goals, core services and target populations. Data was provided on each project's outcomes and process to date. Participants shared in a discussion regarding lessons learned about engaging the target population (recruitment and retention), successful intervention strategies, evaluation measures, overcoming barriers to medical care for non-pregnant women (interconception care) and experience in working with perinatal depression. In addition, successful models for integrating Healthy Start with other intervention services for pregnant and parenting women were discussed.

The purpose of Healthy Start is to reduce infant mortality, improve perinatal outcomes, and reduce health disparities in women and children from birth to two years old. The program has been evaluated as a "program that works" and graded as "promising." National evaluation findings have shown lower rates of low-birthweight babies, lower rates of very low-birthweight babies, lower preterm birth rates, statistically significant higher prenatal care utilization, and lower infant mortality.

Three local perspectives from Michigan Healthy Start projects were presented. **Maajtaag Mnobmaadzi: The Start of a Healthy Life** serves American Indian women, infants and their families in six Tribal communities and one urban community in Michigan. The **Saginaw County "Great Beginnings" Healthy Start Program** serves families of Saginaw County with the concentration of families living in the City of Saginaw. The **Genesee County Healthy Start Program** has seen 1,008 pregnant women and 639 infants less than one year of age, 270 children one to two years of age and 772 births.

Members of the panel discussed the following issues with attendees:

More outreach and networking efforts are needed. This could include churches, domestic violence shelters, signs in laundromats, libraries, Supplemental Food Program for Women, Infants and Children (WIC) and alternative education schools. Another option is to begin seeing families at conception, carry them until children are three years old, then bring them into Head Start. The lag between eligibility for the programs is very frustrating since you can lose the families during that time. We should also pay serious attention to preconception health with universal healthcare for at least women of childbearing age. Also, there is a need to educate middle and high school students in preconception care, valuing women as a whole, and employment at a living wage is vital.

The presenters discussed commitments and next steps needed to further the Healthy Start program. This includes political awareness such as contacting legislators and empowering our consumers to do the same, and improving voter registration. Also, advocating for Early Start funding, looking at policy change and sustainability so we are not moving backwards is important. We can ensure long term sustainability through an institutionalized structure like Head Start. We can also communicate positive outcomes, success stories and share real life stories. At the state level, MDCH can consider supplementary Healthy Start funds and look at Healthy Start as an evidence-based program for more support.

At the community level, we can increase awareness about the costs of infant mortality. Community health workers are critical to engaging women—we need state funds to reestablish MIHAS (Maternal and Infant Health Advocacy Services). Speeding up the Maternal and Infant Health Program (MIHP) redesign is needed, as well as keeping the flexibility with the staff required and with where you can meet clients. MIHP eligibility needs to be expanded to 18 months after birth, especially with high risk women. Increasing the schools' involvement would be helpful and the Michigan Model could adopt some of the "Crib Notes" strategies and curriculum. At the program

level, we need to address cultural and language issues and get funding for translation services. We also need more male community outreach workers. It is important to try to ensure long-term sustainability through an institutionalized structure like Head Start. We need to keep Healthy Start locally funded and locally managed. By maintaining Fetal Infant Mortality Review (FIMR), we can keep them as a critical ally in impacting and monitoring factors contributing to infant mortality.

Some key opportunities for partnership and communication include Faith Access to Community Economic Development (FACED), MIHA (Maternal Infant Health Advocates), hospitals, local health departments, and MIHP. There is also a need for stronger connections to private providers. Engaging the local media to show real life experiences with the program would be helpful. This would publicize Healthy Start's ability to tailor the program to the community. The biggest barrier to engagement is the TANF (Temporary Assistance for Needy Families) requirement of welfare to work—"parenting tasks" should be included as time requirements for Work First.

During the breakout session attendees discussed the following issues with the presenters:

How do MIHP and Healthy Start interface at the local level? In Kalamazoo's community, outreach workers help determine which program would best meet each client's needs, and then they triage referrals and work closely together with MIHP. In Grand Rapids, all five of the MIHP providers in Kent County are linked to Healthy Start. Healthy Start may service the higher risk mom/those in need of more intense and comprehensive services over a longer period of time. MIHP carries the client until the baby is age one, and Healthy Start can carry until age two. Healthy Start can also continue to service a mom following an infant or fetal loss, whereas eligibility for MIHP is dependent upon being pregnant or having a living child under one.

Where do Healthy Start projects get their referrals locally? Healthy Start in Genesee and Detroit generally gets referrals through community outreach, and other places where women meet and gather such as beauty shops, grocery stores, the faith-based community, hospital referrals, clinics, the health department, WIC, Sexually Transmitted Infection clinic, Family Planning, and also by word of mouth, family and friends. In Genesee County, the 211 resource line is another source of referral.

One participant shared her story. She had been a recipient of Healthy Start services in Michigan and the program made a big difference in her life. She asked the panel how she can "give back" in some way from a program which benefited her so much. The panelists recommended that she share her story with her legislator(s), join a local Healthy Start consortium, be on an advisory board or action team for Infant Mortality, and/or be a voice for those receiving services. The ITC project shared the concept that Healthy Start nurses do NOT give up on women, no one gets labeled "non-compliant" or gets dropped from the program for no shows. The caring and sharing is hard to measure--personal relationships and unfailing support are what make a difference in women's lives. Some next steps include advocating for funding for Early Start (similar to Head Start) and addressing diversity beyond race, including language barriers.

#103 Perinatal Regionalization Panel Discussion

Facilitator: Violanda Grigorescu, MD, MSPH, Bureau of Epidemiology, MDCH

Presenters: Greg Holzman, MD, MPH, Chief Medical Executive, MDCH
George Baker, MD, Office of Medical Affairs and Pharmacy, MDCH
Lawrence Reynolds, MD, Mott Children's Health Center

Panel: Joseph Moore, MD, FACOG, Butterworth Hospital
Nigel Paneth, MD, MPH, MSU Department of Epidemiology

Although Michigan once led the nation in developing the regional approach to perinatal care, it is no longer the case. The Michigan guidelines do not reflect the current practice patterns and were last updated in 1986. Experience in other states indicates that a regional system of care may have a positive effect on infant mortality. This session reviewed the current "system" of perinatal care services in Michigan, and discussed the potential for implementing a regional perinatal system of care in Michigan.

Regionalization of perinatal care can be traced to the development of premature infant centers in the United States during the 1930s and 1940s, but with few standards of perinatal practice. Michigan led the nation in pioneering the concept of a regionalized perinatal system in the 1970s and 80s. However in 2005, Michigan ranked 40th in the nation in overall infant mortality, with a rate of 7.9 per 1,000 live births. Michigan has not seen improvement in its overall infant mortality rate for the last ten years, although minor improvements in the white infant mortality rate have been seen over the same time span. State perinatal regionalization, also known as regional perinatal centers or regional perinatal systems of care, can be briefly described as a coordinated system of care to ensure that a variety of processes are in place. In the 1970s, MDCH funding was used to staff perinatal nurse educators who provided technical assistance to birthing hospitals in their regions, to update guidelines for regional perinatal centers, to survey and report on the classification of all hospitals, and to conduct the perinatal effectiveness study. The funding stopped in the late 1970s and the system was defunct by the 1990s. Despite the proven benefit of regionalized perinatal systems nationally and in Michigan, state guidelines do not reflect the current practice patterns and were last updated in 1986. As a result, no formal perinatal system exists in Michigan today. The changes in Michigan's health care system have impacted the proportion of high-risk pregnancies measured by birth-weight and gestational age, infant mortality rates and the risk for certain causes of death.

Some strategies suggested for improvements include:

- Engage health professionals from both medicine and public health in a collaborative effort.
- Develop "regional" teams to advance data-driven projects and activities.
- Create a statewide consortium to promote interaction among regional teams.
- Develop the structures, requirements, and activities in the regional perinatal program.

The panelists discussed perinatal regionalization with attendees:

We need to use resources rationally--fifty percent of births are paid for by the state. Comparing mortality rates between Level I, II, and III hospitals is also critical. We need standards to be developed and backed by the state including:

- Assured access to centers,
- Common data sets, and
- Hospitals should be accountable for infants born and examine where infants who need Level III services are really dying.

Collaboration is needed between centers, providers, health insurers and major community stakeholders. We must convince legislators of the importance of infant mortality and that additional state funding is needed.

#104 Maternal and Infant Health Program

Facilitator: Paulette Dobyne-Dunbar, Women, Infant and Family Health Section, MDCH

Speakers: Pat Fralick, Northwest Michigan Community Health Agency
Sue Gough, Priority Health Services, Inc.

Michigan's redesigned Maternal and Infant Health Program (MIHP) was featured in this session. Participants engaged in a 'dialogue for action' that identified MIHP successes and challenges. Gaps and barriers to services among Medicaid-eligible and the 'at-risk' populations of women receiving inadequate perinatal care were addressed. The interactive dialogue explored untapped opportunities to further integrate MIHP program services with existing local community agencies and programs to maximize positive outcomes.

The WIC/MIHP Integration Program Model was discussed. There is a need to create easy access for pregnant women by providing a centralized intake and appointment scheduling toll-free number for any service, cross-training staff to allow for the integration of the WIC Nutrition Program and MIHP, and ongoing appointment coordination WIC/MIHP/Immunizations. The WIC/MIHP program model allows appointments for pregnant woman to include WIC enrollment, Medicaid application and MIHP screening. The benefits of WIC and MIHP integration include decreased infant mortality, and increased MIHP participation, breastfeeding initiation, immunizations, WIC enrollment in the first trimester, prenatal care in the first trimester and adequacy of prenatal care. The model helps infants because a high percentage of eligible pregnant women are on MIHP, newborn home visits are available to any family, there is service integration with other programs and WIC clinic encounters, and nurses identify families who need more services.

The Priority Health Services, Inc. (PHS) President described using outreach effectively for MIHP to promote healthy pregnancy and infant outcomes. PHS has collaborated with hospital discharge planners to identify and refer mothers and babies to the MIHP. They have integrated with Managed Care Plans and collaborate with obstetric and pediatric case managers in identifying high risk cases. They work with plans to identify members in need of MIHP. They also collaborate with county WIC programs where MIHP is not offered by the health department. They collaborate with Child Protective Services and local Department of Human Services offices. PHS participates on the Child Death Review Team in Macomb County, FIMR teams in Detroit and Macomb County, and Community Action Teams from FIMR that are working on infant mortality reduction in Detroit/Wayne County/Macomb County. PHS developed a website that allows for direct referrals for either the maternal or infant portions of the program and did a mass mailing of brochures to past physicians who had clients enrolled in the MIHP.

During the breakout session attendees discussed the following issues with the presenters:

How can we prevent overlap with other MIHP providers in southeast Michigan? It's very challenging. If we find more than one MIHP provider involved, we ask the woman to choose a provider. This should be resolved once the central data base is operational.

Some suggested strategies include reaching out to churches--they can tell women about MIHP if a woman gets a positive pregnancy test. Also, to connect with domestic violence shelters, leave signs in laundromats, libraries, alternative education schools, etc. Connecting with WIC is also helpful since moms find WIC. One way to recruit from WIC is to find the total number of women eligible for WIC and look at what percentage of them are in WIC. Once you find those women, they can enroll in Medicaid (MA) online and they become MIHP enrollees. The state should give

nurses the WIC income eligibility levels and these numbers should be publicized. Hospitals, nurseries, pediatricians, and nurses should have these numbers. They are also on the WIC website. WIC also does webcast training on calculating income. An FQHC (federally qualified health center) has a staff member who works at WIC too and it's a great link. Women from WIC can use our services if she wants, such as depression services, transportation, etc.--we're one-stop shopping. FQHC has community outreach workers as well which are good contacts for MIHP providers.

When asked what organizations can do to help identify every pregnant woman who is Medicaid-eligible, ideas included: the more people who participate in FIMR reviews, the better. We are all under pressure to do more with less in Washtenaw--we have budget issues and a hiring freeze. We visited the northwest Michigan model and it made sense. Now we're two separate programs, but we are working with MIHP staff. WIC Electronic Benefits Transfer technology (similar to debit card) will help--no more coupons.

#105 R.E.A.C.H. (Racial and Ethnic Approaches to Community Health) US: The Genesee County Infant Mortality Reduction Story

Facilitators: John McKellar, MPA, Personal Health Division, Genesee County Health Department
Tonya French-Turner, REACH U.S. Program, Genesee County Health Department

Speakers: E. Yvonne Lewis, Faith Access to Community Economic Development
E. Hill DeLoney, Flint Odyssey House Health Awareness Center
Bettina Campbell, YOUR Center

The REACH program is a cornerstone of CDC's efforts to identify, reduce, and ultimately eliminate health disparities. Since 1999, the Genesee County Health Department and its partners have received funding to develop and implement a local community action plan to reduce infant mortality, particularly among African Americans. CDC has just refunded Genesee County and authorized the awarding of grants and technical assistance to communities interested in replicating their work. In this session, participants:

- 1. Learned about the REACH US initiative and the community action planning process used to develop this successful local intervention model.*
- 2. Understood the three interconnected spheres of activity—community mobilization, enhancing the babycare system, and undoing racism—and specific interventions that comprise the model.*
- 3. Discussed implications for replication in participants' communities.*
- 4. Explored opportunities for funding and technical assistance support.*

The CDC funded a Community Action Plan (CAP) derived from two points of view--science and community. The science point of view is that no single intervention is likely to eliminate racial disparities in infant mortality and the period of pregnancy is simply too short to effectively address many risk factors important to infant health. The community point of view told us that language, communication, and trust contribute to racism. This was combined to develop the CAP's three themes (enhancing the babycare system, fostering community mobilization and reducing racism). Community dialogue and awareness sessions with mothers, the creation of a media campaign and reporting back to the community were all parts of the structured process. *Black Men For Social Change* (a group of men involved in pregnancy and beyond), *Women Taking Charge of Their Health Destiny* (empowering women), Cultural Competence in Health Care course at University of MI Flint, Intervention Facilitators Training, African American History and Culture Education Center, and Afro-centric healthy eating curriculum were all deliverables of this project.

During the breakout session attendees discussed the following issues with the presenters:

Is PTSD (Post Traumatic Slavery Disorder) a model that the group created or was it pre-existing? It was a pre-existing model. *Did your project work with the Safe Sleep Initiative?* Yes. *What kind of budget do you get to operate this project?* \$900,000 was received from CDC. *Did you impact a greater sense of community among residents through this project?* Yes, men are going out and talking to their peers about this issue. Physicians and women have an enhanced relationship because of establishing quarterly meetings. Community residents have stepped up and taken the lead on teaching curriculum, etc.

One cannot separate the impact of racism on infant mortality--you must address the issue of racism if you are going to impact infant mortality. There is also a need to involve both MEN and women in any effort aimed at reducing infant mortality. There is a need for more funding and good evaluation efforts showing the impact of this project and other initiatives on reducing infant mortality. Also, it would be helpful to replicate the REACH projects in other communities that are interested (which Genesee is pursuing as a next step).

#106 Role of Third Party & Other Private or Non-profit Payors

Facilitator: Jacquetta Hinton, Health Disparities Reduction and Minority Health

Speakers: Bethany Caughlin, RN, McLaren Health Plan
Arthur James, MD, Borgess Medical Center
Tyffany Shadd-Coleman, Blue Cross Blue Shield of Michigan

Good pregnancy outcomes depend upon the health of the mother before she becomes pregnant, early and adequate health care during pregnancy, and appropriate postpartum care to support the goals of the mother and the family in regard to future pregnancies. Resources must be available to permit access to appropriate services and to encourage early entry into prenatal care and risk assessment.

The **Early Care Healthy Families** program enriches lives through education, coordination and outreach with the goal of experiencing a healthy prenatal period, progressing to a full term pregnancy, and continuing to promote a healthy lifestyle for all family members after delivery. The program's target population is those with Medicaid. The focus of the program is to promote prenatal visits, screening, prenatal and postnatal health, ongoing support through the prenatal period, post-partum check-ups (including depression screening) and following the infant for thirty-six months post-delivery while promoting early childhood health education.

Another part of the answer to the inequality of health care and infant mortality in Michigan is community-oriented care such as **Federally Qualified Health Centers**. Federally Qualified Health Centers (FQHCs) are health centers that receive a federal grant. HRSA provides federal grant funding to health centers to deliver primary and preventive care. Consolidated health centers include: Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, and Public Housing Primary Care Programs.

Blue Cross Blue Shield of Michigan (BCBS) programs that are available to help improve pregnancy outcomes were discussed including: BlueHealthConnection, Healthy Blue Incentives, and the Baby Steps Maternity Program. Blue Cross Blue Shield of Michigan provides insurance coverage to approximately 4.6 million members and has a 97% participation rate among MDs and DOs.

During the breakout session attendees discussed the following issues with the presenters:

Questions regarding preconception care, breastfeeding, maternal alcohol use, enrollment in Health Risk Appraisal and follow-up outcomes, birth control in case management, and infant death follow-up/referral were asked. There were concerns regarding non-citizens' access to care (Maternal Outpatient Medical Services are only the tip of the iceberg) and Blue Cross compliance and minority customers. Questions about how HMOs can better coordinate with the Maternal Infant Health Program and referrals to MIHP providers were also asked. Questions about McClaren were asked such as *Does McClaren talk to women about interconception spacing and care?* McClaren mails materials and it is discussed by the provider. Also, *Does McClaren have lactation support?* Just breastfeeding education. *How does Kalamazoo work with mental health and substance abuse networks?* There is a workgroup on substance abuse in pregnancy.

There is some concern that Blue Cross Blue Shield's compliance-based plan will hit minority consumers harder than other populations because of access to phones and the internet. Also, cuts in program funding have reduced the positive outcomes that communities were experiencing previously. It is difficult for non-citizen immigrants to access any care. The Hispanic experience in infant mortality is closer to the white low-income experience.

Strategies include early access to health care and education on regular health care and family planning (can use MSU studies on nutrition intervention in prenatal care as a resource). Also, private insurers should provide infant loss follow-up. It was noted that McLaren case management contact improves with office visits over home visits. Breastfeeding and alcohol reduction needs to be stressed as well. Other strategies include that women need to have early access to prenatal care and early confirmation of pregnancy. They also need early access to health care, family planning services, and information. Education in schools is needed about the importance of regular health care. Education on risks of pregnancy, safety of contraceptives (to destroy myths) is also needed in schools and in the community. Plan First! is a great initiative and it should be made a payer of first resort--federal change is required. Additional strategies include moving out of the silo mentality and working across all domains. Social changes have resulted in more sustained improvement in outcomes for pregnant women (i.e., Black women were finally allowed to give birth in hospitals which reduced mortality rates).

Commitments include continuing to advance the discussion around the non-medical contributors to infant mortality and the complex issues that impact infant mortality. Also, we will work on a speaker series to educate community leaders about problems that impact infant mortality. And, look at perinatal periods of risk--maternal health is part of the life course. Resources include the *Unnatural Causes* video from PBS funded by Kellogg Foundation and MSU studies on nutrition intervention in prenatal care.

#107 Strategies for Change in Targeted Communities

Facilitator: Sophia Hines, Division of Family and Community Health, MDCH

Speakers: Barbara Hawkins-Palmer, Healthy Kent 2010

Oemeeka Liggins, Kalamazoo County Human Services Department

Carolyn Rowland, Detroit Department of Health and Wellness Promotion

Sharon Wallace, Wayne County Health Department

Lydell Wyatt, Macomb County Health Department

Joan Zech, Macomb County Health Department

Local coalitions were formed to raise awareness of the persistent racial disparity in infant mortality in eleven urban communities in Michigan. This session showcased the work of several coalitions in understanding the gaps in service for women of color, listening to the experiences of women, and engaging the community to address this problem. The strategies used to help educate about and change the collaborative nature of the health system to meet the needs of pregnant and parenting African American women were discussed. How the coalition organizes and governs itself for the most effective completion of their strategic plan was also presented.

Infant mortality is not equally distributed by race or place, is not just a health problem, is not the result of women over 40 having children or engaging in drug use and is not unsolvable. But, we must be willing to learn how race, culture, and class interact to influence health behaviors, provider behaviors, access to health care, social support systems, access to economic resources and health outcomes. Also we must be willing to change ourselves, our systems of care, our public policies and our use and distribution of resources.

The Detroit Health Department works with block clubs, focus groups, and other small venues. Infant mortality rates in single women are twice as high as for married women. Comprehensive health and education services make a difference, not just doctor visits. In Wayne County, infant mortality is a massive problem. Everyone needs to be at the table, including faith and community organizations. A Speaker's Bureau is used to get the word out to grass roots groups.

Healthy Kent 2010 is a community collaborative providing a neutral, non-competitive arena where organizations and individuals can work together in areas of mutual interest related to the health of Kent County residents. In Kalamazoo County, premature birth is the primary cause of infant mortality. FIMR is a strong component in the Kalamazoo program. The Kalamazoo Infant Safe Sleep (KISS) coalition includes safe sleep, Healthy Start network and meetings to address racism. Premature birth is also the primary cause of infant mortality in Macomb County. Focus groups identified a need to educate the community about infant mortality racial disparity and the issues of trust and use of a medical model. The county identified areas of risk where an impact would be most effective. It got community leaders, insurance companies and community members involved. Macomb County does not have an NICU for high-risk infants.

During the breakout session attendees discussed the following issues with the presenters:

What role did DHS play in Kent's Initiative? They promote the program in their lobbies, they have the safe sleep video, we work with the home visitation program, they rarely come to the Kent Coalition meeting, and sometimes participate in subcommittee meetings. Detroit and Wayne County DHS try to send representatives to meetings. More connection with DHS is needed.

How did DHS actually help? Both groups found the need to work together to address this issue. Many people want to know how to get DHS more involved in their efforts to reduce infant mortality. Collaboration helped the agencies look outside their own boxes. There was a need for DHS to have a visible role in this effort but it was difficult to get case workers to participate in these efforts. Policies within our systems offer the bare minimum for those who need these resources the most.

Some suggestions include working with churches to promote the message of infant mortality, building upon existing initiatives that partners have in place, talking to parents about their perception of unplanned pregnancy and reducing unnecessary blame. Assuring that the staff is trained on best practices and offering 961-BABY resources for pregnant women and a hotline (313-732-7591) for class and crib access is also important. Wayne County has worked collaboratively

with DHS to impact the infant mortality rate within the county, with an emphasis on case management as a means to reduce mortality.

Local health departments can offer MOMS to show the doctor that the mother is covered with a Guarantee of Payment letter. Also, there is a need to have case workers who deal just with pregnant women. We also need physicians on board—we're trying "lunch and learn" at the office, which is more successful than dinner or breakfast conversations with physicians. We need to have BCBS and HMOs on board and on the Coalition. Participants made a commitment to remain eternally optimistic and work toward guaranteeing the funding. We need to educate the community about the whole picture of hypertension and diabetes mellitus by using real life stories (especially for legislators). Press releases are needed locally so that people know there is a problem. Even a picture will do if there is not room for an article. Churches are also helpful places to connect people and get them involved. We need to educate clients about asking the right questions and navigating the system.

Next steps include Tupperware-like (in-reach) parties inviting neighbors to learn about infant mortality and safe sleep, sponsored by Kent County. We need to enroll more women in programs which impact interconception care (Kent County wants 100 women, Wayne County wants 25 additional), and recruit clients who have had a loss of a child or have had low weight babies. We need to incorporate our work into the Great Start Initiative, and assure that women have access to services when they get pregnant. The program should be a basic resource and support for families of childbearing age because that's when these families need it the most.

Other suggestions were:

- Additional strategies: include BCBS & HMOs in local coalitions; assure staff trained on best practice; use 961-BABY (313-732-7591) hotline for class and cribs. DHS needs more visible role; include faith-based organizations.
- Collaboration helped agencies look 'outside their boxes'.
- Talk to parents about unplanned pregnancy vs. unnecessary blame.
- Put a 'face' on infant mortality to convey messages to individual communities; press releases; communication and regular meetings with Community Action Teams and Community Coalitions important; take information to physician offices (vs. meetings/forums)
- Policies in system offer bare minimum for those who need most; incentives do help navigate the system; TANF work requirements for pregnant women--moms have to work then support is cut if working; some women cannot make it on their TANF grants with baby who has high-risk special needs; DHS support process needs help specific to pregnant women; more health coverage for chronic medical issues beyond/before pregnancy.

#108 Welcome Network and Parent Orientation to the Summit

Facilitators: Bryn Fortune, MI Council for Maternal and Child Health
Michele Strasz, MI Council for Maternal and Child Health

This was an opportunity for any parents to attend a fun and interactive orientation to the Summit. This session was geared for parents to recognize and develop their skills and knowledge for their meaningful participation in the workshop sessions. It was a chance to meet and greet some of the parents around our state who are interested in the issue of the reduction of infant mortality. It was also a chance to ask any questions about specific break-out sessions. This was a chance for participants to connect with a mentor to assist them throughout the day.

The Summit gave parents and consumers the chance to network with one another, discuss the opportunities for parent voices to be heard, and to discuss the needs, concerns and experiences of parents that stakeholders need to know when creating policies and programs. A chance to better understand the process of the Summit and the opportunities to affect the political process was explained. Also, an explanation about the differences in their community programs and how to talk with legislators (telling your stories) was covered.

The facilitators asked the following questions of the attendees:

What do you want to get out of the day?

Responses included:

- Learn about what I can do in my community to improve infant mortality rates,
- Learn what other efforts have worked to reduce infant mortality,
- Learn more about prematurity,
- Learn more about SIDS and causes of death and how they are reported, and
- Gather data and information to share with teens and other parents about how to have a healthy birth. Visual impact is important with young people.

If there was one thing you could tell a legislator about families to help them when they make policy on infant mortality, what would it be?

Responses included:

- Parents and families need access to health care,
- Families need support from health care providers like nurses and midwives,
- Focus on all people of color and the impact of socio-economic conditions as well as the impact of infant mortality,
- Healthy Start is a link to many community resources,
- Give emotional support and motivation to single parents raising children without extended family or a partner, and
- Support for both parents (mom and dad) to be part of their child's life.

Some of the issues raised by attendees about the session include: Parents as a rule did not get a chance to pick their own workshops and are opting to go to others than what were assigned; parents want effective places to use their voices, resources and promotion of midwifery are needed; and a link to early childhood services like Great Parents Great Start after they "graduate" from Healthy Start is also needed.

Some additional key resources include:

www.michiganlegislature.org, www.house.mi.gov, www.senate.mi.gov, www.mcmch.org

Strategies include talking to the leadership of your programs (like Healthy Start and Strong Beginnings) about opportunities for parent voices. Commitments made included: Every parent will make a call to their legislators today and every parent will find out how they can do one thing in their community to improve infant mortality (i.e., get involved in the Healthy Start consortium as a parent participant). Next steps include: Michele and Bryn are willing to do advocacy trainings in your communities and will report back to parent groups and consortiums on the outcomes of the day.

#201 Championing Infant Mortality Reduction

Facilitator: Curtis Hertel, Jr., Legislative Liaison, MI Dept of Community Health

Speakers: Barb Byrum, Representative, 67th District, Michigan House of Representatives
Rick Jones, Representative, 71st District, Michigan House of Representatives
Paul Shaheen, MI Council for Maternal and Child Health

This session examined the public health areas that have received legislative support and the approach used to garner that support. Health priorities to reduce infant mortality were identified and information needed to assure understanding of the needs and allow statewide advocacy of the issues were discussed. Participants committed to continued monitoring and informing this process.

In order to lobby an issue, the presenters recommend contacting legislators in person if possible. Talking with your legislator as a constituent in his or her district can be more effective than writing post cards--however if you can't meet your legislator in person, emails, a handwritten letter or post cards can be effective as well. Some legislators prefer email because of the ease of responding quickly versus a written letter. Coffee hours are a great way to meet in person. If there are no coffee hours listed, call your legislator to find out if she or he has coffee hours or how to best meet in person. Trust and respect are the most effective ways of building relationships with your legislators. With a successful relationship, you can be a conduit from your community to your legislator.

A question was asked by a participant: *What can we do to help you understand what we do as professionals? Sometimes we don't hear anything back after we report to you. Sometimes we go to hearings about what we do and the information isn't even accurate.*

It goes back to relationships - developing relationships by visiting legislators and giving them information quarterly. We have two year terms, so we are constantly moving. The best time to see us is on a Tuesday or Wednesday when we are in session. People can sign up to get emails about upcoming hearings. If we aren't in session, most people aren't in Lansing, so check to be sure before you come. Also, for any report that you give, put a one page summary with the key points and attach it to the front. It's also helpful to have someone from their network come and drop off your report. Sometimes it's hard to tell who is an authority on a topic and who is not.

During the breakout session attendees discussed the following issues with the presenters:

What is needed to change infant mortality? Restore prevention funding, preserve foundation funding for public health, and invest more strategically in infrastructure. Consumer liaisons can be used in communities to spread public messages, such as Safe Sleep. We need to define state and community roles and hold each stakeholder responsible for his or her role. Also, spend our state funds on priorities and more wisely.

How can we as advocates do better to educate legislators when misinformation is rampant in the legislature? Meet and brief legislators regularly, utilize relationships of your board with legislators, summarize reports briefly with recommendations, and bring constituents.

Strategies include: Nurse Family Partnership, Preventing Unintended Pregnancy (Plan First!), Perinatal Regionalization, better utilize Medicaid managed care for outcomes and standards of care. Also, the education of young women is critical to good decision-making. Substance abuse prevention and treatment for women are also good strategies. There are limited physicians accepting Medicaid—physicians need incentives to accept Medicaid. In order to deal with racism and social injustice we need to look at models in Genesee County and Grand Rapids and involve

different sectors in the community--churches, business, and schools. The commitment was made to sign up to be part of network of champions.

#202 The Impact of Fetal and Infant Mortality Review (FIMR) – Teams in Local Communities

Facilitator: Rosemary Fournier, Division of Family and Community Health, MDCH

Speakers: Mary White, Oakland County FIMR Coordinator
Sarah MacDonald, Kent County FIMR Coordinator

This session gave a brief overview of the FIMR program and the 16 active sites in Michigan. FIMR's two-tiered system engages a multidisciplinary team to review individual cases of fetal and infant death in a community to improve the perinatal systems of care. Participants explored ways that local communities have used FIMR data to design and implement initiatives aimed at improving pregnancy outcomes. The session emphasized the importance of engaging the right partners in FIMR review and community action teams, and how qualitative data from Home Interviews enhances knowledge of community-specific determinants of infant mortality.

Fetal Infant Mortality Review (FIMR) is a process that tells us how and why babies die in a community. The purpose of the review is to better understand all the factors contributing to infant deaths, and to identify areas for improvement in perinatal service systems and community resources for women, children, and families. In 1991, two sites in Michigan were among those originally funded by the National FIMR. As of January 2008, there were 16 active FIMR teams in Michigan, establishing a FIMR presence in the communities in which approximately 70% of Michigan's infant mortality occurs. Sleep deaths were highlighted. Annually, infant deaths from 28 days to one year of age account for 30% of all deaths. As a partner, FIMR enhances the ability of communities to work together, brings players to a common table and improves communication among health and human service providers, and provides community-specific information about changing health care systems.

In Oakland County, the FIMR process identified that in years 2004-2006, premature births of infants and positional asphyxia accounted for 75% of the infant deaths in Pontiac, Michigan. In 2004-2006 in Pontiac, the infant mortality rate (Black 23.6 and White 4.9) was higher than both Oakland County and Michigan. Next steps include a recommendation to expand to other high risk school districts (in process), implement in community settings, evaluate students' retention over time (six months to one year) and compare future FIMR data to measure Crib Notes program success.

The total infant mortality in Kent County is approximately 70-80 infant deaths per year and 20-25 of those are African-American infant deaths. FIMR recommendations include 31 recommendations that have been made to the Healthy Kent 2010 Infant Health Implementation Team (IHIT) since they began reviewing cases in 2001. The Community Action Team (CAT) has approximately 40 members.

In response to the recommendations, Kent County developed the Core Concepts of Prenatal Care. They then developed a risk screening tool, a resource guide for providers, a pamphlet for providers to review with their patients who had a positive screen for substance abuse and a Healthy Women's Resource Guide.

During the breakout session attendees discussed the following issues with the presenters:

The Core Concepts of Prenatal Care was developed by the Kent County Community Action Team--the team put this together. Spectrum Hospital's grand rounds feature infant mortality, and are on the monthly agenda. Saginaw is on grand rounds quarterly. In Grand Rapids, Healthy Start is part of FIMR. Healthy Start workers are on Community Action Teams--they help us find the moms. Many FIMR communities don't have community advocates. Oakland County needs help with a major Family Planning provider since there is no current provider (the closest are in two adjacent counties). Community health workers are an asset at Healthy Start.

We need to expand FIMR to other communities in the state who might need it. We also need to expand the Nurse Family Partnership—the numbers are too small for the size of the infant mortality problem.

#203 Finding Answers through Evaluation and Research

Facilitator: Dan Kruger, Ph.D., Prevention Research Center of Michigan

Speakers: Leanne Roman, Ph.D., MSU Department of OB/GYN and Reproductive Biology

This session provided an opportunity for public health providers, academicians, and community partners to share their visions, questions and experiences about how evaluation and research can form a foundation for public health practice. Presenters talked about the questions that fostered their evaluation or research project, such as: Who is the right target for this program, How do we justify continuing this project past this grant period, and How much does this intervention cost? Presenters also talked about their successes and failures at influencing a program change or finding the right audience for data that is produced.

Evaluation is important because it increases the demand for evidence-based programs, and funding is increasingly driven by outcomes. It is important to integrate evaluation into programs because it facilitates the collection of data and it helps maintain a focus on program goals. An example is the Genesee County Racial and Ethnic Approaches to Community Health (REACH). REACH 2010 is the model which includes: enhancing the baby care system, fostering community mobilization and reducing racism. The REACH evaluation was designed to assess: Process (documentation of activities), Outcomes (changes in systems and individuals) and Impact (changes in African American infant mortality rate and disparities with White infant mortality rate). A Racism and Health Disparities Survey was designed to assess experiences of racism, responses to experiences of racism, perceptions of the health care system, relationships with partners, health and birth outcomes.

When asking how you can add evaluation to everything else that you are doing, consider who might already have the data you need (e.g., MDCH data warehouse, Public Health and Health Care Agencies, Early Childhood, Intermediate School District), find partners, examine what are the most important data elements/outcomes (but not everything), and look at whether technology can help. To improve performance/programs, ask an unscripted question to learn something, don't complain, count something (don't leave it to the scientist), write something, change, and then count again.

During the breakout session attendees discussed the following issues with the presenters:

How can we impact smoking among pregnant women? Research shows that depression and smoking can be treated together. Women who are depressed use smoking as a way to self-medicate. What is the evidence-based practice? Just saying “stop smoking” and going over the five A’s probably won’t be enough to get women to stop smoking.

What is available for researchers to use at the state level? This needs to be shared with other state level researchers. Trying to get PRAMS data is difficult. Working with MDCH can also be difficult—it would be nice to know exactly what they have available in terms of data. In addition to state-level data, looking at national data and helping communities see where they are in terms of their local data and how they compare to national data might be useful. March of Dimes is another option for some statistics. Another resource people can access is www.mittrainingcenter.org which covers measuring health disparities. For those who want more education about evaluation, the Michigan Public Health Training Center offers an online course on evaluation. Two suggestions were raised that could be beneficial. In order for people to feel more comfortable tackling evaluation, we need more training opportunities. It would be good to get copies of Dan’s racism survey out to communities. Also, creating a national repository for evaluation data might be useful.

#204 Why Are Mothers Dying? Michigan Maternal Mortality Surveillance

Facilitator: Rose Mary Asman, Division of Family and Community Health, MDCH

Speakers: Joseph Moore, MD, FACOG, Butterworth Hospital
Violanda Grigorescu, MD, MSPH, Bureau of Epidemiology, MDCH

This session gave a brief overview of the Michigan Maternal Mortality Surveillance (MMMS) process, one of the oldest in the nation, as well as of other projects targeted to maternal/women’s morbidity. Participants were engaged in interactive conversations on how to better use the information collected for further research/epidemiological studies and policy development. Community engagement strategies to design and implement other initiatives aimed at improving maternal and infant health outcomes were also discussed.

The Michigan Maternal Mortality Study (MMMS) was first organized in 1950. In 1990, it was no longer funded but volunteer committee members continued to review pregnancy-related deaths and made recommendations for prevention, focusing more on pregnancy-related deaths and less on other maternal death causes. The findings showed that non-medical and accidental maternal deaths made up a significant number of the overall cases in Michigan, confirming the need for a non-medical committee to review these deaths. Reviews of non-medical, non-pregnancy-related deaths by the MMMS Injury Committee began on a consistent basis during 2004.

Establishment of maternal mortality surveillance systems and review committees will enhance collaboration between physicians and other organizations within the health care field. Physicians in specialties other than obstetrics should participate in educational conferences on women’s reproductive health issues and on obstetric care and complications. It is important to remember that continued evaluation of the implemented maternal mortality surveillance is key for improvement. If the goal is to improve mothers’ and infants’ health in Michigan, the focus should be on the two indispensable and interchangeable components in the medical and prenatal care of pregnant women, preconception care and racial and cultural disparities.

During the breakout session attendees discussed the following issues with the presenters:

Was Maternal Mortality Review (MMR) examined by county? No, because the numbers are still too small. *How do you determine if women received care in the first trimester?* It's based on medical charts. However, nobody knows the "quality" of the prenatal care and what information is obtained during the first visit. Prenatal care can be reported as "beginning" when the prenatal assessment is completed.

The start of prenatal care is typically self-reported, so we are relying on women to accurately report the date of prenatal care. We need more discussion about reducing violent deaths (car accidents, homicide, suicide, etc.). We could have significant effect on addressing these areas. We also need health care for everyone. It would be helpful to have state staff work on maternal mortality and morbidity.

Some more strategies include: promoting health in school-based health center networks, addressing female health issues (e.g., reproductive health) in schools (we need acceptance by school boards), and using incentives for physicians and hospitals to encourage health care practices that can reduce maternal mortality/morbidity.

#205 Preparing for a Good Pregnancy

Facilitator: Cheryl Lauber, DPA, Division of Family and Community Health, MDCH

Speakers: Michael Lu, MD, MPH, UCLA School of Public Health
Teresa Branson, Kent County Health Department
Dawn Shanafelt, Saginaw County Healthy Start

Interconception care is a subset of preconception care, a prevention-based strategy that aims to improve pregnancy outcomes by identifying and modifying a woman's biomedical, behavioral, and social risks for poor birth outcomes before she gets pregnant. This session offered participants an opportunity to share concerns and successes in implementing local interconception care projects. The information on racial disparities and strategies for engaging African American clients was discussed. Information from recent community needs assessment and from focus groups with African American women serves as a basis for understanding how to modify protocols to fit local circumstances.

The **Interconception Care Program (ICP) Kent County's** goal is to decrease African American infant mortality, low birth weight and prematurity. Objectives to address the following topics include preventing subsequent pregnancies for at least 18 months after delivery, family planning, dental care, healthy weight before becoming pregnant again, folic acid before becoming pregnant, drug use, depression/stress, abusive relationships, and racial, cultural and socio-economic barriers to care.

The **Interconception Care Program (ICP) in Saginaw County** is based on the Denver, Colorado Trust Project at Denver Health (public hospital and 13 affiliated Community Health Centers) which provides prenatal care to the majority of the low income pregnant women in Denver. Successes of the ICP in Saginaw have been evident in a variety of ways.

Preconception Care is a set of interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management. The potential causes of preterm birth need to be investigated, including infectious/inflammatory causes, neuroendocrine, vascular, and stretching. A risk assessment for preterm birth and another

for stillbirth is encouraged. Promoting good health is also important to preventing stillbirth, and clinical and psychosocial interventions should be given.

During the breakout session attendees discussed the following issues with the presenters:

There are barriers to interconception care--few insurance plans provide coverage for women who are NOT pregnant, including college students (many of whom do not have medical insurance). We need necessary support services, and we need to push for universal health care for coverage of services prior to pregnancy. There also needs to be ongoing awareness related to cultural education and providers who are respectful, kind and considerate.

#206 SIDS and Sudden Unexpected Infant Death

Speaker: Sandra Frank, Tomorrow's Child/Michigan SIDS

Prevention efforts in Michigan have led to a decrease of over 71% in SIDS rates since 1994. However, the post-neonatal deaths have not dramatically decreased during this same time period. Annually, in Michigan, post-neonatal deaths account for about 30% of all infant deaths, and sleep-related deaths account for most of these deaths. Prevention of sleep-related deaths has a large potential to impact the overall infant mortality rate. This session defined the evolution of SIDS (Sudden Infant Death Syndrome) to SUID (Sudden Unexpected Infant Death) and encompassed the public/private strategies to eliminate preventable infant deaths related to unsafe sleep environments. A summary of the 2004 Safe Sleep Workgroup Report and progress toward the recommendations was highlighted. New study findings of knowledge, practice and beliefs of mothers, caregivers and providers were shared with participants.

Tomorrow's Child/Michigan SIDS is a non-profit organization dedicated to preserving infant lives and healing families, one day at a time. It is a resource statewide for the Back to Sleep and Infant Safe Sleep campaigns and Michigan's central referral site for grief services related to all infant deaths. What we know about SIDS has changed. We know more about how and why infants die than we did 10 years ago and vital statistics indicate that SIDS is going away. In Michigan, there has been a 71% decline in SIDS rates since 1993.

We have now evolved beyond SIDS and beyond Back to Sleep and are initiating a new Infant Safe Sleep campaign that will focus on systems change with a strong evaluation component. We will be a community resource for Infant Safe Sleep materials and training. One of the project goals is to develop a hospital model to 'institutionalize' infant safe sleep and nursing policy for clinical practice. We are working with health plans, hospitals, and the community. Focus groups also indicate that families are the main source of information.

During the breakout session attendees discussed the following issues with the presenter:

Is it OK to swaddle a baby? Opinions are varied--it's not an evidence-based issue--it's anecdotal. Some suggest swaddling with the baby's arms flexed so they can get their hands to their mouths. This way babies can self-soothe. Also, don't swaddle babies for too long. What are your thoughts about home monitors? There is no evidence that apnea monitors help to prevent deaths. What about breastfeeding in bed? It's OK as long as the mother is awake.

Strategies and next steps include public service announcements, referrals to websites such as www.michigan.gov and Tomorrow's Child, and pictures/poster of baby on back and trachea. A new

statewide workgroup needs to be convened and we need to continue to educate mothers about sudden infant death. Commitments made include delivery nurses will give this information out and nurses will provide prenatal counseling with short presentations.

#207 Southeast Michigan Infant Mortality Reduction Task Efforts – A Regional Approach

Facilitator/Speaker: Kimberlydawn Wisdom, MD, MS, Henry Ford Health System and Michigan Surgeon General

Speakers: Loretta Davis, Wayne County Health Department
Phyllis Meadows, Detroit Department of Health and Wellness Promotion
Carol Callaghan, MPH, Division of Chronic Disease and Injury Control, MDCH

An interdisciplinary group of Southeast Michigan health system leaders and public health professionals have convened to develop a plan of action to measurably and collaboratively reduce infant mortality in the region. This session discussed the process being used and the key objectives developed to reduce infant mortality in southeast Michigan through a systems approach.

The mission of the **Wayne County Health Department, Place Matters Design Lab** is to contribute to the Health Policy Institute's fair health movement by increasing communities' ability to address the social determinants of health (SDOH). The goal is to establish a national learning community (16 teams) to design and implement strategies to address SDOH. Objectives include providing technical assistance to teams and to connect teams to professional resources and networks. For change to occur, it will take professional and personal transformation, including an increased understanding and awareness of SDOH, willingness to speak out about SDOH, including others in the discussion, and strategic networking. The team's overarching goal is to improve pre-conception and inter-conception health for women by implementing strategies that emphasize, support and strengthen the value of women.

The **Detroit Regional Infant Mortality Task Force** goal (draft) is to "Develop a plan of action to collaboratively and measurably reduce infant mortality in the Detroit region, setting a sustainable precedent for ongoing new levels of regional partnership." Phase I of the task force is to review current reality (including community needs and assets and programmatic inventory) and assess challenges/opportunities to reduce infant mortality in southeast Michigan.

Maternal and child health programs within Detroit Health Department convened to work together on infant health to form the **Health and Wellness Promotion Initiative**. Some of the work being done through this initiative includes coalition building, comprehensive case management, integration of services/cross referrals, improved data and analyses/mapping, staff capacity building, opportunistic interventions and strategic partnerships. Some approaches include outreach, education, links to the media, community-based, co-location of services (wrap-around), focus on high risk, and program evaluation. Some examples of partnerships include public health partnerships, community-based partnerships, service networks, and health systems partnerships.

During the breakout session attendees discussed the following issues with the presenters:

Healthcare providers should be engaged in the effort by encouraging involvement at the institutional level. One model to engage providers is through patient-centered medical homes. The key issues to building a successful consortium include determining who has resources and cares

about the issue, and how can they contribute. Non-traditional thinking is also important--we need to recruit these people to help. Also, consumers need to be involved.

The steering committee provides oversight and direction to the Task Force. Solutions will take re-orientation of the health system and will not happen overnight. We need additional partners, health policy change, different language, and maintaining the focus on women so that the program does not get too diffused.

#208 Unintended Pregnancy: Governor's Blueprint for Preventing Unintended Pregnancies

Facilitator: Nancy Combs, Office of the Surgeon General, MDCH

Speakers: Cheryl Gibson-Fountain, MD, FACOG, Beaumont Hospital
Jackie Prokop, Medical Services Administration, MDCH

This session gave an overview of the Governor's Blueprint for Preventing Unintended Pregnancy with particular emphasis on the development and implementation of the Adult Clinical Guidelines and its potential impact on reducing unintended pregnancy and related outcomes such as infant mortality. Another significant component of the Blueprint is the continued implementation of Plan First!, Michigan's Medicaid Waiver Program, which provides expanded family planning coverage to women over 18 years of age. Participants in this session had an opportunity to discuss additional strategies at the local and state level that impact unintended pregnancy and to identify next steps that could be implemented to further evaluate our response to unintended pregnancy and related consequences such as infant mortality in Michigan.

The United States has one of highest unintended pregnancy rates in the industrialized world—about half of all pregnancies are unintended. In Michigan, almost 40% of pregnancies are unintended. The objectives of the Governor's Plan include:

1. Increase public knowledge and skills related to avoiding an unintended pregnancy.
2. Expand and improve coverage for family planning.
3. Challenge and engage Michigan's health care community in a statewide effort to reduce Michigan's unintended pregnancy rate.
4. An interagency workgroup was established in 2003 with policy-level representatives from key state agencies. In 2004, stakeholders from across the state convened to develop public-private and "public-public" partnerships to reduce unintended pregnancy.

Plan First!, Michigan's Family Planning Waiver Program, is run by the Michigan Department of Community Health and began on July 1, 2006. In Michigan, Medicaid pays for approximately 40% of all births and the cost is approximately \$10,000 each for prenatal, delivery, post partum and the first year of life. A toolkit for providers was developed as part of the Governor's Blueprint for Preventing Unintended Pregnancy. A guideline was also developed by the Provider Task Force and approved by the Michigan Quality Improvement Consortium (MQIC). The goals of the guideline are to increase conversations between providers and patients 18 and older (men as well as women) about risks and consequences of unintended pregnancies, to empower patients with family planning information for responsible decision-making, and to decrease unintended pregnancies in adults age 18 and older in Michigan.

During the breakout session attendees discussed the following issues with the presenters:

How are we evaluating the clinical guideline? MQIC will conduct an evaluation using medical record review. *Are there co-pays for Plan First?* There are no co-pays for any services or medication associated with Plan First. *Can non-citizens qualify for Plan First?* Only if they are a documented "alien." Undocumented persons can go to Title X clinics for services.

There is a clear link between reducing unintended pregnancy and reducing infant mortality. Some marketing strategies include robust communication with Early On Programs about the Adult Clinical Guideline and the Plan First! Program. Also, engage nontraditional partners such as neighborhood groups, older community members (e.g., Kent County), faith organizations (churches), men and neighborhood outreach centers. We need to get HEDIS standard for the Adult Clinical Guideline and a central repository of information for providers, state staff and public on Michigan.gov (current website is hard to negotiate) or some kind of live interface with providers and the state.

The video-recorded sessions, copies of handouts and a report from the summit will be placed on the infant mortality website at:

<http://mediasite.mihealth.org/Mediasite/Catalog/?cid=d171681243534202a88c7fca00d827c2>

FEEDBACK FROM THE SUMMIT

Racism/Diversity:

- ✚ Public policy regarding the effects of racism on infant mortality should include a relational impact statement.
- ✚ Assess social determinants of change for target communities.
- ✚ Address diversity beyond race, including language barriers.
- ✚ Replicate models from Genesee and Grand Rapids and involve different sectors in the community--churches, business, and schools.
- ✚ Promote ongoing awareness related to cultural education and providers who are respectful, kind and considerate.
- ✚ Consider racism as neglect, disrespect, mistrust and economic inequity.
- ✚ Combine "bench" knowledge (science) with "trench" knowledge (community).
- ✚ Understand the role of advocacy.
- ✚ Validate women's experiences.
- ✚ Provide cultural accommodation for clients.
- ✚ Consider application of Dr. Lu's 12-point plan to close racial disparity in birth outcomes.

Research and Evaluation:

- ✚ Perform periodic quality assurance oversight of research efforts to assure compliance with requirements for including the voices of study subjects.
- ✚ Provide more training opportunities in evaluation.
- ✚ Create a national repository for evaluation data.
- ✚ Provide more funding and develop evaluation efforts showing the impact of REACH and other initiatives on reducing infant mortality.
- ✚ Share available data resources and make available MDCH data known.

Funding:

- ✚ Advocate for funding for Early Start (similar to Head Start).
- ✚ Restore prevention funding, preserve foundation funding for public health, and invest more strategically in infrastructure.
- ✚ Spend our state funds on priorities and more wisely.
- ✚ Provide funding for translation services.
- ✚ Consider supplementary Healthy Start funds and look at Healthy Start as an evidence-based program for more support.

Education:

- ✚ Hold Tupperware-like (in-reach) parties inviting neighbors to learn about infant mortality and safe sleep
- ✚ Provide public service announcements on Back To Sleep, referrals to websites such as www.michigan.gov and Tomorrow's Child, and pictures/poster of baby on back and trachea.
- ✚ Convene a new statewide workgroup on S/UID and continue to educate mothers about sudden infant death.
- ✚ Provide education in schools about the importance of regular health care.
- ✚ Provide education on risks of pregnancy, safety of contraceptives (to destroy myths) in schools and in the community.
- ✚ Education of young women is critical to good decision-making.
- ✚ Consumer liaisons can be used in communities to spread public messages, such as Safe Sleep.

Access:

- ✚ Enroll more women in programs which impact interconception care.
- ✚ Assure that women have access to services when they get pregnant. The program should be a basic resource and support for families of childbearing age because that's when these families need it the most.
- ✚ Push for universal health care for coverage of services prior to pregnancy.
- ✚ Promote early access to health care, family planning services, and information.

Coordination:

- ✚ Incorporate our work into the Great Start work.
- ✚ Move out of the silo mentality and work across all domains.
- ✚ Collaboration is needed between centers, providers, health insurers and major community stakeholders.
- ✚ Link to early childhood services like Great Parents Great Start after they "graduate" from Healthy Start.

Services:

- ✚ Re-establish MIHAS (Maternal and Infant Health Advocacy Services).
- ✚ Speed up MIHP re-design.
- ✚ Expand MIHP to 18 months postpartum for high risk women.
- ✚ Add "Crib Notes" strategies to Michigan Model.
- ✚ Recruit more male outreach workers.
- ✚ Expand FIMR to other communities in the state who might need it.
- ✚ Expand the Nurse Family Partnership program—the numbers are too small for the size of the infant mortality problem.
- ✚ Promote health in school-based health center networks, addressing female health issues (e.g., reproductive health) in schools (we need acceptance of school boards).
- ✚ Breastfeeding and alcohol reduction needs to be stressed as well.
- ✚ Recruit clients who have had a loss of a child or have had low weight babies.
- ✚ Include Nurse Family Partnership, Preventing Unintended Pregnancy (Plan First!), Perinatal Regionalization, and better utilization of Medicaid managed care for outcomes and standards of care in infant mortality strategies.
- ✚ Substance abuse prevention and treatment for women are also good strategies.
- ✚ Share WIC income eligibility levels more broadly.

Policy:

- ✚ Negotiate with DHS to include parenting tasks in time requirements for Work First.
- ✚ Use incentives for physicians and hospitals to encourage health care practices that can reduce maternal mortality/morbidity.
- ✚ Involve both MEN and women in any effort aimed at reducing infant mortality.
- ✚ Healthcare providers should be engaged in the effort by encouraging involvement at the institutional level. One model to engage providers is through patient-centered medical homes.
- ✚ Need to get HEDIS standard for the Adult Clinical Guideline and a central repository of information for providers, state staff and public on Michigan.gov or some kind of live interface with providers and the state.
- ✚ Plan First! is a great initiative and it should be made a payer of first resort--federal change is required.
- ✚ We need standards to be developed and backed by the state including:
 - Assured access to centers,

- Common data sets,
- Hospitals should be accountable for infants born and examine where infants who need Level III services are really dying, and
- We need to define state and community roles and hold each stakeholder responsible for his or her role.

Advocacy:

- ✚ We need to convince legislators of the importance of infant mortality and that additional state funding is needed.
- ✚ Parents want effective places to use their voices; resources and promotion of midwifery are needed.
- ✚ Parents should talk to the leadership of their local programs (like Healthy Start and Strong Beginnings) about opportunities for parent voices.

RESOURCES

Inequality Matters: Infant Mortality in the Global Village. Joint Center for Political and Economic Studies Health Policy Institute. www.jointcenter.org

Infant Safe Sleep, Michigan Department of Community Health,
http://www.michigan.gov/dhs/0,1607,7-124-5452_7124_47340---,00.html

March of Dimes, <http://www.marchofdimes.com/>

Maternal and Child Health Epidemiology, MI Department of Community Health,
http://www.michigan.gov/mdch/0,1607,7-132-2942_41657---,00.html

Maternal and Infant Health Project, MI Department of Community Health,
http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_34593-106183--,00.html

Michigan Child Death Review Program, <http://www.keepingkidsalive.org/>

Michigan Community Health Information, <http://www.mdch.state.mi.us/pha/osr/chi/index.asp>

Michigan Public Health Training Center, www.mittrainingcenter.org

National SIDS and Infant Death Project IMPACT, www.sidsprojectimpact.com

National Sudden and Unexplained Infant and Child Death and Pregnancy Loss Resource Center,
www.sidscenter.org

Pregnancy Risk Assessment Monitoring System (PRAMS) 2004,
http://www.michigan.gov/mdch/0,1607,7-132-2944_5327-12856--,00.html

Racial and Ethnic Approaches to Community Health (REACH), Centers for Disease Control and Prevention, U.S. Department of health and Human Services, <http://www.cdc.gov/reach/about.htm>

The Right Start in Michigan – 2008, Michigan League for Human Services, Kids Count,
<http://www.milhs.org/>

Safe Delivery of Newborns,
http://www.michigan.gov/dhs/0,1607,7-124-5452_7124_7200---,00.html

Tackling Health Inequities Through Public Health Practice: A Handbook for Action. The National Association of County and City Health Officials and The Ingham County Health Department, Lansing, MI. www.naccho.org

Tomorrow's Child Michigan SIDS, www.tcmsids.org

UCLA Center for Healthier Children, Families and Communities,
<http://www.healthychild.ucla.edu/DropDownMenu/StaffDirectory/Lu.asp>

Unnatural Causes...Is Inequality Making Us Sick? www.unnaturalcauses.org

Vital Statistics, Michigan Department of Community Health,
<http://www.mdch.state.mi.us/pha/osr/chi/index.asp>

W.K. Kellogg Foundation www.wkkf.org

SUMMARY OF COMMITMENTS FROM THE SUMMIT

We received 73 commitment forms from participants of the Summit, indicating that they were either willing to actively contribute to the ongoing effort to reduce infant mortality or that they wanted more information on specific topics presented at the Summit.

Of those indicating that they were willing to participate in ongoing work:

- 34 were willing to participate in workgroups,
- 31 would be willing to review and comment on draft documents,
- 16 would approach stakeholders who are not engaged,
- 38 would disseminate information,
- 35 would provide input on action strategies, and
- 46 would consider opportunities for their organization to implement or support action strategies.

Area of Interest	Workgroup Participation	Review & Comment on Draft Documents	Approach Stakeholders	Disseminate Information	Provide Input on Action Strategies	Implementing or supporting action Strategies
Perinatal Regionalization	13	11	4	11	13	12
Championing IM Reduction	19	14	9	20	15	19
FIMR	12	14	6	16	15	13
Maternal Mortality	5	4		4	3	7
SIDS	4	4	2	6	7	10
Unintended Pregnancy	14	10	6	14	10	13
Evaluation/ Research	14	15	7	14	14	14

Requests for more information were distributed as follows:

Areas of Interest	No. Indicating Interest
Healthy Start	15
MIHP	12
REACH	17
Strategies for Change in Targeted Communities	17
Role of Third Party & Other Payors	14
Evaluation/Research	14
Pre-/Inter-conception Health	19
SE MI Infant Mortality Reduction Efforts	19
Unintended Pregnancy	20

SUMMIT EVALUATION

Evaluation forms were completed and returned by 115 participants.

Of those responding, 34 reported their primary professional role as nurse, 14 as program manager, 12 as advocate, 7 as health administrator, 6 health educators, 4 researchers, 3 epidemiologists, 3 students, 2 dietician/ nutritionists, one physician, 1 data analyst, and 28 "Other." "Other" professions included lactation consultant, certified nurse midwife, infant mental health specialist, foster care case manager, private consultant, community worker, consumer, nurse practitioner, social worker, genetic counselor, school administrator, foster care supervisor, outreach coordinator and perinatal clinical nurse specialist.

Of the organizations represented at the summit, there were 29 local health departments, 22 community-based organizations, 16 from hospitals, 9 from primary care or managed care organizations, 7 from universities, 6 from non-governmental organizations, 4 from state health department, 3 from university-based clinics, 4 from non-university-based clinics, 3 from federal health agency, one from state education department, and 13 from other organizations, These organizations included Great Start Collaboratives, intermediate school districts, substance abuse agency, Medicaid health plans, advocacy organizations, non-profit organizations and private businesses.

Overall, the majority of respondents agreed or strongly agreed that the summit met their expectations (85%). Four respondents disagreed or strongly disagreed that the summit met their expectations. Some of the comments:

- "Possibly increase time for networking. Encourage discussion at tables, submission of ideas. Making connections with others, both private and public sector, essential."
- Future partners – Senate Republican Caucus
- "What will happen because we had this summit? (... that would not have happened if it hadn't been held)"
- "More young people involved would be nice – collaboration with universities."
- "More opportunities for interaction among participants."
- "To achieve more understanding you need more interactive surveys or informational activities."
- "This conference needs to be repeated in two to three years with creative ways to document outcomes in the interim."
- Monday meetings are difficult for people who have to travel long distances.
- "Need more input on how to help out clients."
- "Excellent job pulling various areas together for the common goal!"
- "In a low economic situation, barriers to care must be decreased, e.g., transportation to services and collaboration between helper agencies."
- "Power Point slides should be made available electronically – they are too small to use back in the community."

Question #3: *This Summit helped me understand the issues related to infant mortality and potential strategies and methods used in assessing the impacts on society, families, and individuals of health conditions and in the evaluation of public health programs and policies.* 94.7% agreed or strongly agreed with this statement. Three strongly disagreed and one was undecided. Some of the comments were:

- "Excellent coverage of the infant mortality issue and racial disparities."
- "Listen to the local communities. Provide medical home choices for women."

- “Didn’t hear much discussion about the big policy and system barriers re: no universal access to health (so how do you assure pre/interconception care); no significant economic and support foundation for pregnant women and families with young children. This is a critical piece of the work.”
- “Focused almost exclusively on black vs. white infant mortality. Are stats similar for African-Canadians, blacks in the UK, non-African blacks (Caribbean Islands, etc.)? What about our Middle Eastern population? Dr. Lu’s stats consistently showed that Native Americans suffer the second highest or sometimes the highest morbidity and mortality rates (above all other races besides African-Americans). They weren’t even mentioned. Their stress levels and lifetime discrimination, poverty rate is equal to or greater than blacks but it doesn’t often result in LBW unless very pre-term. More like LGA. Racism in Native Americans is rampant. 10 pound babies are common.”

Question #4: *The speakers were very knowledgeable and answered all questions in an effective manner.* 96% of respondents agreed or strongly agreed with this statement. Three strongly disagreed and one was undecided. Some of the comments were:

- “Dr. Lu was excellent, the networking was helpful and the maternal mortality review process was very interesting.”
- “Michael Lu is an excellent speaker. Brings new thought process to the area of infant mortality. Liked LeeAnne Roman. Wished she would have had more time. Seemed like wealth of info to keep!”
- “The Lu connection between chronic stress and infant mortality was fantastic!”
- “The speakers didn’t have enough time to present all of the information shared. The whole day felt rushed.”
- “I just feel the presenters should be more out there to try and catch the audience’s attention. I feel they should put more in or get more from everyone else.”
- “I brought some participants of the Strong Beginnings Program. They were disinterested in General Session speakers because it was too scientific, consider something more at their level. On the other hand, I loved the speakers.”
- “Dr. Lu – a great speaker, very interesting but not everyone is from the medical field. I felt uncomfortable for our consumers and for those of us who are not with a medical background.”
- “Speakers did good presentation but due to time restraint speakers’ presentation not fully. Shorter breakout sessions are attention getter and learn more. Workshops were geared toward administrative. Advocates are the stakeholders who need to be present.”

Question # 5: *The breakout session topics were all chosen and allowed participants’ input.* 85% of respondents agreed or strongly agreed with this statement. 11 disagreed or strongly disagreed and five were undecided. Some of the comments were:

- “Perhaps shorter sessions to allow additional topics for participants to attend.”
- “Too many choices to choose from for three breakouts!”
- “Do not repeat sessions, offer something different at all times.”
- “Excellent breakout session topics.”
- “I did not learn anything new. I was looking for action. Advocacy session was too elementary. Wanted to talk about specific legislation budget and lessons learned from summit we could move into action.”
- “Disappointed with section on third party payors – more like an “ad” for their company – wanted to hear what they felt their responsibilities were – how they can help – like research \$, discussions for implementing evidence-based practice.”

- "Session #106 BCBS used their time to advertise their services – not about IM – very disappointing."
- "#306 was overview of what the plans offer. Did not talk about the "obligation." Did not address the real problem – "that the plans do not pay well enough to have enough providers providing the needed services. Dr. Arthur James was great but in wrong session – not insurance-focused."
- "It would be great to get all handouts from all sessions since I would have liked to attend more than three."

Question #6: The facility and audiovisuals were appropriate. 67% of respondents agreed or strongly agreed with this statement. 24% strongly disagreed or disagreed and 7 were undecided. Some of the comments were:

- "It would have been much more enjoyable and easier to pay attention had I not been freezing in every room!!!"
- "This facility was not the best for the size of the crowd. The food was terrible."
- "Have technology figured out before the speakers start."
- "AV technology problems overall should be worked on before presentations. Labels on meeting rooms would have been helpful."
- "Tech issues were annoying and distracting – occurred in more than one breakout session as well as the Unnatural Causes movie."
- "Audiovisuals not well prepared."
- "Make sure all technical support can get the systems up. Try sending material so everyone will be on the same page."