Racine Lifecourse Initiative for Healthy Families

Community Action Plan for Greater Racine

Prepared by the Greater Racine Collaborative for Healthy Birth Outcomes
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**Executive Summary**

An African American baby born in Racine, Wisconsin is three times more likely to die before his or her first birthday than a White baby. Reducing this disparity in Greater Racine cannot be done overnight. It will take time, talent, resources, community engagement and an unwavering, long-term commitment from all sectors of Greater Racine. This Community Action Plan includes recommendations that, if implemented and funded, can significantly reduce the infant mortality rates among Racine’s African-American residents.

This plan was produced by the Greater Racine Collaborative for Healthy Birth Outcomes (GRC4HBO/the Collaborative). The Collaborative is comprised of health care providers and caregivers, educators and service agency representatives, community leaders, concerned volunteers, and business representatives. Funding and support for plan development was provided by the University of Wisconsin School of Medicine and Public Health through the Wisconsin Partnership Program’s Lifecourse Initiative for Healthy Families (LIHF).

The plan was developed after careful examination of research and data, dialogues with community residents, expert presentations and visits to communities where evidence-based models for reducing disparities are in place. The recommendations contained herein address the root causes of unhealthy birth outcomes and provide specific actions to be taken by the affected population, the community-at-large and the Collaborative itself.

The GRC4HBO recommended approaches are:

<table>
<thead>
<tr>
<th>Work of the Collaborative</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Promote community understanding of Lifecourse issues</td>
<td></td>
</tr>
<tr>
<td>(2) Expand, enhance and simplify system integration and coordination among all human service and healthcare related organizations, agencies and programs</td>
<td></td>
</tr>
<tr>
<td>(3) Examine (in consultation with appropriate federal, state, county and local agencies) and develop recommendations for new or revised policies related to but not limited to: child support enforcement, case management systems, potential medical assistance waivers to perform infant mortality prevention work, alternatives to traditional models of prenatal care, and barriers to increasing availability of dental health and mental health services for low income families</td>
<td></td>
</tr>
<tr>
<td>(4) Promote pathways out of poverty including Earned Income Tax Credits, transitional jobs and Children First</td>
<td></td>
</tr>
<tr>
<td>(5) Promote healthy behaviors and access to resources for healthy living across</td>
<td></td>
</tr>
</tbody>
</table>
the Lifecourse such as the new health and wellness program for African American women and expanded availability of community gardens

| Implementation Programs | (6) Expand evidence-based programs and services that build relationships to support pregnant and parenting women and their families |
| (7) Expand evidence-based programs that address relationship building, stress reduction, and the role of fathers in the lives of their children |
| (8) Develop an evidence-based neighborhood center to support families and children using an existing infrastructure |

Recommendations 1-5 relate to the future work of the Collaborative, requiring operating resources for the Collaborative itself (i.e. staffing and support for policy studies, promotion of existing programs, public information campaigns and the like). Recommendations 6-8 relate to implementation projects undertaken by Collaborative member organizations and will require investments made over time. With regard to implementation projects, supported by the Wisconsin Partnership Program or other sources, GRC4HBO recommends the following models be incorporated within existing organizations and agencies and where appropriate replace current practices:

- **Centering Pregnancy**
- Expansion of Prenatal Care Coordination and Home Visitation Models (incorporating Healthy Families America-HFA)
- Birthing Project USA: Sister/Friends & Barber Shop
- Nurturing Fathers Program
- Foundations of Maternity
- Women’s Wellness Initiative
- Baby FAST (Families and Schools Together)
- Health Leads
- Mary Center-Carrera Adolescent Pregnancy Prevention Program
- Northern New Jersey Maternal Child Health Consortium-Irvington Family Success Center
- Racine Fetal and Infant Mortality Review
- Northern Manhattan Perinatal Partnership
Introduction

Being born full-term, at a healthy birth weight, and surviving beyond the first birthday substantially increases the odds of living a healthy full life. Yet, in Racine, Wisconsin almost 16 percent of African American babies are born with a low birth weight, 20 percent are born prematurely and approximately 20 African American babies, per 1,000 live births will not survive until their first birthday (Wisconsin Interactive Statistics on Health (WISH)).

What Are the Costs?

In 2005, preterm births cost the United States at least $26.2 billion or $51,600 for every infant born prematurely (March Of Dimes). The average first-year medical costs, including both inpatient and outpatient care, were about 10 times greater for preterm infants ($32,325) than for full-term infants ($3,325) (March Of Dimes). In Wisconsin the average costs incurred during the first year of life for an infant born weighing less than 2,500 grams can be as high as $165,000 per child (See Table 1) (State of Wisconsin: Department of Health and Family Services, 2010). In Racine babies spending time in the Neonatal Intensive Care Unit (NICU) costs an average of $75,000 according to 2011 data (Wheaton Franciscan Health Care, Personal Communication). Those who survive often have lifelong health problems, including cerebral palsy, mental retardation, chronic lung disease, blindness and hearing loss (March of Dimes).

Table 1: Cost Savings for 2005 Medicaid births in Top 5 Counties in Wisconsin

<table>
<thead>
<tr>
<th>Birthweight (g)</th>
<th>Ave. Total Charges First Year of Life</th>
<th>All Medicaid Infants</th>
<th>Est. Black Medicaid Infants*</th>
<th>General Population Distribution**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>&gt;2,500</td>
<td>$3,514</td>
<td>12,718</td>
<td>89.7</td>
<td>4819</td>
</tr>
<tr>
<td>1,500-2,499</td>
<td>$18,557</td>
<td>1116</td>
<td>7.8</td>
<td>574</td>
</tr>
<tr>
<td>1,000-1,499</td>
<td>$98,505</td>
<td>141</td>
<td>1.0</td>
<td>81</td>
</tr>
<tr>
<td>&lt;1000</td>
<td>$164,257</td>
<td>204</td>
<td>1.4</td>
<td>123</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>14,179</td>
<td>5997</td>
<td>$55,768,200</td>
</tr>
</tbody>
</table>

Source: 2005, Linked Birth Events File, OHI

* Sample calculation for the Medicaid costs associated with Black Medicaid births: (.875)(5507 black births >2,500 grams in the five counties in 2005, per Wisconsin Interactive Statistics on Health) = 4819; (4819)(53,514) = $16,933,966 in Medicaid hospital costs for black births >2,500 grams

** Sample calculation for the Medicaid costs associated with black Medicaid births whereby the birthweight distribution is equal to that of the general population (i.e. all races combined in the five counties in 2005, per Wisconsin Interactive Statistics on Health): (.917)(5597)(53,514) = $18,035,425 in adjusted Medicaid hospital costs for black births >2,500 grams
Recently, research has focused attention on factors outside healthcare to answer the question, “Why are African American babies dying at a higher rate than any other ethnicity?” Researchers are examining the role that community and societal conditions play in health disparities. In essence, the question is “will efforts to improve the mental and physical health of African American women and infants lead to improved biological, environmental, behavioral, and social conditions that impact healthy birth outcomes?” This Community Action Plan incorporates a comprehensive, community-driven, evidence-based approach to improving birth outcomes in Racine, WI.

This will not be business as usual.
Mission, Vision, and Values Statement

The Greater Racine Collaborative for Healthy Birth Outcomes was formed in 2010 after two years of study and discussions. The mission, vision and values of the Collaborative are:

Mission: To reduce African American infant mortality and improve the health and well being of African American women, children and families in the Greater Racine community.

Vision: By serving as a driving force for change that connects resources, organizations and individuals to those most affected, the Collaborative will impact not only the African American infant mortality rate but also the quality of life for all in Racine.

Values: By operating in accord with our overarching principles, the Collaborative will “live” the values it espouses. Each of the principles listed below are detailed in terms of behaviors expected by Collaborative members as shown in Appendix D.

In Racine we will...

1. Maximize cooperation, coordination and integration of efforts among diverse agencies and stakeholders.
2. Create new strategies and Lifecourse approaches—not business as usual.
3. Promote shared learning and mutual respect among community and statewide partners.
4. Recognize the critical voices of African American families and community members.
5. Build upon or expand models and programs that are successful.
6. Integrate, support and strengthen existing efforts and community strengths.
7. Create new partnerships to leverage resources.
8. Build and sustain public and political will for action.

Aspiration Goal: In the next five years, we aspire to see a reduction in infant and fetal death by 50 percent and a reduction in prematurity and low/very low birth weight by 25 percent using 2007 data as a baseline.

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1 Fetal death occurring 20 weeks of gestation or more
Background

**Infant Mortality Data**

Wisconsin’s rank for African American infant mortality has fallen from among the best in the country to third worst. Among 39 states and the District of Columbia with sufficient numbers of deaths to generate reliable rates for the years 2003-2005, Wisconsin ranked 38 at 16.42 deaths per 1,000 live births, approximately 3 times the rate of White infants (TJ Matthews, 2008). During 2006-2008, the African American infant mortality rate in Wisconsin was 15.17 deaths per 1,000 live births, still approximately 3 times the rate for White infants (Wisconsin Interactive Statistics on Health (WISH)).

During 2006 - 2008, the infant mortality rate for African-American infants in Racine was 19.9 per 1000 live births compared to 6.8 per 1000 live births for White infants, almost 3 times higher (WISH). According to the Racine Fetal Infant Mortality Review Report for 2007-2008, there were 82 fetal and infant deaths within the City of Racine, with the highest mortality occurring in zip codes 53403 (39 deaths) and 53404 (26 deaths) (Johnson, 2010). These zip codes contain Census Tracts with the highest concentrations of African American residents (35 to 45%) in the city. According to the Fetal Infant Mortality Review, the top three contributing factors to these deaths in the mentioned zip codes are prematurity, chorioamnionitis (inflammation of placental tissues), and SIDS (Sudden Infant Death Syndrome) (See Figure 1). Also, the majority of the mothers who experience fetal or infant loss in these zip codes were Medicaid recipients, which is an indicator for poverty (Johnson et. al, 2010).
According to the data presented below, African American women ages 20-34 are experiencing higher infant mortality rates than African American teenage mothers and White mothers of all ages. Table 2 illustrates the age ranges of mothers experiencing a loss in the City of Racine. The rate for African American infant deaths is also higher regardless of when the mother received prenatal care (See Table 3). Overall, African American women who sought prenatal care early still had higher rates of infant mortality than White women. Specifically, African American women, ages 20-34 who received prenatal care in the first trimester, had higher rates of infant mortality than young African American teen mothers and White mothers of all ages. Clearly more than prenatal care and age are factors in infant mortality in Racine.
Table 2: Maternal Age and Infant Mortality Rate (<365 days) per 1,000 Live Births [2006-2008] by Race in the City of Racine

<table>
<thead>
<tr>
<th>Mother's Race/Ethnicity</th>
<th>Maternal Age (Grouped)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All ages</td>
</tr>
<tr>
<td>All Selected</td>
<td>11.19</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>6.81</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>19.90</td>
</tr>
</tbody>
</table>


Table 3: Initiation of Prenatal Care and Infant Mortality (<365 days) per 1,000 Births [2006-2008] by Race in the City of Racine

<table>
<thead>
<tr>
<th>Mother's Race/Ethnicity</th>
<th>Month Prenatal Care Began</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Selected</td>
</tr>
<tr>
<td>All Selected</td>
<td>6.51</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>5.37</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>15.17</td>
</tr>
</tbody>
</table>


**Health of African American women over the lifespan**

There are many health disparities when comparing African American women and White women. African American women are more likely to weigh more or be considered obese prior to pregnancy than White women (33.8 percent vs. 26.8 percent respectively) (Centers for Disease Control and Prevention). They are also at higher risk for developing diabetes, which affects 1 in 4 Black women ages 55 years and older. Diabetes affects nearly 12 percent of all Black women ages 20 and older. Black women suffer heart disease at a rate twice as high as White women. In addition to having higher heart disease rates, Black women die from heart disease more often than all other Americans (Black Women’s Health Imperative).

The health factors mentioned above play a major role in maternal/child health. Pre-eclampsia (which is directly related to stress and high blood pressure) and gestational diabetes are major health concerns during pregnancy, and can result in poor health.
during the interconception period. Gestational diabetes occurs during pregnancy and affects 4 out of 100 pregnant women (March of Dimes, 2008). A woman is at increased risk for infant death or premature delivery if she experiences two or more of the above mentioned risk factors.

**Social Determinants of Health**

According to the World Health Organization, Social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. Examples of these determinates include proximity of a home to a major expressway, availability of grocery stores that sell fresh fruits and vegetables, and instances of unnecessary harassment from authority figures. Cultural beliefs and practices such as food preparation and prenatal care are also determinants that play a role in the health of an individual throughout his or her lifetime.

**Description of the Lifecourse theory and the 12 point plan**

The Lifecourse Perspective builds on the principle that a woman’s health is shaped by exposure to protective and risk factors over the span of life (see Figure 2) and relate directly to the social determinants of health (Lu MC, 2008). These factors contribute to her reproductive outcomes, as well as health outcomes for her child. Examples of protective factors include a supportive family and community, ability to access quality health care, involvement of fathers, and employment within a supportive environment. Examples of risk factors include unhealthy behaviors, chronic stress, or lack of prenatal care.
The Lifecourse Perspective seeks to address the social determinants of health, such as socioeconomic status, personal and/or cultural health beliefs and behaviors that influence a woman’s ability to have a healthy pregnancy and healthy baby.

The 12-Point Plan for Closing the Black-White Gap in Birth Outcomes addresses the factors identified in the Lifecourse Perspective (See Table 4). This plan identifies multiple factors that play a role in improving birth outcomes before, during, and after pregnancy. This is the foundation of the work in Racine.

The three major themes of the 12-Point Plan are: (1) improving health care services, (2) strengthening communities and families, and (3) addressing social and economic inequalities (Lu MC, 2008). The priorities under each theme include strategies to ensure a woman is healthy (before, during and after pregnancy), address and increase father and community involvement, and tackle inequities that have an impact on income and chronic stress.
Table 4: A 12-Point Plan to Close Black-White Gap in Birth Outcomes: A Lifecourse Approach

| Improving Health Care Services | 1. Provide interconception care to women with prior adverse pregnancy outcomes  
|                              | 2. Increase access to preconception care to 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 coordination and integration of family support services  
|                              | 7. Create reproductive social capital in African American communities  
|                              | 8. Invest in community building and urban renewal  
| Strengthening Families and Communities | 9. Close the education gap  
|                                          | 10. Reduce poverty among African American families  
|                                          | 11. Support working mothers and families  
|                                          | 12. Undo racism  
| Addressing Social and Economic Inequities |  

The combination of all three constructs - social determinants of health, Lifecourse perspective, and 12-Point Plan - paint a different picture than what is considered popular belief. Health or lack thereof is not merely based on visits to a physician or eating healthy. There are barriers, both self-imposed and systemically imposed, that must be considered, analyzed, and removed in order to reduce disparities in African American and White infant mortality.
Our Community-Greater Racine

Greater Racine is located in the southeast corner of Wisconsin, about half way between Milwaukee, Wisconsin and Chicago, Illinois with Lake Michigan forming its eastern border, and I-94 forming the western border. The community is primarily comprised of the City of Racine, the adjacent villages of Caledonia and Mt. Pleasant, and several smaller villages. The borders between these jurisdictions are highly permeable with residents moving back and forth among them to live and/or work. With the exception of municipal services, residents of these communities share availability of a wide variety of county, non-profit and private services. Together these communities face the same challenges as their larger northern and southern neighbors without a similar level of assets to address those challenges.

The City of Racine, like other industrial cities, lost population between 2000 and 2010. According to the 2010 US Census, the current population is 78,860, down 2,967 from the 2000 Census. The other Greater Racine communities have increased in population for all racial groups. The City of Racine is comprised of 48.8 percent males, 51.2 percent females and has of one of the highest African American populations in Wisconsin. African Americans make up 22.6 percent of the population (See Figure 3). Since the main concern here is childbirth, the emphasis is on females between the ages of 15 to 44. In the City of Racine, approximately 42 percent of the female population falls into this group. For Whites, about 41 percent are female while for African Americans this group encompasses about 45 percent, a substantially larger percentage.

Figure 3: Demographics of Racine, City 2010

![Pie chart showing demographics of Racine, City 2010](source: US Census, 2010)
Racine African American population

The number of African American residents has increased by 1,434 since 2000. For the 2010 Census, the African American percentage total is 22.6 percent, up from 20 percent in the 2000 Census. Unlike Milwaukee, the African American population in Racine is not restricted to one or two zip codes or even a few Census Tracts\(^2\). There are several Census Tracts and zip codes with higher proportions of African American residents than others throughout the city. A greater density of African Americans reside in Census Tracts 2, 3, and 5 (See Figure 4). Census Tracts provide a finer grained look at where the largest proportions of African Americans actually live.

Figure 4: 2010 Census Tracts and Race Density

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\(^2\) Racine zip codes incorporate multiple Census Tracts. The zip codes 53403 and 53404, for example, cover approximately one-third of the city. In addition, useful and reliable population and demographic data is not available by zip code.
Racine Poverty

The 2009 Five-Year American Community Survey tells us that 38.6 percent of Racine’s African Americans population lives in poverty. Digging deeper into the data gives a better view of family poverty. Families living in poverty in the city represent about 14 percent of the total. When broken out by race, less than 9 percent of White families are living in poverty compared to 29 percent of African American families. The per capita income of city residents in 2009 was $20,177 and the percentage of families and individuals living below the poverty level was 13.6 percent and 17.7 percent respectively. The vast majority of all families living in poverty, regardless of race, are those headed by either a male or female without a spouse present with the number of female heads of household outnumbering male head of households by about six to one. According to the County Health Rankings single-parent households make up 33 percent of the households in Racine County (University of Wisconsin Population Health Institute).

Racine Employment and Education

Working and earning a salary is paramount to supporting a family. In the City of Racine, there are about 62,000 residents 16 years old or older. Of those, approximately 24,000 work full-time on a year-round basis. Of those 24,000, 75 percent are White while only 16 percent are African American. Increasing full-time employment would add both a greater standard of living and access to employer sponsored health insurance. An additional aspect of employment is the participation percentage, or how many residents 16 years old or older are either working or looking for work. For Racine, those in the labor force represent about 66.6 percent of the total. For White residents the participation percentage is about 67.6 percent while for African American residents, the percentage is about 61 percent. The city participation percentage is lower than that of the State of Wisconsin which is about 70 percent. Engaging the available population of the city in the labor force is a continuing issue (University of Wisconsin Population Health institute, 2011).

Compounding the issues related to engaging the available workforce is the issue of high unemployment. According to the 2009 5-year American Community Survey, the unemployment rate for the City of Racine was 9.2 percent. Breaking out unemployment rates by race shows that while the City unemployment rate was 9.2 percent, White unemployment was 6.3 percent and African American unemployment was 20.1 percent.

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3 All poverty and employment data reflect pre-recession data, post recession data is not available from a reliable source
Education and standard of living are highly correlated. In general, the higher the educational level, the higher the level of employment and standard of living. In the City of Racine in 2009, the percent of residents with less than a high school diploma is 18.6 percent. For White residents, the percentage was 15.2 percent while for African Americans the percentage is 22.2 percent. On the higher educational attainment level for 2005-2009, those with at least a Bachelor’s degree represented 16.6 percent of the city residents. For Whites, that percentage was 19.2 percent while for African Americans the percentage was 9.1 percent (See Table 5).

Increased educational attainment correlates to earning potential. The higher level of education an individual receives correlates with their earning potential. It also impacts the type and availability of health insurance and living environment. Table 6 illustrates the 2005-2009 education and economic condition of the US, state, county, and city. The percentage of families and individuals living below the poverty level in Racine is much higher than the county and state.

For each of the past 13 years the Public Policy Forum has compared the performance of the Racine Unified School District (RUSD) with nine peer districts using multiple measures. RUSD has consistently been either the first or second worst performing district for each of those years as judged by the Wisconsin Knowledge and Concepts Examination. It has also consistently shown to have the highest dropout rates and a high school completion rate for African American students of between 50 and 65 percent (Public Policy Forum, 2010).

Table 5: City of Racine Educational Attainment by Race, 2009

<table>
<thead>
<tr>
<th>Total:</th>
<th>Total:</th>
<th>White</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than high school diploma</td>
<td>18.6%</td>
<td>15.2%</td>
<td>22.2%</td>
</tr>
<tr>
<td>High school graduate, GED, or alternative</td>
<td>36.8%</td>
<td>37.1%</td>
<td>39.8%</td>
</tr>
<tr>
<td>Some college or associate's degree</td>
<td>28.0%</td>
<td>28.6%</td>
<td>28.9%</td>
</tr>
<tr>
<td>Bachelor's degree or higher</td>
<td>16.6%</td>
<td>19.2%</td>
<td>9.1%</td>
</tr>
</tbody>
</table>

Table 6: Education and Economic Comparison fro U.S., WI, Racine County, and Racine City (2005-2009)

<table>
<thead>
<tr>
<th></th>
<th>High School Graduate or higher</th>
<th>Bachelor's Degree or higher</th>
<th>In the Labor Force (age 16 and above)</th>
<th>Median Household Income</th>
<th>Families Below Poverty Level</th>
<th>Individuals Below Poverty Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>84.6%</td>
<td>27.5%</td>
<td>65.0%</td>
<td>$51,425</td>
<td>9.9%</td>
<td>13.5%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>89%</td>
<td>25.5%</td>
<td>69%</td>
<td>$64,609</td>
<td>7.2%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Racine County</td>
<td>86.6%</td>
<td>22.4%</td>
<td>66.8%</td>
<td>$54,203</td>
<td>7.2%</td>
<td>10.8%</td>
</tr>
<tr>
<td>Racine City</td>
<td>81.4%</td>
<td>16.6%</td>
<td>66.6%</td>
<td>$40,733</td>
<td>13.6%</td>
<td>17.7%</td>
</tr>
</tbody>
</table>

Source: US Census, American Community Survey
Health of Racine County

Racine County is ranked 59th in the state of Wisconsin for health outcomes and 65th in health factors out of 72 counties (University of Wisconsin Population Health Institute, 2011). The county rated higher than the national benchmark for premature death and morbidity. It also rated higher in health factors such as adult obesity, sexually transmitted diseases, children in poverty, inadequate social supports, and violent crime. This has implications for the city since the majority of the county residents live within Greater Racine.

Based on the data provided in the education and employment section, a significant number of African Americans in Racine are experiencing higher unemployment rates and have lower rates of advanced education (Bachelor’s Degree). These factors have a serious impact on health and community interaction, which may affect the health of African American pregnant families and infants.

The chronic stress of not being able to financially provide for a family or themselves can result in chronic disease as can continuous pressure to succeed. Individuals with only a high school degree seldom have job opportunities that pay enough to support a family or provide adequate, if any, health insurance. Chronic conditions such as diabetes, high blood pressure, and coronary disease occur at higher rates in the African American community across all income levels.

Community Assets (opportunities)

The Greater Racine community has a wide variety of assets related to the health and well being of its residents. The area has a beautiful, clean and accessible lake front, a charming downtown, an excellent, low cost zoo, growing numbers of community gardens, well maintained parks and community centers dispersed throughout the city. The city has good municipal services such as garbage pick-up, recycling and water services, police forces and fire departments that engage in community programs, and a variety of cultural assets and health departments that work well together and collaborate on many programs and services.

The non-profit sector and County government provide numerous programs and services throughout the area. There is one primary hospital where over 2,000 babies are born

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4 Reliable county data on African American health was not available.
each year. In addition, there is a major regional health care system affiliated with the hospital, a federally qualified health center, a Health Care Network that provides limited health care to the uninsured and a branch clinic of a second large health care provider.

One school district serves the entire area east of I-94. The community is home to the only independent charter school outside of Milwaukee, a renowned private school and excellent parochial schools. Gateway Technical College has a large campus in Racine and offers programs in several community locations. The University of Wisconsin-Parkside engages in a substantial way in our community, particularly through its Center for Community Partnerships, and is considered “our” university. Several other higher education institutions either offer classes here or are in close proximity to residents and engage in a variety of initiatives within the community. Among these institutions are University of Wisconsin-Milwaukee, Alverno College, Carthage College and Carroll University. In addition, the University of Wisconsin-Extension is involved in numerous activities, including parenting education and community gardens.

A substantial number of residents are engaged in volunteer activities, social, professional and community organizations. Racine has a strong faith-based community representing many denominations, many of which are involved in community outreach and support.

Given this array of assets, and more, the Greater Racine community has the opportunity to build on this base to improve birth outcomes for African American families and to enhance their quality of life. By so doing, we will improve the quality of life for our entire community. This Community Action Plan describes how the Collaborative will build on the base of assets and strengthen connections among them

**Where are the gaps?**

Despite many assets, the community faces real and perceived gaps or needs. A Strengths, Weakness, Opportunities, and Threats (SWOT) analysis (See Appendix G) was conducted in late 2009, and identified needs for (1) improved coordination and linkage across and within existing systems, services and programs, (2) expansion of selected programs to reach more individuals, (3) enhanced delivery of services, (4) the addition of certain program models within existing organizations and agencies, (5) increased employment opportunities, and (6) promotion of existing programs that provide pathways out of poverty. These gaps were identified from the Strengths, Weakness, Opportunities, and Threats analysis (SWOT), and community discussions.

One gap identified immediately by the Collaborative was transportation. There is limited public transportation to and from medical appointments and other essential services. The
Racine Transit System (The Belle Urban System) hours of operation are Monday through Friday 5:30 am until Midnight; Saturdays, from 5:30 am until 10:30 pm and Sundays from 9:30 am until 7:00 pm. Buses run every half hour until approximately 7:00 pm, during the week and every hour in the evenings and all day on weekends while some routes that do not run at all after 6:00 pm on weekends. If an emergency or appointment falls outside of these hours or the bus is off schedule, one may have to use emergency ambulance services to get to the proper entity. In addition, the availability of public transportation will be substantially reduced in 2012 due to budget reductions.

Other gaps identified by the Collaborative and discussion groups included:

1. Healthcare Sector: Bias within the healthcare sector is perceived to be a concern, particularly among those who have at one time had private insurance and then became Medicaid participants. There are also many who are not able to obtain mental health and dental care services, even though they have state insurance. There is also a perceived and real lack of cultural competency skills, based on community discussion group sessions.

2. Funding: Categorical funding poses a challenge with competition for limited funds. There is limited access to sustainable funding, as well as political constraints.

3. Poverty: Poverty presents not only a gap in income but also in general well-being. Many in the community also misperceive and have limited understanding of both the causes and consequences of poverty, not only for individuals but also for the community as a whole. Employment challenges impact an individuals’ ability to obtain and retain employment with a family sustaining wage.

4. Lack of knowledge about infant mortality: Many public and private sector entities provide support for a wide variety of programs and services in Racine; however, there is limited understanding of the issues surrounding infant mortality and the Lifecourse perspective. In some parts of the community, there is a perceived stigma associated with the high rates of infant mortality. Overcoming preconceived notions, misinformation and poorly informed assertions is a significant challenge.

5. System integration: Many programs/agencies have rigid requirements or practices that do not support the reduction of silos or collaboration and information sharing (i.e. BadgerCare, hospital systems, human services and public health services). This results in a lack of access to data and pertinent information that is needed to track and serve high risk families. The requirements can also manifest in areas such as information systems that cannot communicate with each other.
6. Service provision: With a myriad number of services, it can be difficult for individuals to navigate, manage, and understand who accepts which type of insurance and differing eligibility requirements for different programs and services. There are also many who are not able to obtain mental health and dental care services. Racine needs a comprehensive model for navigation, mentorship, and care coordination. According to service providers and discussion group participants, many families in this community are not aware of all of the services for which they qualify.

The Collaborative plans to address these gaps with systems and programmatic recommendations that will address the needs of families at risk.
Our Collaborative

The Greater Racine Collaborative for Healthy Birth Outcomes

In September 2008, The Johnson Foundation convened a small group representing the Racine Infant Mortality Coalition, the City of Racine Health Department and Wheaton Franciscan Healthcare-All Saints to assist in developing a local conference concerning infant mortality in Racine.

Early Planning

The initial meetings were aimed at planning an overall strategy for reducing infant mortality in Racine. Without regard to a specific funding source, the meetings included previous and ongoing efforts by a wide array of entities and organizations. Initially, planning did not focus on the Lifecourse perspective, but as we learned more it became the focus of our work. Between October 2008 and August 2009 what is now called the Greater Racine Collaborative for Healthy Birth Outcomes (GRC4HBO/the Collaborative) (1) identified Strengths, Weaknesses, Opportunities and Threats for addressing infant mortality in Greater Racine; (2) developed a Framework for a Strategic Plan for Reducing Infant Mortality in Greater Racine; (3) defined preliminary goals to reduce the African American infant mortality rate by 50% in 5 years as compared to 2007 and reduce by 25% the African American delivery of pre-term babies in 5 years, as compared to 2007; and (4) expanded a Directory of Services to Reduce Fetal and Infant Mortality in Greater Racine initially developed by the Racine Infant Mortality Coalition.

From October 2009 to April 2010, the Collaborative:

• Selected The Johnson Foundation to serve as our convening organization and received approval to move forward from WPP.
• Determined that The Johnson Foundation will, through a Memorandum of Understanding, partner with the Racine Kenosha Community Action Agency to assist with the planning process.
• Adopted a set of Operating Principles for our work as a community Collaborative which defines how we in Racine operationalize the WPP principles (refer to Appendix D).
• Adopted 3 priorities under the 12 point Plan
  • Improving healthcare for African American women and families
  • Strengthening African American families and communities
  • Reducing allostatic load over the Lifecourse
• Established teams to investigate and lead planning activities for priorities identified under the 3 Racine Lifecourse priorities (these teams were open membership,
meaning additional members are welcome to join at any time). The priorities chosen were:

- Expand healthcare access over the Lifecourse
- Strengthen father involvement in the African American families
- Enhance service coordination and systems integration
- Invest in building and urban renewal
- Reduce poverty among African American families
- Support working mothers and families

**Planning Under the Lifecourse Initiative for Healthy Families Project**

In April 2010, The Collaborative was awarded funding for the Lifecourse Initiative for Healthy Families Community Action Planning Grant from the University of Wisconsin-Madison, School of Medicine and Public Health Wisconsin Partnership Program, and continued work. The planning process was driven by the Collaborative, with support from the Project Manager, and the Partnering and Convening Agencies. The Collaborative developed and agreed to use Operating Principles, originally created in October 2009 and adopted in March 2010 (see Appendix D) as the foundation for their work together.

Currently, The Johnson Foundation serves as the convening organization and fiscal agent for the initiative. The Foundation partners with the Racine Kenosha Community Action Agency in carrying out the work of the Collaborative under the Lifecourse Initiative planning grant. The Collaborative consists of members of the community, health departments, health care facilities, social service agencies, and community volunteers. (See below and Appendix C). The Collaborative is diverse in terms of both ethnicity and scope of practice. Participants are recruited through methods which include e-mail, general announcements at community meetings, deliberate recruitment and word of mouth. In addition to the community residents and volunteers, the members of the Greater Racine Collaborative for Healthy Birth Outcomes represent these organizations:

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5 Later in the planning process, team 2 decided to focus their efforts on “Enhancing and system coordination of family support services” instead of “Investing in building and urban renewal”.
<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact/Location</th>
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<tbody>
<tr>
<td>The Johnson Foundation at Wingspread</td>
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<tr>
<td>Racine Kenosha Community Action Agency</td>
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<tr>
<td>City of Racine Health Department</td>
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<td>Professional Women's Network for Service-Sister</td>
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<td>Friends and Racine African Friends and Racine African Health Coalition</td>
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<tr>
<td>Next Generation Now, Inc.</td>
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<td>Infant Death Center of Wisconsin</td>
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<td>Racine Community Health Center</td>
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<td>Wheaton Franciscan Healthcare-All Saints Foundation</td>
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<td>Gateway Technical College</td>
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<td>UW-Milwaukee-College of Nursing</td>
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<td>United Way of Racine County</td>
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<td>Kenosha-Racine Black Nurses Association</td>
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<td>Franchise Healthcare-All Saints Foundation</td>
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<td>Racine County Human Services Department</td>
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<td>Racine County Workforce Development Center</td>
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<td>Racine Family YMCA</td>
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<td>Racine Infant Mortality Coalition</td>
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<td>Wisconsin Literacy Council-Health Literacy Initiative</td>
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<td>Racine Unified School District</td>
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<td>United Way of Racine County</td>
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<td>Kenosha-Racine Black Nurses Association</td>
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<td>Wheaton Franciscan Cultural Medical Group</td>
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<td>Care Medical Group</td>
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<td>Dr. Martin Luther King, Jr. Community Center</td>
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<td>Foundations of Life, Inc.</td>
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<td>UnitedHealthcare Community</td>
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<td>Plan Children’s Community</td>
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<td>Health Plan</td>
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<td>Care Net Family Resource Center</td>
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<td>Grace Church</td>
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<td>University of Wisconsin-Extension</td>
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<tr>
<td>Alverno College</td>
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<td>Racine Police Department</td>
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The Collaborative is an organizing strategy, a way in which the information about the Lifecourse model and African American infant mortality can be presented to broaden the base of informed individuals and residents committed to positive change. It is a means to develop strategic and tactical change in the community, based upon conscientious and continuous efforts to develop relationships for the purpose of altering racial and cultural assumptions that may create stress which creates poor birth outcomes. It is a method to accomplish the work of establishing models of care and support that have provided evidence of the capacity to improve African American infant mortality rates. The Collaborative is a central point of contact and context to develop coordinated programming and improve systems that may have been limited in meeting the needs of African Americans. It is a model that employs a number of methods and means to inform communicate and engage community members such as video, social media, print media, meetings, presentations at events, discussion groups, and billboards.

Each Collaborative member self-selected into one of three teams based on the three goals of the 12 Point Plan to Close the Black-White Gap in Birth Outcomes report (Improving Health Care Services, Strengthening Families and Communities, and Addressing Social and Economic Inequities) (Michael C. Lu, et al, Winter 2010). The 12 Point Plan and the Guiding Principles became the governing documents in determining priorities. Within each team, members selected the priorities to explore. These decisions were based upon the collective understanding of the Racine community, the SWOT analysis, potential for
impact, information gathered from data, shared knowledge of the issue and results from discussion groups involving community residents.

Table 7: Team Goals and Selected Priorities

| Team One: Improving Health Care Services | 1. Provide interconception care to women with prior adverse pregnancy outcomes |
| 2. Increase access to preconception care to African American women |
| 3. Improve the quality of prenatal care |
| **4. Expand healthcare access over the life course** |

| Team Two: Strengthening Families and Communities | 5. Strengthen father involvement in African American families |
| 6. Enhance coordination and integration of family support services |
| 7. Create reproductive social capital in African American communities |
| 8. Invest in community building and urban renewal |

| Team Three: Addressing Social and Economic Inequities | 9. Close the education gap |
| **10. Reduce poverty among African American families** |
| **11. Support working mothers and families** |
| 12. Undo racism |

*bolded are the selected priorities of the Collaborative

Source: Closing the black-White gap in birth outcomes: A life-course approach

**Our Structure**

The Collaborative has a unique structure that emphasizes the role of the members and the community (See Figure 5). Each member of the Collaborative has an “equal vote” during instances of decision-making and determining recommendations. The circles overlap to illustrate how the idea sharing and learning process takes place across the three teams. The point of intersection represents the connectedness of the three priority areas within the 12 Point Plan working together to achieve the mission. In addition, the point of intersection includes the Early Implementation Project, as a reminder that the decisions made must have an impact on individuals like the participants in Sister Friends.
Early Implementation Project

The Collaborative unanimously selected the Racine/Kenosha Birthing Project (RKBP) as the Racine evidence-based project to receive the $10,000 early implementation grant for Racine. The RKBP is operated by the Professional Women’s Network for Service, Inc. (PWNS) (a Racine-Kenosha based 501(c) 3 that has a community advisory board and academic partners). This program is in its second year of operation and needed these resources to continue and expand.

The Birthing Project focuses on the health and well-being of pregnant women and their children in Racine and Kenosha by utilizing the strengths of the community members to
create an environment where pregnant women feel confident and empowered to seek assistance and prenatal care early in pregnancy.

Program Design & Activities

The process design was based on an open, participatory and broad community involvement approach, similar to the processes used in Community-Based Participatory Research and Learning Community models. Experts provided information based upon requests from Collaborative members and Teams for data and systems information to assist in the development of the plan. Information was provided by individuals with specific knowledge and expertise in various aspects of health, employment, public transportation, City of Racine services, State of Wisconsin and local fatherhood programming to name a few. This also aided in creating new partnerships with the involvement and engagement of many of those who came to present information to the Collaborative, thus broadening the numbers, knowledge and diversity of the Collaborative.

Some of the planning activities included:

- Wingspread Briefing with Dr. James Collins to describe his extensive research on the impacts of racism and the stress it produces over the Lifecourse
- Review of previously conducted community assessments (e.g. RKCAA & United Way) and literature of interest
- Monthly meetings where experts in the field of infant mortality, social determinants of health, and other disciplines provided data and information
- Development of a social media campaign aimed at the general public (billboards, web-site, flyers, postcards etc.)
- Geographic Information System (GIS) Mapping of demographic data related to social determinants, infant mortality and fatalities in Racine (See Appendix B)
- Several community discussion groups to solicit community input on needs and concerns(See Appendix I)
- Examination of evidence-based models
- Completion of the needs assessments used for model selection purposes (See Appendix G) Community Briefing on the Plan for community leaders.
- Site visits and presentations to learn more about the models and programs
- Community forum, open to the general public and designed to solicit community input on recommended programs, led by the Program Manager and moderated by the Collaborative members.

Team meetings occurred both during each monthly meeting and outside of those meetings when individual teams determined the need for more frequent discussions. In addition, special full Collaborative meetings were conducted periodically. Each Team determined the priorities to be addressed under their respective goal. These priorities
were affirmed by the discussion groups, community briefings, community forum participants and confirmed by the Collaborative as a whole.

The Collaborative requested that the convening and partner organizations and project staff provide leadership for the Collaborative. This leadership team was also expected to perform functions of meeting management (e.g. meeting schedules, invitations and attendance, agenda setting) and meeting facilitation as well as overall grants management. These organizations were also charged with organizing presentations requested by the Collaborative and developing tools and processes to help organize their work. The convening and partner organizations and staff were further expected to fully engage in all Collaborative discussions.

Members from the Collaborative participated in the WPP evaluation and communications workgroups, chaired by Paul Molberg of the University of Wisconsin-Madision and Lorraine Lathen, LIHF Senior Project Manager, respectively. Staff provided input and feedback on products such as the evaluation measures for the planning and implementation phase and the LIHF promotional materials.

**Partnerships**

The growth of Collaborative membership is attributable to ensuring that the process is open and often the result of seeking information and local resources. The Collaborative has been able to work with UW-Parkside instructors and their students to take on projects that served as real world experience for students; produced useful products (website, outreach campaign materials, Twitter© and Facebook© designs) while simultaneously creating a vehicle for informing students and engaging them in the initiative.

Staff worked with a senior-level communications class to develop a Racine-based social media campaign during the 2010 Fall semester. The students made recommendations for short and long messages, usage of social media resources such as Facebook® and Twitter®, and recommendation for a Racine project website. A University of Wisconsin-Parkside senior level web-design class constructed the Collaborative website during the 2011 Spring term. The Collaborative adopted the student designed website at its April 2011 meeting ([www.healthybabiesracine.org](http://www.healthybabiesracine.org)).

In addition, the Collaborative partnered with the 2010 Leadership Racine Class to hold a Healthy Baby Fair. The majority of exhibitors included members of the Collaborative. Many of the workshop presenters were members of the Collaborative.
Roles and responsibilities during program planning

The roles and responsibilities during the program planning phase were divided among the project manager, The Johnson Foundation at Wingspread (TJF), and Racine Kenosha Community Action Agency (RKCAA). TJF provided the Collaborative with equipment for day-to-day business, meeting and logistical support (invitation, participation tracking, printing, space, laptop computers and refreshments), financial management support, filed required reports and documents with WPP, and served as a centralized “electronic home” for all pertinent data using SharePoint. SharePoint is a private electronic file housed within the Johnson Foundation website. Use of SharePoint supported the building of a common base of information, research and notes enabling all members to stay up to date and informed even when a meeting was missed. It also became a way for staff to keep track of the progress and direction of each team.

RKCAA was responsible for hiring, direct supervision and housing of the Project Manager and assistant, providing meeting space as well as full engagement in all operational decisions. As an employee of RKCAA, the Project Manager was responsible for day-to-day management of the project, ensuring that tasks were accomplished and goals were met. The Project Manager also coordinated community outreach efforts, developed materials and tools to assist the process, provided general project support, served as the key liaison between the Collaborative and the Senior Project Manager and engaged in WPP work groups. The Project Manager was also responsible for recruiting Collaborative members and participating in activities created by WPP to facilitate the process.

Early in the project, the Project Manager, TJF and RKCAA began to function as a Leadership Team to provide a comprehensive and shared facilitator role for the Collaborative. The combined roles of the Project Manager, TJF, and RKCAA were to provide the Collaborative with information, resources needed (such as data and speakers) for monthly meetings, and were responsible for structuring the processes to be used by the Collaborative.

In turn, the Collaborative was responsible for communicating their needs, taking notes during their team meetings, providing feedback on documents from the workgroups, reviewing data and information, welcoming and orienting new members, determining priorities within their team’s areas of focus and identifying, examining, and selecting models for potential implementation and overall decision-making. They were also responsible for coordinating meetings that were held outside of the monthly meeting schedule.

The Collaborative model is one that has developed organically to be open, inclusive and continuously emerging as the collective grows in membership and knowledge. While the
charge of the Collaborative was to develop a Community Action Plan, the Collaborative has become an operational model of a learning community with the capacity to design and implement system changes and programming. This body has demonstrated its ability to lead, seek out resources and develop a space for the community to have a voice. Individually, members of the Collaborative have assumed leadership roles within their teams. Members independently arranged meetings outside of the regular meeting times and recruited members of the Greater Racine community.

Collaborative members have convened subgroups to develop proposals that will coordinate, provide services and ensure they connect to the strategy to reduce African American infant mortality, even when funding will not be provided to their respective agency. Examples of the Collaborative’s accomplishments include a grant approved for funding by the Department of Children and Families to enhance use of evidence based practices in home visitation, development of Baby Express, and a grant from The Children’s Trust to develop a Family Resource Center Network. Two other grant opportunities, in which Collaborative members are involved, are in the developmental stage.

The Process

In the Beginning

Collaborative members began to grow as a cohesive, yet flexible and inclusive group when they developed the guiding principles and structure in 2009. A presentation by Lorraine Lathen, WPP Senior Project Manager, on the Lifecourse Perspective further enhanced the work and provided a clear foundation for Collaborative efforts. Prior to April 2010, the Collaborative began to build common knowledge and use common terminology related to infant mortality in Greater Racine. The discussions and Socratic processing led the members to identify informational needs which were filled by a variety of experts (e.g. employment, social determinates of health, public transportation systems). The Collaborative self-selected into teams organized around the three main goals of the 12 Point Plan. Using the information they gathered and results from the SWOT analysis conducted prior to the LIHF Project (See Appendix G), The Collaborative selected the following priorities:

- Expand healthcare access over the Lifecourse
- Strength father involvement in African American families
- Enhance coordination and integration of family support services
- Create reproductive social capital in African American communities
- Reduce poverty among African American families
- Support working mothers and families
Each meeting, presentation and discussion led to the next level of exploration of literature and data. Staff worked with members to determine how best to organize information and data in order to increase understanding by the group. The compilation of notes on the Johnson Foundation shared drive enabled Collaborative members to maintain a record of their discussions and keep absent members informed. The combination of large group sharing, reporting and discussion with small group work created an environment of cooperative learning.

The Collaborative as a whole took responsibility for examining literature (See Appendix G) starting with the Dr. Richard Aronson’s White Paper, on racial disparities in birth outcomes, Dr. James Collins presentation titled *Impact of Racial Discrimination and Acculturation on Birth Outcomes*, Dr. Michael Lu’s Life Course model, as well as a range of data such as local employment and other Census data that was used to inform their work. Information sharing also took other forms, such as when Team Two viewed *Place Matters* from the *Unnatural Causes* documentary, and arranged for the entire Collaborative to view it.

This compilation of information led to the development of requests for maps to gain insight through a visualization of community assets and challenges. GIS Maps (See appendix B) with overlays of social determinants of health were developed with ongoing input from the teams to get the most helpful depiction of the community data. Teams developed questions to gather information from a broad range of community members such as young mothers, grandmothers, women in homeless situations, fathers, etc. The members conducted community discussion groups and used the data compiled from the groups as a part of the arsenal of information to begin investigating models and methods of evidence based services (See Appendix G for a tools used to selected models).

**Community Voice**

**Community Discussion Groups**

In addition to individuals from the community participating as Collaborative members, input from community members outside of the Collaborative assisted in identifying the priorities for site visit criteria and development of the recommendations. The community participated in a number of activities and through the following events provided insight for developing recommendations specific to Racine.

During the months of November and December 2010, the Collaborative conducted seven discussion groups and spoke with 62 individuals in the Racine community (See Appendix I for summary of responses).
<table>
<thead>
<tr>
<th>Date Conducted</th>
<th>Location</th>
<th># of Participants</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/4/10</td>
<td>Martin Luther King Center</td>
<td>10 participants, Foundations of Life (Teen Moms)</td>
<td>all female</td>
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<tr>
<td>11/13/10</td>
<td>General Converters Assoc., Sister Friends</td>
<td>8 participants, Professional Women’s Network for Service, 6 young mothers, 2 Big Sisters</td>
<td>all female</td>
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<tr>
<td>12/9/10</td>
<td>Racine Community Health Center</td>
<td>7 participants, Participant sign-up</td>
<td>6 female, 1 male</td>
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<tr>
<td>12/18/10</td>
<td>Racine Community Health Center</td>
<td>14 participants, Participant sign-up</td>
<td>13 female, 1 male</td>
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<tr>
<td>11/30/11</td>
<td>YMCA</td>
<td>7 participants, Fatherhood Group</td>
<td>all male</td>
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<tr>
<td>12/16/10</td>
<td>Workforce Development Center</td>
<td>7 participants</td>
<td>all female</td>
</tr>
<tr>
<td>12/10/10</td>
<td>HALO Homeless Shelters</td>
<td>Homeless Program 9 participants</td>
<td>all female</td>
</tr>
</tbody>
</table>
What Did We Learn from the Discussion Groups

The majority of discussants revealed they had either lost a baby themselves or knew someone who had (miscarriages, preterm births, or infant loss). Discussants identified:

- issues that play a role in health (racism, safety, stress, and food)
- actions/behaviors needed to have a healthy baby (prenatal care, help with anger issues, personal health, using resources appropriately, etc)
- perceived factors that contribute to infant mortality (lack of support, lack of knowledge, poor sex education in schools, poor health, and single family homes)
- issues related to father engagement and relationships with fathers

We learned the following from residents:

- Participants saw an opportunity in reversing this trend starting with the youth of Racine. They believed that some type of intervention to provide youth with life skills and appropriate health education would increase their chances of having healthier outcomes.
- There is a disconnect in the relationships between doctors and residents, according to majority of the participants.
- There is a lack of knowledge about support services that are available and challenges in accessing them.
- There is a need for support for fathers and soon-to-be fathers
- There is a need for the improvement of neighborhoods (infrastructure, education, healthcare access).

Based on these major themes that stood out during group discussions, the Collaborative used this information to guide them in identifying models to address them. The Collaborative moved forward with finding models that addressed the following:

- Improving relationships between healthcare professionals
- Connecting families and healthcare professionals with services
- Establishing some type of neighborhood improvement initiative
- Support and guidance for parents of the next generation
- Support for new parents and parents-to-be
- Increased father engagement and support
- Methods to bring services out of their silos and into a convenient neighborhood location

In addition to the discussion groups conducted by the teams, four discussion groups were held with physicians, health related personnel and 20 professionals. The first was conducted by staff at Wheaton-Franciscan Healthcare-All Saints and three by Johnson Foundation staff at the foundation. These discussion groups revealed:
• Strong need and support for pregnancy prevention and life skills programs for middle and high school youth (male and female)
• Need for father engagement
• Need among health care providers for improved knowledge of and connections to social service systems
• Reduced duplication/redundancy between health care systems and other systems
• Need for programs that assist in communications with patients
• Enthusiasm for continued dialogue and agreement to engage additional professionals (a fourth discussion was held at The Johnson Foundation at Wingspread in September)

Community Forum
In June 2011, the Collaborative conducted a community forum to solicit feedback on the recommendations contained in the Community Action Plan and the models/programs proposed for implementation. Fourteen individuals participated. They strongly supported programs that prepared men for fatherhood. They were also in favor of programs that improved teen skills and overall preparedness for adulthood. The majority of the feedback validated the need for navigation services related to health and social services in the community.

One concept that emerged was the need to begin sexual health education in middle school. The groups felt that a program targeted to middle school students, prior to initiation of intercourse, would be helpful. They also expressed, that in addition to programs to prepare men for fatherhood there was a great need for a “womanhood” program. The female participants emphasized that there was no place to get help, education, or support in making the transition from girl to womanhood. Their perception was that current resources are designed for women in the context of their roles as mothers.

Additional program/model feedback was:

• Location is important and should be seriously considered -
  o “Gateway would be a good location for programs because of the stats on the map locations, it is in the center of the problem area” (In response to presentation of GIS map)
• Encouraging systems to talk together would reduce stress -
  o “What’s in effect now requires too many places and too much paperwork.”
  o “Navigating people are very important”
Mentoring and support programs would be key in developing good mothers and fathers-

- “WE NEED Sister Friends”
- “It should be available for all men not just fathers to teach them how to prepare for becoming a father”
- “We need to teach men how to spend time with their children even if they can’t provide child support”
- “We need to teach manhood”

Additional important feedback:

- “We should combine programs because a lot touch on the same thing”
- “Start a program for women to teach them womanhood”
- “If you’re getting WIC or W2 etc you should be mandatory to participate in program for womanhood and parenting classes.”
- “It would be great to have people come together”
- “We need somewhere to go and get this info from about all these programs so they can refer clients”
- “Need to promote 211 better”
- “Sexual education needed for teens and women”

What Did We Learn from the Community Forum

The Collaborative learned that we were on the right track with our recommendations. There was a strong support for our recommendations that encourage support for fathers and mothers, neighborhood access to services, support of young adults, and a mentorship/navigation program that connects individuals to services.

Community Briefing

On June 23, 2011, The Johnson Foundation conducted a Wingspread Community Briefing to present the Community Action Plan to the broader community. The Johnson Foundation produced a summary of the plan entitled Changing Perceptions. Changing Reality. Reducing Infant Mortality in Racine and produced a brief video to be used by the Collaborative to introduce the issues and the Collaborative.

During the Briefing an overview of the plan was presented followed by a panel composed of Collaborative members. The Briefing was available via webcast and had 38 viewers. The 91 Briefing participants were asked to complete a short questionnaire at the conclusion of the Briefing with a 51 percent return. Responses showed:
• 91 percent strongly agreed and 7 percent agreed that African American infant mortality is an important issue in Racine
• 87 percent strongly agreed and 11 percent agreed African American infant mortality is more than a prenatal care issue
• 48 percent strongly agreed 39 percent agreed that they understood the recommendations
• 28 percent strongly agreed and 57 percent agreed that the recommendations adequately address the issue
• 66 percent strongly agreed and 34 percent agreed that they would look to the Collaborative if more information is needed
• 76 percent strongly agreed and 21 percent agreed that they want to help in some way.

Some of the other recommendations to improve the plan included:

• Connect to K-12 Education (2)
• Connect with local businesses (2)
• Connect with policymakers
• Add a PR component
• Further define recommendations (2)
• Take issue to the community so they can understand
• Incorporate personal accountability into the plan

In addition, 23 participants asked to join the Collaborative. Six are local elected officials, 6 are members of the Sentinel Black Men’s Group, 3 are participants in the physician discussion group, and 8 are active community members. Included among these are 4 faith based organization leaders.

Model Selection

After gathering information from group discussions, the teams reviewed a document developed by the Project Manager (See Appendix E). This tool was a list of data, research, community assessments, models/programs designated as evidence-based/best practices (including models recommended by WPP), Racine resources, and Wisconsin resources. Resources such as the Aronson White Paper, National Registry of Evidence Based Programs and Practices, and What it Took from the University of Wisconsin were used to create this document for the Collaborative to review. This list was compiled by the Project Manager using a list of documents reviewed by the Collaborative since April 2010. The needs assessment that was created by the WPP Evaluation Workgroup in
January 2011 was used as a model selection tool. Using content from the SWOT analysis, the hierarchy of evidence based programs document, recommendations from the RFP released by WPP and results from the discussion groups, the teams used this tool to strategically select models they wanted to visit (See Appendix E).

**Site Visits**

All three teams selected models/programs to investigate in February 2011. They included:

- Centering Pregnancy
- Northern Manhattan Perinatal Partnership
- Baby FAST
- Northern New Jersey Maternal Child Health Consortium-Irvington Family Success Center
- Mary’s Center-Mommy Baby Bus
- Washington DC Maternity Outreach Mobile and WIC Mobile Unit
- Miles Square Midwifery/University of Illinois-Chicago Partnership
- Healthy Beginnings Program

In addition to traveling to sites, members of The Collaborative requested presentations from models that existed in Racine (Nurturing Fathers and Birthing Project-Sister Friends). Appendix H includes documentation of the visits including what each team learned from the visit.
Our Recommendations

**Team One-Improving Healthcare for African American Women**

The goal of Team One was to investigate ways to improve or expand healthcare for African American women and families. The Team priority was to work on ways to expand healthcare access over the Lifecourse. Their strategy to accomplish this goal was to examine the quality of and access to healthcare and prevention interventions, identify key policies and influencers, and to examine the definition of “medical home” as it applies to the infrastructure of Racine.

Process objectives for action were to examine transportation barriers, analyze the Medicaid enrollment process, map locations of all healthcare providers, examine the flow of activities for women from discovery of pregnancy through birth, identify programs at the local health departments, identify successful practices using WPP and other resources, and conduct site visits/study tours to at least one site. Since April 2010 Team One has engaged in the following activities:

- Selected priorities to focus efforts (April 2010)
- Reviewed results from the Strengths, Weakness, Opportunities, and Threats analysis performed in October 2009 (October 2010)
- Analyzed data from Wisconsin Interactive Statistics on Health (WISH) and PeriData (April 2010)
- Performed a “walk through” activity of the steps a women would take if she thought she was pregnant (See Appendix G) (October 2010)
- Engaged community participants in discussion groups on infant mortality (December/January 2011)
- Reviewed evidence-based models such as Centering Pregnancy, home visitation, Sister/Friends and Midwife/Doula programs, and GIS maps (Ongoing)
- Utilized a model selection tool (based on the needs assessment tool provided by WPP) to better understand resources and policies that exist, and to explore resources and policies that are needed (January 2011)
- Selected models for site visits (February-March 2011) and reported results to the Collaborative (April 2011)
  - Centering Pregnancy
  - Miles Square Midwifery/University of Illinois-Chicago Partnership
  - Healthy Beginning Program

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6 Some of the recommendations made by the Collaborative will overlap. This is consistent with our planning operational structure (Figure 5: Collaborative Operational Structure: Our Operating Approach), it addresses the fact that the challenges are not discrete and addresses more than issues, and shows internal consistency of identified issues and solutions.
Birthing Project

- Identified priorities for implementation and developed logic models for their respective priority area (May 2011)
- Participated as facilitators in a community forum to review plan recommendations (June 2011)
- Participated as panelists at the Community Briefing in which the Community Action Plan was unveiled at The Johnson Foundation (June 2011)
- Reviewed, commented on and provided input into the draft of this plan (June 2011)

After conducting the “walk through” activity and the community discussion groups four barriers emerged; racism, lack of knowledge of services, lack of support and guidance in navigating the system, and insufficiency of mental and dental health services. This also led to an understanding for the need for medical providers to be able to assist their patients in getting to appropriate supportive services.

Team One proposed the following components of service to address the needs of African American women and families:

1. Expand current comprehensive prenatal care coordination (PNCC) and home visitation programs, making them available to all pregnant African American women regardless of their insurance eligibility.

2. Address the issues of racism where all staff is held to performance standards of providing culturally competent care and services.

3. Establish navigators or mentors to help guide participants through the health care and social services system, and maximize access to available services.

4. Expand service learning/volunteer opportunities for students and others through engagement of and collaboration with colleges, universities and other volunteer organizations to provide support and assistance to pregnant women and their families.

They used these findings to guide their decision making in selecting models to visit. They reviewed evidence-based models such as Centering Pregnancy and Midwife and Doula programs during the month of January 2010. In February they selected the programs/models to visit, and during the months of February through April. They visited the Milwaukee Healthy Beginning Program, University of Illinois-Chicago Midwifery Partnership, and Centering Pregnancy at Sixteenth Street Community Health Center in Milwaukee. They also gained insight through presentations regarding Sister-Friends and HealthLeads.
Team One, Improving Health care Access, recommends the following programs in an effort to improve healthcare access and expand the knowledge of the community’s available resources:

1. Birthing Project Sister Friends Expansion (existing/funds needed)
2. Centering Pregnancy (funds needed)
3. Healthy Families America (expansion/no funding needed)
4. HealthLeads

**The Birthing Project USA** is an evidence-based model that provides non-medical support for African American mothers. Through Sister-Friends, pregnant women and teens are assigned a volunteer sister-friend from the community in which they reside. The goal of The Birthing Project is to “keep more babies alive by recruiting, training and supporting community volunteers to provide direction, emotional support and education to the mothers” (Birthing Project USA). These participants remain in the program for one year after the birth of the babies.

The Collaborative’s early implementation program is the Racine/Kenosha Birthing Project-Sister Friends Program. Since receiving funding, their program has served 22 women and welcomed nine healthy, full-term normal birth weight babies into the community. Thus far their success rate is 100%. They attribute their success to the one-on-one support given by the Sister Friends to their little sisters (pregnant women). They help the women navigate through the systems and provide them with education beyond health and nutrition. Team One supports their expansion plans to serve more women, which includes adding staff to coordinate their bunch meetings, as well as adding a community Doula training program. Research supports the effectiveness of community-based Doula, birth outcomes and maternal support, especially with African American mothers (Breedlove, 2005; Low, Moffat, & Brennan, 2005, University of Wisconsin Population Health Institute, 2011)

**Centering Pregnancy®** is an evidence-based model that is medically-based client-centered and designed to empower the pregnant woman and her support person (Reid, 2007). Women of similar gestational ages meet to learn three components of care; health assessment, education, and support. There is evidence that group prenatal care is effective in achieving positive birth outcomes, especially in women of color (Potter,

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7 Note: Team 1 did not visit a Health Leads site. The Founder of Health Leads participated in a conference involving the MacArthur Foundation Genius Grant Awardees co-sponsored by the MacArthur Foundation and The Johnson Foundation at TJF. This model is highly recommended by the Robert Wood Johnson Foundation.
Individual care provides limited contact with providers, typically does not provide support services, and is often too fragmented to respond to the complex needs of pregnant women. Group care permits substantially more time compared to traditional individual prenatal care (e.g., 120 hours vs. 15 minutes for each visit, or 20 hours vs. 1.5 hours throughout the prenatal period, respectively) (Massey, Rising, & Ickovics, 2006).

Groups, consisting of 8 to 12 women, meet for peer learning, prenatal education, and individual assessments by a provider. This provides important opportunities to truly gain the experience, knowledge, and skills necessary for a healthy pregnancy and childbirth. It is based on the philosophy that pregnancy is a process of wellness, and a time when many women can be encouraged to take responsibility for their own health and learn self-care (Massey, Rising, & Ickovics, 2006). The care can be provided by a Nurse Practitioner, Certified Nurse Midwife, or physician. Since the number of sessions is comparable to the recommendations by the American Academy of Pediatrics and the American College of Obstetrician and Gynecologists, services can be billed to insurance companies.

Team One recommends Centering Pregnancy sessions be held in the local community health centers and neighborhood centers with the support of the local hospital. They also recommend that a Nurse Practitioner who is well known in the community and respected by hospital physicians lead group sessions.

Healthy Families America: Healthy Families America (HFA) is an evidence-based, nationally recognized home visiting program model designed to help families have a healthy start. It pays special attention to overburdened families who are at-risk for instances of child abuse and neglect, and other adverse childhood experiences (Healthy Families America Website, 2011). It is the primary home visiting model designed to work with families who may have histories of risk factors such as trauma, intimate partner violence, mental health and/or substance abuse issues that can have an impact on birth outcomes and family stability. This program is voluntary and follows families for up to 3 to 5 years after the birth of a baby. Reviews of evaluation studies of HFA programs where African Americans are participants showed the following significant outcomes (Galano & Huntington, 2004 Klagholz, 2005):

- Increased birth weight of newborns
- Increased utilization of prenatal care and decreased pre-term, low weight babies
- Improved longer term health outcomes (physical development and health of children after 3 years)
• Increased access to primary care medical services

• Increased immunization rates

**Health Leads** is a promising practice that provides student volunteers, from college and university students, in partnership with providers in urban clinics, with an opportunity to connect low-income patients with the basic resources. Health Leads volunteers and physicians can make a significant impact on the health outcomes of children and families through access to employment opportunities, housing and food. In 2010, according to the Health Leads website, 9,000 low-income patients and their families were connected to the resources they need to be healthy. Over 50% of them solved at least one critical need – receive food, get their heat turned back on, find a job – within 90 days of getting their “prescription.” All patients receive ongoing follow-up until their needs are met, such as food, housing, and heating assistance. In the process, Health Leads impacts both the clinics where they operate and the volunteers, most of whom are majoring in health or human services related fields, laying the groundwork to make a systemic impact on the way America’s health care systems work. Health care providers can “prescribe” food, housing, health insurance and/or other resources for their patients. Volunteers link patients to key resources and provide follow up services.

Racine has access to numerous colleges and universities that prepare nurses, allied health professionals, health and wellness professionals, human service and social work professionals. Several of these institutions are members of the Collaborative, and solid relationships exist with others.

The rationale for these recommendations is based on the need for comprehensive approaches to navigation, mentorship, and care coordination for pregnant and parenting families. According to service providers and discussion group participants in the Greater Racine community, many families are not aware of all services for which they may qualify. In addition, according to the Collaborative’s affiliated physician group, physicians and other health care professionals may be unaware of services that may help patients reduce stress and other issues that impact health outcomes. This approach is inclusive and provides a foundation for other services through the lifespan (from birth to death). The recommended models, when taken together, are comprehensive and will enhance existing services, serve as a means to support working families in accessing resources while maintaining a busy life, lead to improved birth outcomes, increase access and influence future health.

In the community, Greater Racine has organizations performing pieces of the recommended practices and programs. However, there are insufficient infrastructure and resources to meet the capacity that is needed. Many of the partners needed to create
change are already at the table as Collaborative members. In addition, the Collaborative will be building on part of an already Medicaid-funded program for PNCC.

Parts of the models listed have been implemented in some of the largest cities in the US with the highest rates of African American infant mortality. Some of these cities are Milwaukee, Harlem, Los Angeles, and Chicago. All of these cities are larger macrocosms of a diverse population. While Racine is considerably smaller than these cities, it shares many of the same challenges. Team One believes that by adopting these evidence-based practices in a comprehensive manner and on an appropriate scale for the Greater Racine community, the Collaborative can improve current poor birth outcomes.

Rationale

In Racine County, African American babies are dying at a rate 3 to 4 times higher than White babies. This statistic is worse than what is seen in some third world countries. It doesn’t have to be this way. By adapting proven methods for use in Greater Racine, a necessary change will be made, child by child, family by family.

According to recent data on live births, 23 percent of African American women who gave birth during 2006-2008 in Racine experienced inadequate prenatal care; 9 percent started care within the 3rd trimester or received no care; and only 67 percent of African American women initiated prenatal care during their 1st trimester in Wisconsin (WISH). A study which explored African American women’s views about key barriers to seeking prenatal care revealed several issues, including problems scheduling appointments, inadequate childcare, disliking the doctor, and transportation (York, et al., 1999).

A more recent focus group conducted in the Greater Racine area, ABC’s for Healthy Babies, showed that women believed that their insurance coverage influenced the medical services offered. For example, the provision of 3-D sonograms and the encouragement of early induction of labor were perceived to be different based on insurance (Lathen, 2011). In addition, the women in the focus group perceived a disparity in their health care that they attributed to race, which resulted in distrust of their physician. During a discussion group with local physicians, the physicians echoed feelings that their patients did not trust them based on their race, and they sometimes needed their African American colleagues to intervene.

In addition to the discussion groups, Team One completed the following:

- comprehensive analysis of possible programs
- review of literature and data
- site visits
Goals

The goals of these recommendations:

• Increase support for mothers-to-be and new mothers
• Increase the number of babies born at full term
• Increase the number of babies born at normal birth weight

Objectives

The objectives of the recommendation are:

• By 2015, the Birthing Project-Sister Friends Program will have increased the number of volunteers and participants by 25 percent. This will be achieved by maintaining a tracking system, working closely with the local hospital and existing teen/mother support programs; hiring a Doula; actively recruiting at local churches using existing volunteers and participants supported by WPP funding.
• By the end of 2011, all programs providing HFA will have staff trained and certified in the HFA model.
• By 2012, the HFA model will be in place and 50 families will demonstrate improved outcomes based on assessment tools used in the HFA.
• By fall 2013, start-up of Health Leads will be completed with 4 postsecondary institutions. Services will, based on follow-up surveys, have successfully addressed the needs of 70 percent of families served.
• By 2013 a Community Awareness program will be developed and implemented for the purpose of educating the community regarding physicians that are participating in, and sensitive to, the Collaborative and its goals and objectives. The number of participating physicians will increase by 10 percent as a result of more patients utilizing the services of those providers that are endorsed by the Collaborative.
• By 2013, the Centering Pregnancy Program, led by a Nurse Practitioner or Certified Nurse Midwife, will have improved health care access by recruiting at least 100 participants through working with community sites and the local hospital with the support of WPP funding and cooperation between the entities.

Expected Outcomes

The expected outcomes from the implementation of these models/programs are:

• Improved access to culturally competent and sensitive health care
• Increased peer support for mothers through medical and non-medical group
• Increase the skill set of the future workforce
• Positive birth outcomes for participating mothers and families
• Increased access to community services
Team Two-Strengthening African American Families and Communities

The goal of Team Two was to investigate ways of strengthening families and communities. Their priorities were to find methods to strengthen father involvement in families, create reproductive social capital in communities, and to enhance service coordination and system integration. Their strategies to accomplish this goal included increasing opportunities for fathers to start/maintain involvement, increasing awareness of Lifecourse issues and community cohesion around those issues, and addressing service integration issues that affect families.

The process objectives for action were to evaluate existing programs for outcomes, review policies for child support enforcement, review discussion group responses, identify and pursue ways and means to combine services, develop new services or restructure programs, and identify evidence-based research and outcomes based programs. Team Two engaged in the following activities:

- Reviewed results from the Strengths, Weakness, Opportunities, and Threats analysis (April 2010)
- Selected priorities to focus efforts (May 2010)
- Identified ways and means to combine services, develop new services or restructure programs (ongoing)
- Engaged community participants in discussion groups on infant mortality (December 2010)
- Evaluated existing programs for outcomes (Ongoing)
- Reviewed policies for child support (December 2010)
- Researched evidence-based models (February 2011)
- Utilized a model selection tool (based on the needs assessment tool provided by WPP) to better understand resources and policies that exist, and to explore resources and policies that are needed (January 2011)
- Reviewed information provided by expert presenters (April 2010-April 2011)
- Reviewed evidence-based models such as Nurturing Fathers, the Northern Manhattan Perinatal Partnership, and GIS maps (Ongoing)
- Selected models for site visits (February-March 2011)
- Conducted site-visits and reported results to the Collaborative (March-May 2011)
  - Northern Manhattan Perinatal Partnership
- Identified priorities for implementation and developed logic models for their respective priority area (May 2011)
- Participated as facilitators in a community forum to review plan recommendations (June 2011)
- Participated as panelists at the community Briefing (June 2011)
The barriers that Team 2 discovered were policies that created barriers for fathers because of incarceration and interest accrual for non-payment of child support, “blame” placed on mothers by the community for infant loss, the physical environments that do not support healthy living (i.e. lead, poor upkeep of apartments, etc), the need for service system navigation and poor integration and coordination among service systems.

Team 2 proposed the following components of service and models to address the needs of women and families:

1. Address issues of African American men and fathers with regard to child support and parenting skills.
2. Promote father engagement over the life of the child
3. Increase reproductive social capital and increase support for women and families
4. Improve system integration

Based on their findings Team Two recommends following programs for implementation and/or expansion:

1. Nurturing Fathers Program-Focus on Fathers (expansion/needs funding)
2. Sister Friends (expansion/funding)*
3. Healthy Families America/Prenatal Care Coordination program (expansion/no funding needed)*
4. Foundations of Life Maternity (expansion/ needs funding)

**Nurturing Father’s Program** (NFP) is an evidence – based, 13-week training course designed to teach parenting and nurturing skills to men. It is also culturally effective when implemented with African American participants (Daire, Manuscript under review). Since 2007, the Racine Family YMCA has provided the NFP to over 1000 fathers. The YMCA’s NFP provides group-based activities challenging men to re-examine their attitudes and behaviors regarding their male identities, domestic violence, and child abuse. The NFP puts emphasis on preventing infant mortality by addressing barriers such as recognizing and reducing stressors and learning what is required to have effective relationships regardless of the status of the relationship between the parents of a child.

**The Birthing Project USA** is an evidence-based model that provides non-medical support for African American mothers (see description in Team One section). Team Two recommends this model based on the impact it has on increasing social
reproductive capital. Women who graduate are encouraged and often become Sister-Friends to a new group of women. This has the potential to create a web of support for experienced, new, and soon-to-be mothers.

**Healthy Families America** (HFA) is an evidence-based, nationally recognized home visiting program model designed to work with overburdened families (Additional information is located in the Team One section above). Team Two recommends this model because of the capability to reach families and impact family stability.

**Foundations of Life** empowers young adults and teen parents throughout the City of Racine by providing in-home visitation and community based intervention and programming (Foundations of Life, Inc.). The program combines evidence-based models (Parents as Teachers and Ages and Stages) in addition to family support (engaging the entire family), relationship building skills, goal setting and life planning activities. Group support sessions are provided for young mothers on a monthly basis. The program encourages healthy behaviors during and after pregnancy, positive parenting skills and good prenatal care. Results from the program include all babies born full term and at healthy birth weights, and 90 percent non-repeat pregnancies after 3 years. Mothers remain in the program until their child reaches the age of three.

**Rationale**

According to the community discussion groups and our examination of literature, father involvement and social support are very important to an expectant mother. It is also important for families to access services effectively and avoid being “bounced around” when applying for programs.

Paternal factors may influence birth outcomes through a number of pathways (Misra, Caldwell, Young, & Abelson, 2010). Compared with children living with both biological parents, children in father-absent families often have fewer economic and emotional resources and do not fare as well on many health outcome measures (McLanahan & Carlson, 2002). During a presentation by a child support specialist, members from Team Two learned about barriers that fathers face with regard to child support policies, and how this has an impact on the presence of fathers. This in turn adds stress on the mother to provide all of the needs for herself and the child, and it puts a strain on or could destroy the relationship between the parents.

Without paternal support, a mother may have to navigate services alone. Silos of public services and programs create an environment where a mother has to bounce from program to program and submit the same information repeatedly. This opens the door
for ineffective and inefficient communication and the woman may fall through the cracks.

After conducting the community discussion groups the barriers identified were limited father-centered resources and programs, and need for programs that focus on building positive relationships and programs that provide support for women and families. They also discovered the lack of connectedness among health, human and social service programs and agencies. This led them to search for a way to create a paradigm shift in the way business is conducted and in how communities view themselves.

**Goal**

The goal of these recommendations is threefold:

- Increase opportunities for fathers to be involved by providing them with skills and support through expanded fatherhood programming
- Create reproductive social capital for women and families
- Improve systems integration of social, health and human services in Racine, thereby providing better networks amongst organizations and services and improved services to people.

**Objectives**

The objectives of the recommendation are:

- By 2014, the Focus on Fathers Program will have improved fatherhood opportunities and parenting skills by expanding participation in an evidence-based program through expanding the reach of the program, the creation of a Fatherhood Coalition, and actively recruiting at local churches, Head Start, Next Generation Now, Foundations of Life, CareNet and other Collaborative member organizations using existing volunteers and participants and WPP funding.
- By 2015, Foundations of Life will successfully serve an additional 15 young mothers and their families per year showing full-term births, healthy birth weights, delayed second pregnancies, and continued education.

**Expected Outcomes**

The expected outcomes from the implementation of these models/programs are:

- Improve access to programs and services via connections through the Collaborative
- Increase the well-being of fathers and their capacity to contribute to their family
- Improve the health and connectedness of African American women
Team Three-Address Social and Economic Inequities

The goal of Team Three was to investigate ways to reduce the allostatic load (level of chronic stress) over the Lifecourse. Their priorities were to work on ways to reduce poverty and to support working mothers and families. Their strategies to accomplish this goal were to (1) identify existing programs in Greater Racine designed and intended to assist people in moving out of poverty, (2) identify key policies and individuals who influence each area, and (3) identify gaps and limitations in existing programs.

The process objectives for action were to (1) examine food security issues and programs and efforts to promote healthy choices and increase availability of fresh foods\(^8\), (2) investigate the feasibility of creating a comprehensive service model for enrollment in and possible direct delivery of services in neighborhoods, (3) investigate ways to enhance the use of community centers to expand access to family-supporting programs and services, (4) identify models that are working on these issues and achieving some success, and (5) conduct site visits/study tours to models that will work in Racine. Since April 2010 Team Three has engaged in the following activities:

- Selected priorities to focus efforts (April 2010)
- Reviewed results from the Strengths, Weakness, Opportunities, and Threats analysis performed in October 2009 (October 2010)
- Engaged community participants in discussion groups on infant mortality (December 2010/January 2011)
- Gathered information from literature and expert presenters (April 2010-June 2011)
- Examined evidence-based models and GIS maps (December 2010-February 2011)
- Utilized a model selection tool (based on the needs assessment tool provided by WPP) to better understand resources and policies that exist, and to explore resources and policies that are needed (January 2011)
- Selected models for site visits (February-March 2011)
- Conducted site-visits and reported to the Collaborative (April 2011)
  - Baby F.A.S.T (Families and Schools Together)
  - Mary’s Center-Mommy Baby Bus
  - Northern New Jersey Maternal Child Health Consortium-Irvington Family Success Center
  - Washington DC maternity Outreach Mobile and WIC Mobile Unit
- Identified priorities for implementation and developed logic models for their respective priority area (May 2011)

\(^8\) During the planning process, a new program emerged through the University of Wisconsin Extension program called 12\(^{th}\) Street Grows. Team Three decided to eliminate process objective one.
• Participated as facilitators in a community forum to review plan recommendations (June 2011)
• Participated as panelists at the community briefing (June 2011)
• Reviewed, commented on and provided input into the draft of this plan (June 2011)

The barriers that Team Three discovered were food security, transportation, access to social services, and the need for a new pregnancy prevention and life skills education model.

**Site Visits**

Team Three used these findings to guide their decision making in selecting models to visit. They reviewed and visited the following sites:

- Baby FAST Program
- Mary’s Center-Mommy Baby Bus
- Family Success Center (Northern New Jersey Maternal Child Health Coalition)
- Mobile Bus-Washington DC Department of Health

Team Three visited the mobile unit models of the Mary’s Center and the Washington D.C. Department of Health, Irvington Family Success Center in Northern New Jersey, and hosted a presentation to learn more about Baby FAST at The Johnson Foundation at Wingspread. Based on their visit to investigate mobile units at the Mary’s Center and the Washington DC Department of Health, they found that the units are very expensive and logistically complex to operate and manage. Ultimately they decided not to recommend it for implementation. While they visited with staff from the Mary’s Center, they learned about an evidence-based comprehensive program for youth, the Carrera Adolescent Pregnancy Prevention Program.

Based on their site visits, Team Three recommends the following programs/models for implementation:

1. Irvington Family Success Center-Northern New Jersey Maternal/Child Health Consortium
2. Baby FAST (Family and Schools Together)
3. Carrera Adolescent Pregnancy Prevention Program

**Irvington Family Success Center**

Northern New Jersey-Irvington Family Success Center (IFDC) exemplifies the type of a one-stop resource center we envision. The goal of the IFDC is to strengthen and empower families. The center is a friendly neighborhood gathering place where individuals can go to receive different types of services for themselves and their families.
It is also a place where anyone can go for family support, job readiness workshops, and other general support services. It helps to strengthen lives by empowering all families to seek out resources and take an active role in addressing their needs. Team 3 was impressed by this evidence based model’s approach of engaging the community (members of their advisory committee), the politicians (such as the Mayor) and state level agencies.

Another activity that could take place near Racine’s version of the Success Center is community gardening. Racine has several community gardens all of which have substantial assistance from UW-Extension. The model involves teaching nutrition, in conjunction with growing a garden, and instruction on how to prepare home grown foods. The City is also allowing community groups, with approval by the City Council, to develop gardens in small pocket parks throughout the community. Racine’s initiative proposes to engage neighbors, to improve trust, by getting to know each other, sharing of skills (meal preparation and gardening) and positive intergenerational activity. This is also consistent with Baby FAST and the Carrera models discussed below. The Family Success Center serves as the focal point of community development, promoting health awareness, strengthening family supports, and providing life skills development. Community ownership is fostered with input from the community it serves, through a community advisory committee and ambassadors, shared responsibility.

Baby FAST

Families and Schools Together (FAST) is a group-based intervention designed to empower parents to support their children, and is listed in *What Works for Health* database (University of Wisconsin Population Health Institute, 2011). This program has been expanded to target Kindergarten through high school aged children and infants. Baby FAST is an evidence-based, intensive family support and intervention model focused on families with a child from birth to three years of age. The program addresses issues related to teenage parenting, first time parents, and reducing stress. The model is inclusive of any and all family members. The family is defined by the participants and is designed to develop a support system for the baby, even in cases where family dynamics are strained. While many parents are teens (ages 12-24) often the age limitations are based on the funding not the model, it is adaptable to any age. A FAST model has been created to specifically address African American families.

Although Baby FAST is supported by school systems and preschool programs as a way to help parents ready their small children for their first learning steps, it is normally sponsored by local mental health and AODA professionals to support parents, especially
moms during this critical time in the family lifecycle. It is often used to supplement home visitations for isolated and at risk families. Baby FAST has been embraced by families from all walks of life across North America (Baby FAST Website, 2011).

**Carrera Adolescent Pregnancy Prevention Program**

This program is part of the comprehensive education and support services for young adults between the ages of 13 - 21. The program advocates for primary health care, which includes family planning, health education, pregnancy prevention, HIV/STD testing, academic support, and college preparation services. The sole purpose of the program is “to help adolescents make responsible decisions and realize their full potential in partnership with their families” (Mary's Center, 2011). It is evidence-based and has reduced teen birth rates in communities served by 50%.


1. **Education**: Daily engagement includes one-on-one or small group tutoring, PSAT and SAT preparation, and college trips. Individual academic plans for participants are developed
2. **Employment**: Weekly Job Club class is a full introduction to financial literacy and the “world of work,” including opening bank accounts, exploring career choices and providing summer and part-time jobs. Participants are paid a stipend and make monthly deposits in their bank accounts
3. **Family Life and Sexuality Education**: Weekly medically and scientifically comprehensive sexuality education sessions are taught in an age-appropriate fashion
4. **Mental Health Services**: Weekly discussion sessions called Power Group are led by certified social workers, with 24 hour counseling and crisis intervention provided as needed
5. **Full Medical and Dental Care**: No cost, comprehensive medical and dental services are provided in partnership with local providers;
6. **Self Expression**: Multiple exposures to music, dance, writing and drama workshops are led by theater and art professionals, where children can discover talents and build self-esteem
7. **Lifetime Individual Sports**: Multiple exposures to a program emphasizing sports that build self-discipline, impulse control and can be enjoyed throughout life, including golf, tennis, squash, swimming, and bowling
Team 3 believes that easy access to services within the targeted neighborhood can be provided by trained facilitators or navigators as well as utilizing the “prescription-checklist” model from Health Leads recommended by Team One. We envision this program to enhance the programs and support the goals of the other teams in a coordinated, holistic, neighbor helping neighbor approach.

Rationale

Where you live plays a major factor in your health. Research found a two to three-fold increase in the risk of very low birthweight births (most of which were preterm) among African American women who rated their neighborhoods unfavorably in terms of the following eight characteristics: police protection, protection of property, personal safety, friendliness, delivery of municipal services, cleanliness, quietness, and schools (Hertzman, 1999). These characteristics, if viewed as negative, can increase the allostatic load of a family. During community discussion groups, members of the community provided the Collaborative with feedback that resulted in a change in their strategy.

The main issues that surfaced during community discussion groups were the lack of work supports, lack of service coordination poor life skills and pregnancy prevention programs. This prompted Team Three to change their strategy to focus on models with components to address service access needs of women and families, improve adolescent decision making skills, and support for working families. These gaps in a neighborhood increase the likelihood of parents and adolescents falling through the cracks and not getting the services they need. This could have an adverse effect on the health and development of the parents and the parents of the future.

Through a series of brainstorming sessions and review of GIS Maps (See Appendix B), Team 3 conceptualized a neighborhood approach to deliver effective strategies to reduce the allostatic load over the Lifecourse. The neighborhoods of focus are in Census Tracts 3, 4, and 5 in the City of Racine with the highest proportions of African American residents (45 percent, 36 percent and 47 percent, respectively). These areas also have high instances of infant mortality, low education attainment, high levels of unemployment, poor air quality, and inadequate housing (2010 Census data, City of Racine housing data).

This team believes that a neighborhood approach can be used to address their focus in several ways. They also identify closely with some of the goals and objectives of Team 2. Strengthening neighborhoods and families can occur through bringing city and county services and selected programs operated by community based organizations to the
neighborhood and empowering the people who live in them to serve as neighborhood/community ambassadors and center advisors.

Utilizing an existing community center or re-purposing a facility, we envision establishing a central location, staffed with a variety of program facilitators (navigators) trained to work with clients to access health and social service systems.

**Goals**

The goal of these recommendations is to increase service coordination, neighborhood building, personal empowerment, and social interaction.

**Objectives**

- By 2014 Baby FAST will have improved family relationships in our targeted area by 25 percent among those who participate in the program and 10 percent will exhibit an increase of family cohesiveness through program evaluation monitoring of changes in family dynamics using space, staff, and funding by WPP.
- By 2014 the Carrera Adolescent Pregnancy Prevention Program will have served 10 percent of the adolescent population (ages 10-17) in the targeted community and demonstrate, through program monitoring and evaluation, increased utilization of health services, college preparedness, and improved decision making skills using our partnerships with Racine United School District (RUSD) and a community center, and funding by WPP.
- By 2014 the Family Success Center Model will have reached and improved service coordination for 25 percent of the targeted community population as measured by tracking and program evaluation and leveraging using co-location and cooperation with existing community centers, partnerships, and WPP and other funding.

**Expected Outcomes**

The expected outcomes from these initiatives will be:

- Increase in parenting skills
- Increase in academic preparedness
- Increase in preparedness for adulthood
Fetal and Infant Mortality Review

The Collaborative recommends commissioning a Fetal and Infant Mortality Review (FIMR) for 2008-2009 and 2009-2010. FIMR is an action-oriented community process that continually assesses, monitors, and works to improve service systems and community resources for women, infants, and families (National Fetal-Infant Mortality Review Program, 2011).

The purpose of a Fetal and infant mortality review (FIMR) is to provide a community-based investigation into fetal and infant deaths. Data collected includes prenatal, hospital, and outpatient records, in addition to fetal and infant death certificate data, autopsies, and maternal interviews. FIMR investigations are initiated in the event of a fetal or infant death. FIMR uses community-centered strategies to evaluate several public health components of care for women, children and families to improve the health outcomes of infants, pregnant women, and their families. FIMR members include members from local health departments, community organizations, hospital staff, and health care professionals who are involved throughout the review process. The review process includes information collection, case review, and community action. The key steps in the FIMR process are information gathering, interviews, case review, design and implementation of interventions.

The FIMR process consists of 3 important steps. The first is data and information collection. Authorized experts obtain and examine public health and clinical records and other details of the case. A home interview is also conducted to determine the woman/family's perspective of the fetal or infant loss. In addition, women are asked to describe the services she used and received as well as ones she would have liked to use and receive. During interviews, appropriate referrals to bereavement support, mental health professionals, and other community resources are provided as appropriate.

The second step of FIMR is addressed by the Case Review Team composed of health, social service and other community experts. This team identifies factors contributing to risk of fetal and infant loss with each case. The appropriateness and accessibility of services and performance of public health functions are reviewed. Finally, the Case Review Team develops recommendations for addressing deficiencies in the community and perinatal health system that contributed to the death.
The final step of FIMR is the Community Action Team, who reviews and prioritizes recommendations from the Case Review Team. They design and implement the culturally-diverse strategies by changing or developing programs, practice, or policy; or by communicating issues to the larger population of health care providers. The implemented strategies are intended to be precursors to improved outcomes in the five essential MCH services (http://www.acog.org/departments/dept_notice.cfm?recno=10&bulletin=144).

A review was conducted in Racine between January 2007 and December 2009 and published data for fetal and infant mortality occurring during 2007-2008. The results from the review proved to be integral to the work of the Collaborative such as providing new information for GIS maps to improve community response. There is a great need for a review to document mortality from 2008 to present, to document the impact of the Collaborative and implementation programs.

**Objective**

- By 2013, a Fetal and Infant Mortality Review covering 2008-2010 is in progress using funding from WPP

**Northern Manhattan Perinatal Partnership**

The Collaborative further recommends adoption of the basic constructs of the Northern Manhattan Perinatal Partnership for the fundamental operation of the Collaborative and as a model for linking the various recommended models to one another and to current practices, programs and services. The Northern Manhattan model provides a functional approach and framework through which we can continue to learn and evolve.

Team research and discussion groups guided their decision making in selecting models to visit. They investigated and visited the Northern Manhattan Perinatal Partnership as a potential model for Racine. The mission of the Northern Manhattan Partnership, to “reduce the incidence of infant mortality, morbidity and developmental disabilities and the incidence of maternal mortality and morbidity” reflected what Racine is trying to achieve. This program is a community-based regionalized model of perinatal care that utilizes a block-by-block approach, which fits our neighborhood structures. Further, it integrates services across systems and simplifies access for participants.

It includes home visitation programs that target high-risk communities and provides adolescent reproductive health programs that work with health care providers and school based health centers to deliver accessible, and comprehensive sexual and
reproductive health care. It also has a strong fatherhood program and direct connections to social services. The range and scope of services provided fits well with the priorities of Teams 1 and 3 as well as Team 2.

Team 2 was especially drawn to the Northern Manhattan’s Comprehensive Prenatal-Perinatal Services Network that coordinates perinatal services in Northern Manhattan. It is responsible for coordinating outreach and education campaigns, collection and analysis of perinatal data, identification of gaps in the delivery system and filling them programmatically.

Objective

- By 2013, Greater Racine Collaborative will develop and build a cohesive partnership of organizations that refer African American families by effectively linking families to resources through utilizing the Northern Manhattan Perinatal Partnership approach, using Memorandums of Understanding and coordination.
Policy Recommendations

Policy and practices can have a big impact on how a community cares and supports a pregnant woman and her families. While some policies are dictated by the federal government, some practices can be impacted on a local level by the voice of the community and other stakeholders. The Collaborative identified a need to establish a connection between the community and decision-makers to improve steps along the Lifecourse to improve birth outcomes. The Collaborative also expressed a need to learn more about the policy and practice decision making process, and how they can influence them.

Implementation

During the planning phase, the Collaborative identified areas they want to explore during the implementation phase. Based on Collaborative discussions, community discussion groups, and data examined, the Collaborative will engage in examining the following policy and practice questions:

- Does Medicaid provide sufficient access to dental and mental health services? If not, what are the barriers and how can they be addressed?
- Do health plans provide early prenatal care with integral roles for expectant fathers? If not, how can this be addressed?
- How can annual funding be secured to conduct FIMR where African American infant mortality rates exceed the state average for African American fetal and infant deaths using a three year rolling average?
- What are the child support enforcement barriers for fathers? What policy and/or practices can be addressed?

The Collaborative will take the following steps to these address policies and practices:

- Further define the issues
- Research facts and data on the issue and how they will impact the target community
- Determine an approach for addressing the issues (policy brief, media attention etc.)
- Engage with appropriate policy/practice decision makers at the local, state and federal levels (human services, healthcare, education, etc.)
- Evaluate outcomes

For a comprehensive view of the recommendations and the domains they address, refer to Appendix E and Table 9.
### Table 9: Recommendations and Goals of the 12 Point Plan

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Preconception to One</th>
<th>Childhood (2-11 years)</th>
<th>Pre-teen to Adult (12-50 years)</th>
<th>Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improving Healthcare Access</strong></td>
<td>Centering Pregnancy</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Healthy Families America</td>
<td></td>
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<tr>
<td></td>
<td>Birthing Project</td>
<td></td>
<td></td>
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<tr>
<td><strong>Strengthening Families and Communities</strong></td>
<td>Birthing Project</td>
<td></td>
<td>Birthing Project</td>
<td>Child Support Enforcement</td>
</tr>
<tr>
<td></td>
<td>Foundations of Maternity</td>
<td></td>
<td>Focus on Fathers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health Leads</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Northern Manhattan Perinatal Partnership*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Addressing Social Economic Inequities</strong></td>
<td>Northern New Jersey Maternal Child Health Consortium-Irvington Family Success Center*</td>
<td></td>
<td>Carrera Adolescent Program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Baby FAST</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Cross team recommendation

Note: Funding for a Fetal and Infant Mortality Review is not listed about because it does not directly pertain to a single goal of the 12 Point Plan, but we are recommending that WPP funds a review.
The Collaborative During the Implementation Phase

Roles and responsibilities during program implementation

Looking forward, the Collaborative will move ahead to implement the plan it has developed. Over the first six months the Collaborative will continue to develop community buy-in to both the issue of African American infant mortality as a community issue and the recommendations for means to address it. In addition, the Collaborative will be a resource where residents and service providers can engage in the ongoing work of developing new service delivery systems: Determine the processes to be used and partners to engage in policy analysis, and identify potential funding sources to support implementation initiatives.

Beginning in January 2012 the roles of Collaborative will be to work together to remove barriers, to integrate and coordinate systems, maintain high levels of communication, develop sub-groups to respond to appropriate Requests for Proposals (RFP) and grant applications that will further the work of the Collaborative. In addition, the Collaborative members will:

- hold each other responsible for maintaining the vision of the Collaborative
- continuously assess progress of the implementation initiatives
- provide oversight to ensure that service providers are held accountable for delivery of services in a culturally competent and high quality manner
- hold implementation grant recipients accountable for continued engagement in the Collaborative

In addition, their role will include work to:

- Design and endorse systems changes, including assisting in the implementation of the change
- Engage pertinent service providers to initiate systems changes
- Participate in public information activities, presentations, and develop other communication opportunities
- Work with providers to gather data and establish systems to track data and information to document changes in systems, birth outcomes and related information
- Assist in determining how data will be maintained and presented for analysis
- Develop training plans to ensure all staff are held to performance service standards to meet cultural competency
- Continue outreach activities to community residents to inform them about the issues related to African American infant mortality, the Lifecourse Perspective,
the Community Action Plan, the work of the Collaborative, and recruit new members

- Continue to engage the African American community and mobilize them to advocate for issues pertaining to infant mortality
- Work with staff to prepare grant proposals to implement the recommendations of the Collaborative
- Work directly with WPP LIHF funded projects and initiatives such as PRAMS

RFP for the Planning Process with the following additions:

- Academic Partner, as applicable
- LIHF-Funded Implementation grant recipients (mandatory)
- Increased number of individuals who live, work, play, and worship in Census Tracts 3, 4, and 5

The Collaborative will be supported in its work and in making the transition from planning to implementation by a Coordinating Organization and a Linking Organization. The Collaborative has identified the Racine Kenosha Community Action Agency (RKCAA) to serve as the Coordinating Organization and The Johnson Foundation (TJF) to serve as the Linking Organization. The Coordinating Organization (RKCAA) will provide fiscal management and staff support for the Collaborative. Further, the Coordinating Organization will provide administrative leadership for the Collaborative, including:

- support overall work of the Collaborative
- coordinate information and data sharing across implementation projects and with WPP
- organize and manage regularly scheduled meetings with the Linking Organization
- maintain and develop tools and processes for use by the Collaborative
- maintain records of Collaborative activities
- develop non-WPP funding requests
- monitor progress of the Collaborative

In addition, the Coordinating Organization will:

- Provide support for and implement a fund development plan,
- Promote current initiatives such as the Family Resource Center Network
- Convene, with support from the Linking Organization, Collaborative members and others in pursuit and coordination of funding opportunities
- With the linking organization, identify and pursue systems changes that do not require additional funding
- Investigate the opportunity for a sister city project with Irvington, New Jersey
RKCAA has a proven capacity to responsibly manage and adequately protect Federal funds with a fiscal management system that complies with CFR Part 74. The organization has a budget of $12.9 million accounting for more than a dozen programs and several projects and initiatives. The agency receives, manages and reports on non-government funding as well as public funds. RKCAA has served as the fiscal sponsor for several projects including Racine Urban Garden Network, Juneteenth Day celebration, Sustainable Edible Economic Development, Inc. The organization operates under the Board of Directors approved policies and procedures for maintaining strong internal controls documented in the Financial Procedures Manual, Purchasing Policies & Procedures Manual and Business Conduct & Conflict of Interest Policies which govern fiscal operations. The Board of Directors is composed of one-third individuals appointed by the County Executive, one-third low-income individuals elected by community low-income residents and one-third civic and business representatives. All funding is tracked separately and accounted for according to generally accepted accounting procedures and fund source rules. Accounting for program funds is integral to RKCAA’s daily functions and accounting procedures are in place to create accurate and consistent methods for ensuring accurate and appropriate use of funds. Policies and procedures are continuously reviewed updated and modified to meet current financial reporting requirements. The Finance Department works closely with program management to ensure quality and accountability around budgeting, inventory and financial management. RKCAA uses the Sage MIP Fund Accounting System. All revenue and expense is tracked. The system is capable of generating separate revenue and expenditure reports for each program, project initiative or event. RKCAA is closely monitored by the Finance Committee of the Board of Directors. The Committee is comprised of individuals possessing finance, accounting and budget experience. The agency has annual third-party, A-133 audits (required by federal funding sources) and periodic audits from other funding sources. These audits are readily available for review, and contain an unqualified opinion on the financial statements of the agency.

With the February 2009 implementation of the American Recovery & Reinvestment Act, the focus was to get funding out to “shovel-ready” projects. RKCAA experienced an influx of funding and rapid infrastructure expansion as its operating budget grew by
64% in less than a year. RKCAA’s January 1, 2009 operating budget was in excess of $12,500,000 and the December 31, 2009 operating budget in excess of $19,500,000, demonstrating the capacity of the organization to ramp-up and appropriately manage significant and diverse funding sources.

The Linking Organization broadly will:

- Connect partners to the Collaborative
- Develop and manage three Collaborative affiliated groups (physicians, local officials and businesses)
- Pursue supporting related initiatives and connect related community initiatives to the Collaborative
- Support systems changes that align with the recommendations of the Collaborative and the Lifecourse but which may be undertaken by entities outside of the Collaborative (e.g. School Readiness)
- Assist the coordinating organization in convening meetings and maintaining participation records
- Conduct community briefings on topics relevant to the Collaborative
- Connect related community initiatives to the Collaborative
- Partner with RKCAA in support of the Collaborative
- Assist the Collaborative with policy studies and development of recommendations
- Assist RKCAA with grant writing, public relations, and evaluation

Responsibilities of Coordinating Organization project staff will include:

- Continue and increase community engagement
- Develop materials for ongoing outreach and public information
- Develop and implement a public information plan with the Collaborative
- Work with Collaborative to organize community events
- Assist the Collaborative in organizing itself for the next phase of work
- Establish methods and means of collecting and maintaining information and data for the implementation phase of the project
- Work with Linking Organization to document plans, programs and models of other initiatives that relate to infant mortality work
- Maintain attendance at Steering Committee and WPP workgroup meetings
- Work with community partners to develop required reports
- Work with nearby universities and colleges on project opportunities
- Work with WPP and the Collaborative to effectively carry out new campaigns that pertain to the work of the Collaborative
- Assist in the development of neighborhood based initiatives
- Maintain Website, Twitter, and Facebook updates
- Work with staff and members to write implementation grant proposals for non-WPP funded projects
- Work with academic partners on the evaluation
• Conduct site visits to LIHF funded programs to ensure full coordination and fidelity to the concepts proposed in the Community Action Plan

Shown below is the framework we plan to use to execute the community action plan (See Figure 10). Next is graphic description of the roles of the Collaborative and the Coordinating and the Linking Organizations (See Figure 11). This graphic is followed by the Logic Model for the Collaborative.

Figure 6: Framework for Community Action Plan Execution


Execution of Greater Racine Collaborative Strategies for Systems Change

Community Engagement

Coordination

Mobilization

Advocacy

Implementation of High Quality Lifecourse Programs

Recommended Evidence-Based Models & Promising Practices
Figure 7: Collaborative Framework for the Implementation Phase

**Partnership**
- Academic Partner
- Technical assistance

**Coordinating & Linking Agency**
- Fund Development
- Training
- Marketing
- Advocacy
- Program Development
- Conference/Special Events
- Evaluation

**Collaborative**
- Public presentations
- Sub-group development
- Identify new needs
- Advocacy
- Design systems change activities
- Engaging Partners
## Logic Model
The Greater Racine Collaborative for Healthy Birth Outcomes
The Work of the Collaborative: Implementation Phase

### Inputs
Facilities, Knowledge, Equipment, Community Action Plan (Brochure, summary, full plan)
Collaborative members, Collaborative management, Collaborative funding

### Main Components

<table>
<thead>
<tr>
<th>Engagement</th>
<th>Coordination</th>
<th>Advocacy</th>
</tr>
</thead>
</table>
| **Implementation Objectives** | To develop buy-in from key resources for the Community Action Plan (CAP) including:  
- The problem  
  (Poor AA birth outcomes)  
- Guiding framework  
  (Lifecourse perspective)  
- Our community response | To coordinate efforts of LIHF-funded and other initiatives | To examine, develop and promote recommendations for healthy behaviors, processes and policies |

### Activities

- **Develop and implement resource engagement and development strategy**  
  - Identify individuals, organizations, funding sources, and sectors  
  - Distribute & present CAP  
  - Engage targets/individuals in conversations  
  - Review and revise CAP (based on conversations) as needed

- **Identify effective strategies for cross-communication**  
- **Implement effective strategies for cross-collaboration**  
- **Assess programs and services (i.e.: site visits)**  
- **Identify gaps, duplication, barriers in programs/services**

- **Analyze identified gaps, duplication, barriers in processes/policies**  
- **Develop recommendations**  
- **Promote recommendations**

### Outputs

- **# of targets identified**  
- **# of targets receive copy of CAP**  
- **# of targets that receive presentation of CAP**  
- **# of community conversations**  
- **# of cases for support/funding proposals submitted**

- **# of Collaborative meetings**  
- **# of advisory team meeting**  
- **# of site visits**  
- **# of resources shared**

- **Targeted stakeholders and decision-makers understand and endorse recommendations**

### Linking Constructs
(Target factors that connect outputs to outcomes)

- Targeted individuals, organizations, funding sources and systems contribute resources (financial, social, human)

### Short-Term Outcomes

- Increased community awareness of CAP messages  
- Targets see Collaborative as key information source in the community  
- Targeted individuals, organizations and systems contribute resources (financial, social, human)  

- Improved efficiency and impact of implementation projects  
- Reduced duplication  
- Improved service delivery

- Adoption and/or enforcement of messages, policies and regulations

### Intermediate Outcomes (5 Years)

- Increased resources that support efforts to improve birth outcomes (Collaborative, LIHF projects, other initiatives)  

- Improved coordination of all community initiatives aimed to improve birth outcomes

- Improved attitudes, processes and policies that support and amplify efforts of LIHF-funded initiatives  
- Reduced barriers

### Long-Term Outcomes (10 Years)

- Improved health care services for African American Women  
- Strengthened African American families and communities  
- Reduced allostatic load over the Lifecourse

- Reduced racial disparities in birth outcomes

### Linking Constructs (5 Years)

- Targeted individuals, organizations, funding sources and systems contribute resources (financial, social, human)

### Long-Term Outcomes (10 Years)

- Improved health care services for African American Women  
- Strengthened African American families and communities  
- Reduced allostatic load over the Lifecourse

- Reduced racial disparities in birth outcomes
Outcomes

- Improved African American women’s health status
- Improved African American infant survival and health
Figure 12 illustrates the governance structure for implementation phase. The decision making process occurs on two levels; Committees and the entire Collaborative. Members of the Collaborative self-select into committees. The black arrow, pointing north, represents the report out of decisions/recommendations made by committees regarding their goals and plans for action. The black arrow pointing south represents the ideas and recommendations of the Support Team. The purple arrow represents a reciprocation of requests, support and recommendations between the Support Team and the Committees. Committee requests may include information, tools to help with their process, and/or presenters. The green arrow represents the same type of process between the Support Team and the Collaborative. Ultimately the Collaborative makes final decisions via general consensus as illustrated by the blue arrow.

This structure is based on the decision making process followed during the early planning period, and the direction of the Collaborative documented in the Community Action Plan. Every individual in the Collaborative has an “equal vote” in decisions. African Americans from all walks of life are part of all aspects of the decision making of the Collaborative. The Collaborative empowers the Support Team to carry out their wishes, as needed. For example, if the Policy Recommendation & Systems Integration Committee wants to investigate child...
support enforcement in Racine, the Support Team works with the committee to provide them with information and resources. Once this committee completes its investigation and creates a recommendation, it presents the recommendation to the Collaborative for approval. If the Collaborative agrees, the Support Team then will work with the committee to present the recommendations to the appropriate entities and policy bodies.

**Engaging Partners and African American Residents**

Although a high concentration of the infant and fetal deaths occurred in Census Tract 3, 4, and 5, the Collaborative realizes that this health issue affects all African American women and men of reproductive age, and the entire community. The Collaborative plans to continue engagement of all Racine residents, specifically members of the African American community, to join the Collaborative and serve on all committees. Removing any barriers to attendance that may exist is very important, and the Collaborative will continue to provide transportation and meals in addition to other assistance recommended by the Collaborative. New members will receive information about the Lifecourse, the work of the Collaborative, and information about WPP prior to their first meeting.

Members of the Collaborative will also recruit members for a “community ambassadors” group that could enrich the neighborhood success center. This group of individuals will serve as the champions for the initiative and will be an integral part of the overall outreach strategy in the targeted community. The Collaborative, Project Manager, and identified community members will define the goals and some activities of this group. The combination of these activities will ensure continued engagement of the community and buy-in of the Community Action Plan.

The Collaborative will continue to engage physicians and other health care professionals for the health based models. They will also engage community members and organizations and the faith-based community to assess the best locations to implement neighborhood based models such as the Success Center and placement of Centering Pregnancy. Collaborative members and support Team will present recommendations to the appropriate “owners” of selected locations and assist with negotiations as necessary. Overall, the Collaborative will engage the community through activities such as presentations, discussion sessions, and the unveiling of the new programs and locations.
Timeline and Activities

The GRC4HBO will engage in the outlined activities in order to ensure our recommendations are implemented. The activities are organized by the Collaborative’s implementation objectives (which broadly capture the Collaborative-level recommendations) as well as the specific recommendations for evidence-based project implementation.

The outlined GRC4HBO activities, although presented as time-sensitive, are a part of the ongoing and constant work of the Collaborative. In order to ensure effective start-up and implementation, the following table prioritizes and places the activities in a chronological order to help guide the work.

<table>
<thead>
<tr>
<th>Implementation Objectives</th>
<th>Activities</th>
<th>Methods</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>Parties Responsible</th>
</tr>
</thead>
</table>
| Effectively engage Collaborative members in a process that ensures fulfilled outcomes | Recruit, hire and orient new positions:  
• Project Administrator  
• Fund Development Consultant  
• Public Information and Communications Consultant | Advertise positions  
Interview candidates  
Hire and orient new staff | X | | | | | Collaborating Agency  
Linking Agency  
Collaborative |
| Review and revise (if necessary) current Collaborative process and structure | Identify best process and structure for ensuring Collaborative work is accomplished. For example:  
• Form committees (advisory, outreach/engagement) made up of team members  
• Create committee work plans that work to achieve implementation objectives | X | | | | | Collaborative Project Administrator  
Project Manager |
<p>| Develop buy-in from key resources for the Collaborative and Community Action Plan | Develop resource engagement strategy | Identify individuals, organizations, funding sources, and systems to target | X | X | X | | | Collaborative Project Administrator |</p>
<table>
<thead>
<tr>
<th>Implementation Objectives</th>
<th>Activities</th>
<th>Methods</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>Parties Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>(CAP) that leads to leveraged local/other resources</td>
<td>Implement resource engagement strategy to promote/develop buy-in for:</td>
<td>Create customized engagement strategies for each identified target</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Fund Development Consultant</td>
</tr>
<tr>
<td></td>
<td>• Poor AA birth outcomes</td>
<td>Distribute Community Action Plan to targeted individuals, organizations, funding sources, and systems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Public Information &amp; Communications Consultant</td>
</tr>
<tr>
<td></td>
<td>• Lifecourse perspective</td>
<td>• Hold community briefings/forums</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Lifecourse issues</td>
<td>• Write funding proposals</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Our community response</td>
<td>Engage targets/individuals in conversations</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>Collaborative Project Administrator</td>
</tr>
<tr>
<td></td>
<td>Review and revise CAP as needed</td>
<td>Gain feedback from targeted individuals, organizations, funding sources, and systems</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Project Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Present feedback to Collaborative</td>
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<td></td>
<td></td>
<td>Integrate feedback into the Community Action Plan and Collaborative work (as approved by Collaborative)</td>
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<td>Public Information &amp; Communications Consultant</td>
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<td></td>
<td>Collaborative Project Manager</td>
</tr>
<tr>
<td>Coordinate/govern efforts of LIHF-funded and other initiatives</td>
<td>Recommend organizations for identified evidence-based programs and neighborhood center</td>
<td>Review available community organizations</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>Collaborative Project Administrator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify organizations best suited</td>
<td></td>
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<td></td>
<td>Collaborative Project Manager</td>
</tr>
<tr>
<td>Implementation Objectives</td>
<td>Activities</td>
<td>Methods</td>
<td>2011</td>
<td>2012</td>
<td>2013</td>
<td>2014</td>
<td>2015</td>
<td>Parties Responsible</td>
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<td></td>
<td></td>
<td>for selected evidence-based implementation programs</td>
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<tr>
<td></td>
<td>Implement effective strategies for cross-communication between LIHF-funded and other initiatives</td>
<td>Review and identify method for effective cross-communication. For example: • Quarterly presentations/updates to Collaborative • Bi-annual site visits to projects</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Collaborative Selected Implementation Project Organizations</td>
</tr>
<tr>
<td></td>
<td>Provide assistance and support to implementation programs and services</td>
<td>Provide assistance at Collaborative meetings, through other identified communication strategies</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Collaborative Selected Implementation Project Organizations</td>
</tr>
<tr>
<td></td>
<td>Continue to identify gaps, duplication, barriers in programs/services</td>
<td>Collaborative members and implementation projects bring ongoing issues to the attention of the larger Collaborative</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Selected Implementation Project Organizations</td>
</tr>
<tr>
<td></td>
<td>Develop and promote recommendations for healthy behaviors, processes and policies</td>
<td>Analyze identified gaps, duplication, barriers in processes/policies</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>Collaborative Project Administrator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utilize Collaborative’s preferred method for analysis</td>
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<tr>
<td></td>
<td></td>
<td>Design advocacy campaigns, events, training sessions</td>
<td>X</td>
<td>X</td>
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<td></td>
<td></td>
<td>Collaborative Project Administrator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Implement advocacy campaigns</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>Collaborative Public Information &amp; Communications Consultant</td>
</tr>
</tbody>
</table>
### Implementation Objectives

**Utilize evaluation information consistently in order to ensure continuous improvement of Collaborative activities and impacts**
- Evaluate the Collaborative’s progress in achieving implementation outcomes
- Collect information at the cadence outlined in the evaluation plan
- Analyze and organize data
- Present and review compiled data
- Integrate results

**Expand evidence-based programs and services that:**
- Build relationships to support pregnant and parenting women and their families
- Address relationship building, stress reduction, and the role of fathers in the lives of their children

**Develop an evidence-based neighborhood center to support families and children using existing infrastructure**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Methods</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>Parties Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hold training sessions</td>
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<tr>
<td>Utilize evaluation information consistently in order to ensure continuous improvement of Collaborative activities and impacts</td>
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<td>Collaborative Project Administrator</td>
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<tr>
<td>Expand evidence-based programs and services that:</td>
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<td>Selected Implementation Project Organizations</td>
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<tr>
<td>- Build relationships to support pregnant and parenting women and their families</td>
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<tr>
<td>- Address relationship building, stress reduction, and the role of fathers in the lives of their children</td>
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<tr>
<td>Implement Project Organizations begin start-up processes</td>
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<tr>
<td>Implementation Project Organizations provide services</td>
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<tr>
<td>Evaluate the Collaborative’s progress in achieving implementation outcomes</td>
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<tr>
<td>Collect information at the cadence outlined in the evaluation plan</td>
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<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Analyze and organize data</td>
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<tr>
<td>Present and review compiled data</td>
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<tr>
<td>Integrate results</td>
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<tr>
<td>Develop an evidence-based neighborhood center to support families and children using existing infrastructure</td>
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<td>Implementation Project Organizations provide services</td>
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<tr>
<td>Birthing Project-Sister Friends (Teams 1, 2)</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
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<tr>
<td>Centering Pregnancy (Team 1)</td>
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<td></td>
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<td>X</td>
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<tr>
<td>Health Leads (Team 1)</td>
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<tr>
<td>Nurturing Fathers (Team 2)</td>
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<tr>
<td>Foundations of Life (using Healthy Families America) (Team 2)</td>
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<tr>
<td>Carrera Adolescent Pregnancy Prevention Program (Team 3)</td>
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<td></td>
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<td>X</td>
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<tr>
<td>Baby FAST (Team 3)</td>
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<td>X</td>
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<tr>
<td>Family Success Center (Teams 1,2, 3)</td>
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</tr>
</tbody>
</table>
Capacity to address system and community level changes

Instead of focusing primarily on interventions and models to implement, we explored system and social change to support new and existing models. Our planning process uncovered both the connections and disconnections between and among entities Racine currently has in place in relation to the overall concept of the Lifecourse perspective.

The Collaborative believes that it has the capacity to address system and community level changes. Our Collaborative is comprised of program administrators and directors, academic professionals, and community members. Further, Collaborative members represent a wide array of programs, organizations and agencies that provide direct services to residents of the Greater Racine area. Collectively the members have the capacity to institute changes within their respective enterprises and to influence changes in others.

Further, the Collaborative investigated ways and means through which these entities can work together to improve, expand, and address the needs of families efficiently and effectively. Through this approach Racine can reduce infant mortality and pre-term births, reduce maternal stress, increase maternal health and positively engage fathers in their children’s lives.

Current Activities

The Collaborative and its members have begun the work of systems change. Through the convening of the Johnson Foundation, Collaborative members who are service providers, and members who are part of the Collaborative, have been working on projects, programs and initiatives that directly influence the kind of community change; and that can improve outcomes for African American families. The following initiatives are examples of ways the Collaborative has begun to influence and leverage change within existing programs.

- **Baby Express** - Baby Express is a business venture designed to meet the specific needs of transporting low income Medicaid eligible women to their doctor’s appointments, grew from the Collaborative’s pursuit of information on the transportation barriers in Racine. The portal to portal service enables fathers to go to appointments with mothers and for mothers to bring other children, an option not available with traditional Medicaid transportation providers. The model has already enabled the operator of Baby Express to garner more information about the concomitant stressors and barriers for mothers and their families and to share that knowledge with the Collaborative. This direct
information is of benefit to both the families and for the Collaborative to use as input in determining ways to support families.

- **School Readiness Coalition** – Racine Unified School District, RKCAA Head Start, Next Generation Now, 21st Century Preparatory School and United Way of Racine County established and executed a formal agreement to use common child development assessment tools that engage parents and provides a base for a longitudinal system to track student progress and provide feedback to early education programs. The Johnson Foundation convenes and facilitates the Coalition.

- **Home Visitation model development**-Department of Children and Families funded a project that supports an evidence-based model for home visitation among PNCC providers. The Racine County Human Services Department is the grant recipient, The Healthy Families America model will initially be implemented by two Collaborative members: Central Racine County Health Department and Children’s Service Society of Wisconsin and will add a third, Foundations of Life, in year 2. The project was developed by eight Collaborative member organizations.

- **Family Resource Center Network**- An initiative of Collaborative members United Way of Racine County, Children’s Service Society of Wisconsin, Racine County Human Services, RKCAA, YMCA, Next Generation Now and the Racine Community Health Center to provide services aimed to prevent child abuse and neglect. This initiative has been funded by The Children’s Trust. These organizations are working together despite the fact that some of them will receive financial support and others will not.

- **The Sentinel Black Men’s Group of Racine County**- A newly formed group African American men of Racine: faith leaders, community leaders and concerned individuals are thoughtfully convening with the goal of improving outcomes for Black boys and young men.

- **Pregnant and Parenting Teens Initiative** – Service providers of programs for teen parents have developed a Compendium of Services, identifying the type of services, the range of programming and the data connected with their programs

- **Fatherhood Coalition**- YMCA is convening those providing fatherhood programming, Child Support Enforcement and Workforce Development to develop a more comprehensive approach to supporting fathers and improving

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9 Prenatal Care Coordination (PNCC)
relationships of fathers with their children and the mothers of their children whether or not they are married.

These groups are ongoing and in various stages of development but committed to continue their work that is focused on changing the way business is done to be more responsive to the needs of the recipients, better coordinated, focused on broad community outcomes, not just program outcomes. With the exception of the Fatherhood Coalition, The Johnson Foundation has been the linking organization connecting the organizations involved and providing support for their work. A number of those engaged in the groups identified above also are members of the Collaborative. The purposes of these groups are specific to their area of focus but their work has implications for the Collaborative and connects to various stages of the Lifecourse. African American families are not the exclusive focus of these groups, but do receive priority consideration. These relationships and initiatives will contribute to the goals and the theory of change of the Collaborative.

Theory of Change

According to Theory of Change: A Practical Tool for Action, Results and Learning prepared by the Annie E. Casey Foundation, changes for the individual are the first things that occur as a result of the programs, services, actions or planned strategies of a community initiative. As individual changes reach greater scale, they may contribute to population level changes. We believe through implementing our recommended programs, in coordination with linkages made during the planning process, we can impact, influence, and leverage chance for change.

### Impact

<table>
<thead>
<tr>
<th>Outcome Areas</th>
<th>Outcome Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in attitudes (perception and beliefs)</td>
<td>Increased desire among neighborhood residents to become engaged in community change efforts.</td>
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<tr>
<td></td>
<td>Increased positive view of the local hospitals and community health centers.</td>
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<tr>
<td>Change in skills</td>
<td>Increase parenting skills for parents and family members</td>
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</tbody>
</table>

### Influence

<table>
<thead>
<tr>
<th>Outcome Areas</th>
<th>Outcome Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change public will</td>
<td>Community will display a decreased</td>
</tr>
</tbody>
</table>
| Change in service practices | Service provider will expand locations for service to better match the location and needs of residents  
Political leaders increase awareness and willingness to take action  
Service providers directly interact with residents to increase knowledge of cultural backgrounds |
| Change in business practice(s) | Service providers improve daily interactions with residents and each other |
| Changes in visibility of issues | Local media will cover the issue and major activities of the Collaborative |
| Changes in community norms | Community decreases tolerance for certain behaviors pertaining to or attitudes about infant mortality |
| Changes in Local Partnerships | Partnerships become more strategic  
Partners deepen their Collaborative relationships  
Partners increase sharing of resources, information and data |

**Leverage**

<table>
<thead>
<tr>
<th>Outcome Areas</th>
<th>Outcome Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in public funds</td>
<td>New funding methods to align with Lifecourse perspective</td>
</tr>
<tr>
<td>Changes in philanthropy</td>
<td>Foundations will support initiatives that follow the Lifecourse perspective</td>
</tr>
</tbody>
</table>
Capacity to organize and coordinate maternal/paternal and child health services

As a Collaborative, the combined membership has enormous capacity to organize and coordinate maternal/paternal health services and to significantly impact the attainment, over time, of the 12 Point Plan. Collaborative members include the three Greater Racine area health departments, the hospital system where the majority of births in Racine County occur and that provides extensive adult, pediatric and family health care, the two area WIC offices, the County Human Services Department which administers a variety of health related services and the Federally Qualified Health Center. The Collaborative also includes representatives of two DHS approved Health Maintenance Organizations.

In addition, other members of the Collaborative provide a wide array of direct services to specific population groups such as teen-age parents, fathers, abused or neglected children, low income families, young children, and pregnant women. Others provide services such as rent and energy assistance, access to food, home weatherization, child care, Pre K-12 education, employment and job training and higher education.
Evaluation Plan

Based on the Wisconsin Partnership Program and the LIHF evaluation workgroup’s guidance, the impact of the overall initiative will be measured in three different spheres:

1. **LIHF Project Grantee Sphere**—Measuring the evidence-based and promising practice program outcomes

2. **LIHF Collaborative Sphere**—Measuring community systems change outcomes

3. **Wisconsin Partnership Program Sphere**—Measuring widespread change in the three Lifecourse domains that leads to population-level outcomes such as: improved African American infant survival and health, improved African American women’s health status, and reduced racial disparities in birth outcomes.

According to the evaluation plan created by the Wisconsin Partnership Program and the Evaluation Workgroup during the planning process, the Collaborative will have responsibility for measuring and monitoring:

- **Process measures** to document activities and assess the functioning of the Collaborative
- **Outcomes** focused on the extent to which the Collaborative is successful in:
  - Providing strategic leadership in the community
  - Developing buy-in and sustaining commitment for the Community Action Plan.
  - Implementing policy, community-level and other environmental changes
  - Leveraging resources to support efforts to improve birth outcomes and health among African Americans

The Collaborative has re-framed those key impact areas to fit into three implementation objectives. The GRC4HBO will monitor and measure outcomes as they fit into these objectives. We believe the WPP and evaluation workgroup framework fits well and is fully addressed within these three implementation objectives:

- Develop buy-in from key resources for the Collaborative and Community Action Plan (CAP) including:
  - The problem (Poor AA birth outcomes)
  - Guiding framework (Lifecourse perspective)
  - Our community response (priorities and rationale)

- Coordinate/govern efforts of LIHF-funded and other initiatives

- Develop and promote recommendations for healthy behaviors, processes, and policies

The GRC4HBO will continue to utilize the evaluation recommendations from the Partnership and the evaluation workgroup throughout the implementation phase. In addition, a Collaborative evaluation group will be formed to determine, review, and prioritize the best method(s) of data collection as well as ensure the evaluation plan is executed and outcomes reported during implementation.
The following is a **sample framework** for the Collaborative evaluation plan that includes measures for the Collaborative process and the Resource Engagement & Development component of the Collaborative’s work during implementation. The WPP main outcome measures are bolded inside the GRC4HBO sample evaluation plan and categorized by the Key Area and Main Outcome numbers provided in the *Summary Activities and Outcome Measures for the LIHF Collaboratives: 6/27/2011 Draft* (Example: Key Area 1, Main Outcome 2 or KA1, MO2) for easy comparison. The Collaborative will ensure that all WPP and evaluation workgroup main outcomes are included in the final, fully expanded Collaborative evaluation plan.
**Measurement Framework:** Process and Resource Engagement & Development Components

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>OUTPUT</th>
<th>METHOD</th>
<th>DATA SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source engagement</td>
<td># of resource engagement strategy planning meetings</td>
<td>Collaborative attendance log</td>
<td>Convening agency</td>
</tr>
<tr>
<td></td>
<td># and % of Collaborative members reporting successful engagement in resource engagement strategy development</td>
<td>Collaborative member survey</td>
<td>Collaborative members</td>
</tr>
<tr>
<td></td>
<td># and % of Collaborative members engaged effectively through process (KA1, MO4)</td>
<td>Wilder survey</td>
<td></td>
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<td></td>
<td># of targets identified*</td>
<td>Meeting notes</td>
<td>Collaborative members</td>
</tr>
<tr>
<td></td>
<td># of targets receive copy of CAP</td>
<td>Presentation log</td>
<td>Presenters</td>
</tr>
<tr>
<td></td>
<td># of targets receive presentation of CAP</td>
<td>Collaborative member survey</td>
<td></td>
</tr>
<tr>
<td></td>
<td># of Collaborative review sessions of CAP</td>
<td>GRC4HBO Resource Engagement Plan</td>
<td>Collaborative members</td>
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<td></td>
<td># of revisions (if necessary)</td>
<td>Distribution log</td>
<td></td>
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<tr>
<td></td>
<td># of cross-communication strategies reviewed</td>
<td>Meeting notes</td>
<td>Collaborative</td>
</tr>
<tr>
<td></td>
<td># of cross-communication strategies identified</td>
<td>Community Action Plan</td>
<td></td>
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<tr>
<td></td>
<td># of Collaborative meetings</td>
<td>Meeting notes</td>
<td>Collaborative LIHF projects</td>
</tr>
<tr>
<td></td>
<td># of LIHF project participants at meetings</td>
<td>Collaborative member survey</td>
<td></td>
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<td></td>
<td># of resources shared</td>
<td>Meeting notes</td>
<td>LIHF projects</td>
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<tr>
<td>Needs for cross-</td>
<td># of site visits</td>
<td>Site visit log</td>
<td>Collaborative</td>
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<td></td>
<td># of cross-communication barriers in applications, barriers in processes for improvement</td>
<td>Meeting notes</td>
<td>Collaborative</td>
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<tr>
<td></td>
<td># of processes analyzed</td>
<td>Community Action Plan</td>
<td>Collaborative</td>
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<tr>
<td></td>
<td>% of identified problematic processes analyzed</td>
<td>GRC4HBO Resource Engagement Plan</td>
<td>Collaborative</td>
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<td># of recommendations</td>
<td>Meeting notes</td>
<td>Collaborative</td>
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<tr>
<td>Resource Engagement &amp; Development</td>
<td>ONGOING ACTIVITY</td>
<td>OUTPUT</td>
<td>METHOD</td>
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</tbody>
</table>
| **Targeted individuals, organizations, funding sources and systems understand and endorse CAP:**  
  - Poor AA birth outcomes (KA1, MO1)  
  - Lifecourse perspective  
  - Our community response (priorities and rationale) (KA2, MO1) | # of targets understand the issue (Poor AA birth outcomes)  
# of targets understand the Lifecourse perspective  
# of targets understand our community response (priorities and rationale)  
# of targets physically sign an endorsement of the plan (KA2, MO3)  
# of targets “like” or “follow” on Facebook/Twitter  
# of letters of support | Target Feedback Questionnaire  
Endorsement log  
Facebook/Twitter follower counts  
Letter log | Targeted individuals, organizations, funding sources, systems |
| **Increased community awareness of CAP messages:**  
  - Poor AA birth outcomes (KA1, MO1)  
  - Lifecourse perspective  
  - Our community response | # or % of community members with increased awareness of CAP messages | Community opinion survey | Sample of Racine residents |
| **Targeted individuals, organizations, funding sources and systems contribute resources (financial, social, human)** | **Dollars raised (KA4)**  
# of volunteer hours mobilized (KA4)  
# or $ value of in-kind donations (KA4)  
# of advocacy groups formed  
# of additional Collaborative members (KA1, MO4)  
# and % of grants received  
# of new funders (KA4) | Target Feedback Questionnaire  
LIHF project budget  
Volunteer logs  
Collaborative attendance logs | Collaborative, LIHF projects |
| **Increased resources that support efforts to improve birth outcomes (Collaborative, LIHF projects, other initiatives)** | **% increase of Collaborative, LIHF projects, other initiatives revenue (KA1, MO4)**  
% increase of Collaborative, LIHF projects, other initiatives’ volunteer hours | Collaborative budget  
LIHF project budgets  
Volunteer logs | Collaborative, LIHF projects |
Budget and Resources to Address the Plan

**Budget Summary**

<table>
<thead>
<tr>
<th></th>
<th>Proposed Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Salaries</strong></td>
<td></td>
</tr>
<tr>
<td>Project Administrator (1 FTE)</td>
<td>$60,000</td>
</tr>
<tr>
<td>Project Manager (1 FTE)</td>
<td>$56,650</td>
</tr>
<tr>
<td>Project Assistant (.5 FTE)</td>
<td>$12,480</td>
</tr>
<tr>
<td><strong>Total Salaries</strong></td>
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<tr>
<td><strong>Fringe Benefits</strong></td>
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<tr>
<td>Project Administrator</td>
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<tr>
<td>Project Manager</td>
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<tr>
<td>Project Assistant</td>
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</tr>
<tr>
<td><strong>Total Fringe</strong></td>
<td>$38,352</td>
</tr>
<tr>
<td><strong>Total Personnel</strong></td>
<td>$167,482</td>
</tr>
</tbody>
</table>

|                       |                |
| **Consultant Services** |             |
| Public Information and Communications Consultant | $15,000       |
| Fund Development Consultant  | $10,000       |
| **Total Consultant Services** | $25,000     |

| **Other Expenses** |                |
| Administrative Support | $26,391       |
| Telephone            | $967           |
| Rent                 | $10,265        |
| Regional Travel      | $2,000         |
| Project Supplies     | $5,000         |
| Employee Development | $500           |
| Public Information and Education | $4,800       |
| Community Engagement | $3,910         |
| **TOTAL**            | $246,315       |

**Budget Narrative and Justification**

As part of the process of making recommendations for the implementation phase of the project, the Collaborative discussed and recommended that RKCAA be the coordinating
organization. Based on the Community Action Plan, the group also determined the staffing, functions and on-going needs to support the Collaborative and its work. It is understood that RKCAA project staff and TJF staff would continue to work together under the administrative leadership of RKCAA. However, the RKCAA CEO has dedicated significantly more time to the project than anticipated. It would be impractical to expect the same level of work to continue and therefore additional staffing has been called for in this budget.

While the RKCAA CEO will continue to dedicate time and effort to the project, the Collaborative members recommend a full time Project Administrator, with specific expertise in public policy and evaluation. In addition to the new position, the membership concluded that knowledge and skills to assist in the public education and fund development functions are critical. The public education and fund development work will be performed by consultants under contract to RKCAA, guided by the Collaborative.

RKCAA contributed significant dollars to the support of the project despite reductions in funding for the agency. The budget reflects the true cost to cover time and functions that were not covered by the planning grant and, therefore, is predicted to be a best funding plan based upon the experience of expenditures in the planning phase of the project.

**Personnel Expenses**

**Project Administrator (1 FTE)**  
$60,000 per year salary (with fringe benefits - $82,690)

This position will take on the work of ensuring the implementation of the Community Action Plan. The administrator will supervise and direct the work of the staff, administer the direction of the Collaborative, lead policy review efforts and develop recommendations under the guidance of the Collaborative membership. The Administrator will review data and information and establish an evaluation process for the Collaborative and for the integration of program and initiative information to track and report on the progress of the initiative in reaching goals. The position will provide leadership in guiding the Collaborative members through the process of designing and organizing the implementation strategy. The Administrator will be skilled in understanding and interpreting and analyzing public policy and have an understanding of the policy review and development processes. The Administrator will have knowledge of the health care, mental health and social services systems and related policies, be experienced in organizing data and information to be useful to the public, data analysis
and evaluation principles, working with diverse individuals and community groups with cultural competence, sensitivity and tact.

**Project Manager (1 FTE)**
$56,650 per year salary (with fringe benefits - $70,607)

Under the direction of the Project Administrator this position will provide staff support to the Collaborative, organize meetings, assist in community engagement, document progress and meetings develop and submit reports, work with media and community engagement efforts, assist the Administrator in the evaluative and policy work. This staff will be responsible for the day to day coordination of the project, maintaining the website, Facebook and Twitter information, assisting the ongoing coordination of groups (e.g. University, community volunteers), ensuring the progress of the initiative, recruiting Collaborative members and keeping current members engaged, gathering information and data as required and needed, and assisting in report and grant writing.

**Project Assistant (.5 FTE)**
$12,480 per year (with fringe benefits - $14,185)

This position provides Clerical support for the team.

**Consultant Services**

**Public Information and Communications Consultant**
$15,000

This consultant will assist in the development of a public information/education campaign; will develop materials, press releases and short informational documents. This will assist in the efforts to inform community residents of the Lifecourse model, ensure the message of healthy habits reaches the community and support the efforts of the Collaborative outreach and engagement using print material and information suitable to various audiences. They will also use concepts of the LIHF Communication Plan, with guidance from the Collaborative.

**Fund Development Consultant**
$10,000

This consultant will assist the Collaborative and staff in identifying resources for the projects and programs not funded by WPP, will assist in developing a fund development strategy, develop a proposal template for use in submitting proposals, organize and design the assessment and outcomes frameworks for use in grant submissions.

**Other Proposed Expenses**
Administrative Support
$26,391
For direct administrative time and support of RKCAA staff supervision of project staff, administrative oversight and a full range of administrative functions including fiscal management; calculated at 12%.

Telephone - $967
Three phone lines (office land lines) including internet connections

Rent - $10,265
Office space with RKCAA for exclusive use by project staff.

Regional Travel - $2,000
Mileage and related travel expenses for WPP related meetings by project staff.

Project Supplies - $5,000
Supplies including office supplies, computer supplies including email accounts, copying costs, postage for project staff - $3,000.
Computer printer and other peripherals for Project Administrator - $2,000 printer

Employee Development - $500
Training for project staff.

Public Information and Education - $4,800
Printing of educational materials - $1,500.
Billboards - $3,300.

Community Engagement - $3,910
Participant gift cards 100@$30 - $3,000
Transportation - $200
Meeting expense - $500
Childcare - $210
Sustainability Plan

Membership: Over the past six months, the Collaborative expanded its membership. Collaborative members and TJF identified and recruited prospective members. From April 2010 through June 2011, the Collaborative recruited 116 members which include 2 HMO organizations. Collaborative members have been involved in attending meetings and participating in special events. The Collaborative will continue to recruit targeted community members and develop additional opportunities for outreach.

In addition, due to the relationships developed through the Collaborative, knowledge gained of each other’s work and the trust that has been developed, two grant proposals have been submitted and approved for funding. Both grants directly relate to priorities and discussions within the Collaborative. Further, additional initiatives that required no outside funding and involve multiple Collaborative members have been linked to the Collaborative and the Lifecourse by TJF.
Conclusion and Recommendations

The Greater Racine Collaborative for Healthy Birth Outcomes created this Community Action Plan based on (1) examination of data on African American infant mortality in Racine, (2) study of the Lifecourse perspective, (3) examination of data and information about the Racine Community, its assets and challenges, (4) examination of literature and evidence-based practices, (5) visits to sites practicing selected evidence-based models, (6) expert presentations, (7) exchanges of knowledge and information about systems, services and programs currently operating in Racine and, most importantly (8) discussions and listening sessions with community residents. This Plan builds upon the discussions and deliberations undertaken to address this issue, over the past several years by a variety of groups and organizations.

This section of the Plan presents our recommendations for reducing African American infant mortality in Racine. They are in two parts. The first identifies the six considerations that directed our path to determining approaches. The second relates to the recommended approaches for achieving our goals. These approaches tie directly to the discussion of the Collaborative going forward, the Collaborative Logic Model, the timeline (approaches 1-5) and the recommendations made under each priority area (improving health care access, strengthening families and communities, reducing the allostatic load – approaches 6, 7 and 8 respectively).

CONSIDERATIONS DIRECTING THE PATH TO RECOMMENDATIONS

a) We will take a comprehensive systems approach to determining interventions
b) We will take an integrated perspective that addresses multiple risk factors simultaneously
c) We will be a collaborative in sharing knowledge and insights across disciplines
d) We will search for interventions that impact individuals, families, neighborhoods, services and systems rather than simply examining discrete programs
e) We will search for interventions that address needs expressed by both community members and those that provide services to community members
f) We will search for interventions that are evidence-based, reflect cultural competency and are appropriate for our community

In order to create effective social and environmental change, there needs to be an element of programs, policy, system integration that can be applied to all areas based on the Lifecourse perspective and its principles. The Collaborative believes that reducing elements that impact root causes, such as stress, can have an impact on infant mortality.
Working on policies/practices and systems that increase stress for African American families such as child support enforcement, lends itself to expanding/recommending evidence-based programs that decrease this stress by providing support to parents.

**RECOMMENDED APPROACHES**

It is important while reviewing the recommended approaches below that they be viewed in the context of the considerations listed above. While the selected approaches are identified separately they are mutually supportive and interactive. The recommended approaches are:

<table>
<thead>
<tr>
<th>Work of the Collaborative</th>
<th>Implementation Programs</th>
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<tbody>
<tr>
<td>1. Promote community understanding of Lifecourse issues</td>
<td>6. Expand evidence-based programs and services that build relationships to support pregnant and parenting women and their families</td>
</tr>
<tr>
<td>2. Expand, enhance and simplify system integration and coordination among all human service and healthcare related organizations, agencies and programs</td>
<td>7. Expand evidence-based programs that address relationship building, stress reduction, and the role of fathers in the lives of their children</td>
</tr>
<tr>
<td>3. Examine (in consultation with appropriate federal, state, county and local agencies) and develop recommendations for new or revised policies related to but not limited to: child support enforcement, case management systems, potential medical assistance waivers to perform infant mortality prevention work, alternatives to traditional prenatal care, and barriers to increasing availability of dental health and mental health services for low income families</td>
<td>8. Develop an evidence-based neighborhood center to support families and children using existing infrastructure</td>
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</table>
1. **Promote community understanding of Lifecourse issues**

**Rationale:** The Community forum and Community Briefing participants supported the need for greater community understanding of the Lifecourse Perspective. The Lifecourse Perspective provides a different way for individuals and the community as a whole to understand the complex interplay of factors that contribute to African American infant mortality and the integrated perspective it requires to achieve real change. Understanding the Lifecourse is a pre-requisite to understanding the Community Action Plan to address those risk factors. Increased understanding of both will increase community support and buy-in for the plan and the approaches it recommends. In turn, increased community buy-in ultimately will lead to community and systems change and increased healthy birth outcomes. Embracing this concept has the potential of improving overall health of African Americans. The Collaborative believes that with understanding comes an opportunity to take individual ownership and alter the Lifecourse.

**Implementation:** The Collaborative will organize and carry out community-based discussion groups, briefings and presentations at community events to inform the community about the Lifecourse Perspective and the Action Plan. The Collaborative will engage community residents, organizations, funders and policy leaders in this process, and create print material and messages to reinforce the understanding of the Lifecourse.

2. **Expand, enhance and simplify system integration and coordination among all human service and healthcare related organizations, agencies and programs**

**Rationale:** Currently human service and health care systems operate in silos and often have redundant application processes. In addition, recipients of those services described these disconnects as frustrating, confusing and stress inducing leading to misunderstandings and miscommunication. Service providers expressed similar frustrations. By working to streamline, enhance and simplify systems and services, individuals will have improved access and service providers will gain a more accurate understanding of the wide range of service options for recipients. Ultimately this may result in better service to more people at the same or less cost. Collaborative members and others identified will develop memoranda of understanding (MOU) between agencies to ensure that each partner has a clear understanding of the vision, expectations, roles, and responsibilities to ensure success in implementation of new ways of doing business.
Implementation: The Collaborative will develop a plan for analysis of system disconnects and methods for overcoming them. The plan will identify effective means for cross system communication, systematically identify opportunities for system improvements, and consult with service recipients in the process. Current efforts to expand cross system coordination will be continued among Collaborative members.

3. Examine and develop recommendations for new or revised policies

Rationale: Throughout the planning process, the Collaborative encountered systemic and policy challenges that presented barriers to effective use of resources and reinforced ineffective or inefficient practices. These challenges frustrate, confuse and cause stress to individuals and service providers alike. This issue was raised in discussion groups and in Collaborative meetings. Some of the policy and systemic challenges cited relate to but are not limited to: child support enforcement, case management systems, potential medical assistance waivers to perform infant mortality prevention work, alternative prenatal care models and barriers to increasing availability of dental health and mental health services for low income families.

Implementation: The Collaborative will systematically examine policies suggested above among others, verify the issues involved from the perspective of community members and system stakeholders, and develop and promote recommendations for policy and/or practice revision or development. The Collaborative will engage appropriate federal, state, county and local agencies and policymakers in the process.

4. Promote pathways out of poverty

Rationale: Living in poverty and the stressors that accompany it produces intense strain on individuals (men and women), families, neighborhoods and communities. For pregnant women and their partner (and others) poverty limits access to quality and culturally competent prenatal care and other services, transportation, health insurance, and food security and are often a way of life. The women and men who participated in our discussion groups raised these issues. The key was seen as employment and earning a sufficient wage, particularly for men. There are current programs that can help. The Collaborative will promote programs that have been successful in helping individuals. They include: Earned Income Tax Credits, transitional jobs and Children First.

Implementation: The Collaborative will further identify with the help of the Workforce Development Center, employers and educators, programs and educational opportunities
available to link individuals and jobs. Information about these opportunities will be shared with case managers, programs serving fathers, teen mothers and pregnant women. Co-location of services for job seekers in community centers and the Family Success Center discussed below will be explored. Volunteer assistance to applicants for earned income tax credits will be expanded through increased outreach in neighborhoods and coordinated through existing programs.

5. Promote healthy behaviors and access to resources for healthy living across the Lifecourse

**Rationale:** Access to information about ways to improve and maintain health and programs that can help women acquire healthy behaviors delivered in a competent manner can make a substantial difference for women before, during and after pregnancy. While messaging about the importance and ways to achieve healthy behaviors is critical, opportunities to learn by doing are also important. Excellent messaging work has been done by the March of Dimes, ABC’s for Healthy Families and the CDC. The Collaborative recommends building on those efforts by encouraging participation in programs designed to meet their needs in areas where they live. Part of the participatory process will include getting direct input from residents about the services needed. Improving the health of African American women ultimately will impact the quality of their lives.

**Implementation:** The Collaborative will promote two local initiatives that support improved health. The first is a new health and wellness program designed specifically for African American women and operated and funded by the YMCA. The second is community gardening initiative being undertaken in neighborhoods throughout Census Tracts 3, 4 and 5. The program at the Y wraps fitness and health information together and promotes smoking cessation, nutritious eating, and weight management among other concepts. The community gardening initiative, with the assistance of UW-Extension and the Racine Police Department Community Centered Policing Offices, teaches individuals how to grow fresh vegetables and fruit, how to prepare them and how to introduce them into their family’s daily living.

6. Expand evidence-based programs and services that build relationships to support pregnant and parenting women and their families

**Rationale:** Human society has long understood that social relationships are important for the health and well-being of pregnant women. The Collaborative has come to understand the importance of “psychosocial support” to improved health and pregnancy
outcomes. Social support includes emotional and informational support, and direct links to resources for material support. Interventions aimed at providing social support to pregnant women include: one-on-one “case management” or “care coordination,” outreach to aid in access to resources, support groups, adolescent mentoring programs, and Doulas. The most successful of these address multiple concerns though not all chronic stressors at once. Multiple models are needed to enhance, augment and expand currently available approaches. The aim of this approach is not only to involve health care providers and home visitors, but also the woman’s partners, families, and the community in providing social support to pregnant women.

**Implementation:** The approach recommended by the Collaborative is to expand two existing models and implement two models that will be new to Racine. The two models for expansion are Prenatal Care Coordination (PNCC) and the Birthing Project U.S.A.-Sister/Friends. For PNCC, the Collaborative has two recommendations: 1) incorporate the Healthy Families America model into existing home visiting practice (this was recently funded by the Department of Children and Families) and 2) expand the availability of PNCC services to all pregnant African American women regardless of income and history of infant loss. For the Sister/Friends program the Collaborative recommends expansion to provide more pregnant African American women the social support that has proven so successful in delivery of healthy, full birth weight babies.

The two programs new to Racine, Centering Pregnancy and Health Leads, will provide 1) improved social support as well as medical support for pregnant women in facilities close to where they live and in collaboration with the primary health care provider in Racine and 2) direct connection to programs and services needed by individual families, and by engaging physicians in the process, will enhance the health and well being of individuals and families.

Taken together, these four models have a high probability of improving birth outcomes for African American women and for expanding the menu of options available to address the needs of pregnant women and their families. Community members participating in the Community Forum and Briefing strongly supported this recommendation.

7. **Expand evidence-based programs that address relationship building, stress reduction, and the role of fathers in the lives of their children**

**Rationale:** In the extensive examination of the literature conducted by the Collaborative and through Community Discussion Groups, the physician group, the Community Forum
and the Community briefing, the need for father engagement with mothers and their children was repeatedly raised in all teams. Father engagement before, during and after pregnancy was viewed as a key in stress reduction for mothers and children, improved social and emotional outcomes for children and improved self-esteem, anger management and sense of responsibility among fathers.

Relationship building and stress reduction can be enhanced by programs that involve the baby’s entire family, those that specifically teach stress reduction techniques and that emphasize relationship skills. When offered in a culturally sensitive manner, these approaches can increase the likelihood of healthy birth outcomes.

**Implementation:** The Collaborative recommends five programs for addressing relationship building, stress reduction and the role of fathers. One specifically targets fathers through expansion of the Nurturing Fathers program operated by the YMCA. Two address these issues through a family centered approach. The first, Birthing Project U.S.A: Barber Shop model provides weekly sessions for fathers and their families and emphasizes improved communication, social support and fulfillment of basic needs. This program would readily augment the Nurturing Fathers program. The second is an expansion of the Foundations of Maternity program operated by Foundations of Life. This program integrates home visitation, Parents as Teachers and Healthy Families America. It engages pregnant and parenting teens, their mothers and the father of the baby. Expansion will provide the resources needed to serve more young mothers. In addition, the Nurturing Fathers program will become an added element in this program.

The Birthing Project: Sister/Friends program reduces stress through relationship building and social support for African American mothers and expansion is recommended. The African American Women’s Health and Wellness program funded and operated by the YMCA is also viewed as a key to stress reduction for African American women before, during and after pregnancy.

In addition to these programs, the Collaborative believes its work on system integration and improving policy and practice will aide in reducing stress and enable women and families to have better access to services. Community members participating in the Community Forum and Briefing strongly supported this recommendation.

8. Develop an evidence-based neighborhood center to support families and children using existing infrastructure
Rationale: Difficulties with transportation, service offerings in different locations and poor coordination among available health information and social services resources make access difficult for individuals and families, particularly those living in the least wealthy neighborhoods. Lack of high quality adolescent pregnancy prevention and life skills education as well as programs that support parents and families after the birth of a baby are deficiencies in our community according to discussion group and physician group participants. Combining multiple programs, including adolescent pregnancy prevention, life skills education and post pregnancy family support, under one roof in neighborhood centers would substantially reduce these barriers. This strategy also reduces some of the complications of transportation. The stress and lack of accurate information and complicated referral processes could be dramatically impacted by this approach. Knowledge of healthy practices and relationship building will improve health outcomes for individuals, neighborhoods and the community as a whole.

Implementation: The City of Racine is currently examining utilization of its community centers and looking for new approaches to programs offered there. The Collaborative will engage with the City and advocate for the conversion of at least part of one center, located in Census Tracts 3, 4, or 5, to a Family Success Center modeled after the Irvington, New Jersey Family Success Center. Along with co-location of existing community services, the Collaborative recommends co-locating the Carrera Adolescent Pregnancy Prevention program and the Baby FAST model using their design for African American post-delivery families in the same center. The Collaborative envisions this new Family Success Center approach as a way to directly impact neighborhoods, change community norms and improve the health and well being of individuals and families. Community members participating in the Community Forum and Briefing strongly supported this recommendation.

One further recommendation to the Partnership: Provide sufficient time and resources, beyond 4 or 5 years, to have an impact on disparities in birth outcomes.

Rationale: Why?

(1) It takes time to reduce disparities. In Racine disparities have persisted over many years. Substantial reductions will take careful, integrated and cohesive approaches and the time for them to take hold within the community.

(2) It takes time and resources to build capacity. Coordinating services and systems, filling current gaps, developing buy-in, and adding new approaches require time and consistency to build and maintain capacity.
As we have learned through the planning process, it takes time to build collaboration. Bringing more voices to the table and helping them gain deep understanding of the issues and approaches and establishing their buy-in takes time and face-to-face contact.

It takes time to build systems for assessing progress and time for progress to actually occur.

It takes time to leverage resources. The Collaborative does not expect the Partnership to fund every strategy recommended. But it takes time to find and leverage existing and new resources to fully implement our vision and reduce the disparities we so clearly see. We have been successful in both using existing resources and acquiring new ones and fully intend to seek others. Seeing the fruit of that effort will take time.

**Lessons Learned**

1. **Community change is complex, takes time, and takes an intergenerational approach.**

   The Collaborative has developed an appetite for creating lasting community change. It is understood that the high rate of African American infant mortality is a symptom of deeper, difficult, and complex issues that have an impact on everyone. Perceptions of people of race differences and stereotypes can be viewed as entrenched and not retractable, but with the high levels of understanding and respect that are present; this Collaborative has been able to make a commitment to improve Racine. Dr. Collins and Dr. Lu have made it clear that this is a long-term and an intergenerational challenge and therefore requires a long-term and comprehensive approach to solutions. It will require ongoing commitment to creating and implementing change, evaluating and analyzing the implementation, and creating the flexibility to change course as needed. It is the view of the Collaborative, based on its experience as well as the literature, that long-term sustainable change must be managed by those who understand it and are committed to it. The members of the Collaborative are best positioned to monitor the progress of the initiative, reach out and inform others and ensure its ongoing capacity by seeking and educating new members to take on roles as inevitable changes in membership will occur over time.

2. **Organizations will commit if and when they have real opportunities to affect real change.**

   Professionals and communities often engage in work to produce community change, and often times their work is not valued or the recommendations are not put into action.
Ensuring that all input was valued and appreciated enabled us to communicate and make decisions effectively.

3. **Developing guiding principles is important.**

Having agreed upon principles made an enormous difference while growing the Collaborative. By sharing in the development of operating and decision-making principles, shared ownership of the work to be undertaken was established. The Collaborative has steadfastly lived the principles it agreed upon.

4. **“Face-time” is critical**

Meeting face-to-face proved very effective when developing ideas during the planning process. Collaborative members were willing to commit this time because they were able to see progress and gain knowledge and insight. This time together was important to develop and increase trust and mutual respect. The time together also reinforced the commitment to the cause of reducing African American infant mortality and recognition and appreciation that there are others equally committed. Time together also supported the development of common understanding and language. Members were also able to learn from each other as “in house” experts in their fields.

5. **Leadership (TJF and RKCAA) and support by staff is necessary to keep the Collaborative on track with our community partnerships to meet our goals and benchmarks.**

The work of the Collaborative moved forward with the guidance of the convening and partner organizations and project staff to ensure that time frames and benchmarks were met. Staff also assisted in the developmental progress of the Community Plan by creating tools to identify, acquire, and organize information. More subtlety, the mutually supportive and positive relationship between the convening organization, partnering organization and project staff set a tone for productive and respectful engagement.
Call to Action

The Collaborative will strive to deepen its roots in the community and institutionalize this initiative. We will accomplish this by providing additional volunteer opportunities, community awareness events, and recruiting additional champions who want to be involved in the movement and are effective in recruiting others. We feel that champions will provide us with instantaneous feedback on projects, outreach, and other activities. We also plan to provide orientation meetings for these champions and any new members to assure full participation and long term involvement in the Collaborative.

Community involvement is the key to the success of these efforts. There a number of ways concerned citizens can help. We urge concerned residents to visit the www.healthybabiesracine.org website to learn more about the issue, review the Community Action Plan, consider joining the Collaborative, recruit others to join as well, invite GRC4HBO members to speak at informational meetings, and give time and financial support to the Collaborative.

Conclusion

Our recommendations are nothing short of a change in how we do business in Racine. We are recommending a comprehensive approach consisting of existing and evidence-based programs. We are recommending the improvement of relationships between the mother with her healthcare team and her community. We are using community-based participatory research to improve birth outcomes. This plan is truly community-based and community-driven. We are recommending programs and models to close service gaps and strengthen systems and families, and increase social capital. This is a very innovative and ambitious plan to improve pregnancy and birth outcomes in Racine, WI, with the support of the community and its partners.
Works Cited


Greater Racine Collaborative for Healthy Birth
Outcomes- Community Action Plan


