Milwaukee
Lifecourse Initiative for Healthy Families (LIHF)
Community Action Plan

EXECUTIVE SUMMARY

Jasmine Zapata, a medical student at the University of Wisconsin-Madison, gave birth to Aameira in her 25th week of pregnancy. Zapata is educated, married, didn't smoke or drink, and yet her odds were higher for premature delivery. . . . Only one factor suggested risk: Zapata is African-American.
-- Milwaukee Journal Sentinel April 16, 2011

Zapata and her daughter, who is now over one year old, experienced a happy ending to their ordeal. But babies born too early are at increased risk of not reaching their first birthday and complications of prematurity are the number one cause of infant death in Milwaukee. Across many years and nationwide, both the rate of premature births and the infant mortality rate (defined as the death of a baby before reaching his/her first birthday) for black Americans has consistently been much higher than the rate for white Americans. In fact, in Milwaukee, the black infant mortality rate is almost three times higher than the white rate, and worse than the rate in Jamaica, Ukraine, Costa Rica, Ecuador, Malaysia, and 56 other countries.[1]

From fall 2010 through spring 2012, a group of concerned Milwaukeeans—front-line workers and professionals, practitioners and academics, everyday citizens and experts, both black and white—came together to learn about the city's black-white infant mortality gap and decide what to do about it. With generous funding from the Wisconsin Partnership Program (WPP) of the University of Wisconsin School of Medicine and Public Health and incalculable in-kind support from participating agencies and individuals, this planning phase led to the formation of a Lifecourse Initiative for Healthy Families (LIHF) Collaborative in Milwaukee, and the creation of a community action plan to eliminate birth disparities in the city.

The community action plan put forth by the Milwaukee LIHF Collaborative envisions a community where all African American families have less stress and experience healthy birth outcomes. Task forces organized around three domains (Health Care, Families and Communities, and Social Determinants) developed goals and strategies within these domains. The African American Task Force established guiding principles and vetted all task force recommendations. The guiding principles specify that strategies should:

a. Be culturally appropriate;
b. Be community-driven;
c. Be family-centered;
d. Recognize the unique role of African American organizations;
e. Address racism;
f. Integrate the concept of the Lifecourse; and
g. Work toward fulfilling the project vision of reducing stress and improving birth outcomes.

The newly formed Milwaukee LIHF Collaborative is determined to seek the resources and partnerships necessary to eliminate racial disparities in infant mortality in Milwaukee by the year 2020.

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[1] *Evidence of Trends, Risk Factors, and Intervention Strategies*, US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, 2006 http://mchb.hrsa.gov/healthystart/evaluation/benchmarkreport/appendixa.htm

Recommendations

The specific goals and related culturally relevant strategies that are recommended as having the greatest effect on reducing black infant mortality in the city by the domain task forces and vetted by the African American Task Force are as follows:

A. Improving healthcare for African American women by expanding healthcare access over the Lifecourse

1. Facilitate access to healthcare services (including preconception, prenatal and interconception care)
2. Reduce financial barriers to African American utilization of medical homes
3. Increase the capacity and quality of medical homes
4. Expand access to specialty care (including behavioral health and dental care)

B. Strengthening African American families and communities by strengthening father involvement in African American families

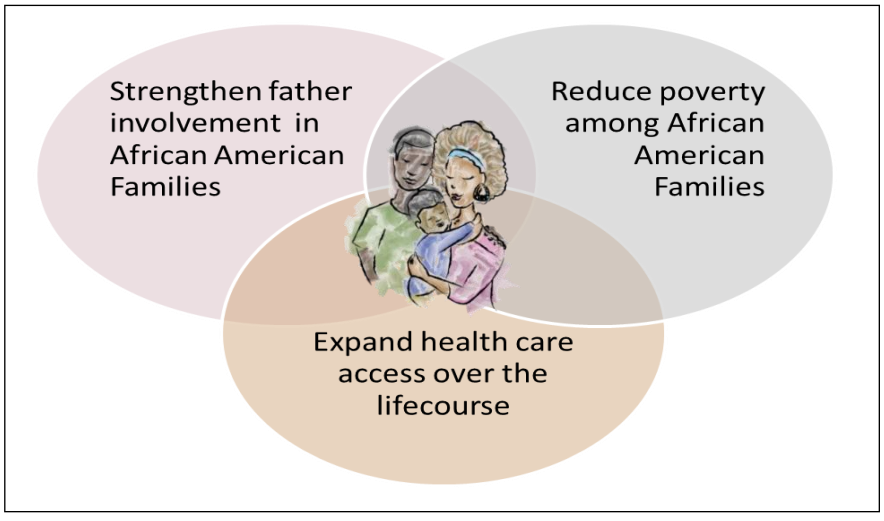
1. Engage/partner with/fund grassroots and informal efforts in the development of a comprehensive network of fatherhood resources and supports.
2. Increase relationship building skills and self-worth for African American men and their families (culturally appropriate and community driven)
3. Increase the role that fathers play in the community
4. Increase access to education and employment opportunities among African American males by providing mentoring, internships and job opportunities
5. Strengthen formal and informal partnerships to address structural barriers, which include racism and discrimination (both informal and formal partners have equal value)

C. Addressing social determinants by reducing poverty among African American families.

1. Remove structural barriers to obtaining/retaining jobs
2. Increase family-sustaining jobs for low-income African American men and their families.

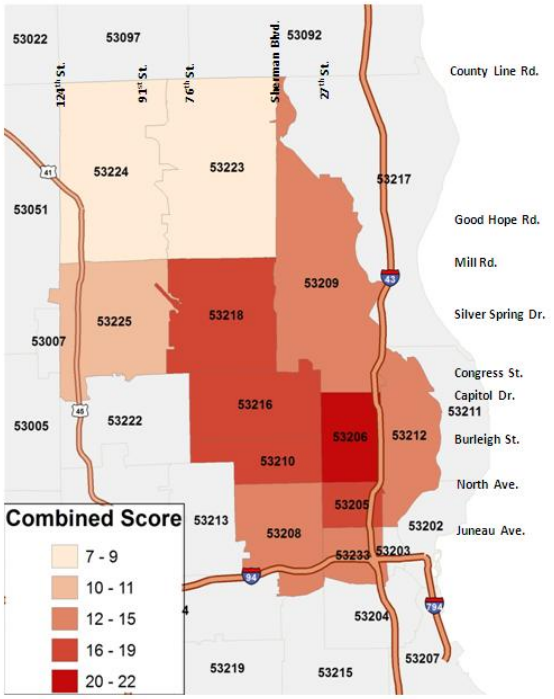
These goals are far from independent of one another. Rather, they are interconnected and Milwaukee LIHF is interested in pursuing strategies that are located in the common ground where all three goals intersect.

MILWAUKEE LIHF GOAL INTEGRATION



The Importance of Geography, Place and Community

Based on factors known to be associated with infant mortality, the Collaborative has recommended a specific geographic focus which incorporates the ZIP codes of highest need. The planning took into consideration three-year rolling averages of infant mortality rates, cumulative live births, total population, African American population, average household income, median female age, percent male, as well as unemployment and involvement in the corrections system in examining data by ZIP codes. The Collaborative identified twelve ZIP codes to be those of highest need and therefore the target of the implementation effort. Due to Milwaukee's hyper-segregation, the included ZIP codes reflect the majority of the African American population's location in the city. It would be necessary to significantly reduce the rate of infant mortality in these ZIP codes to meet the 2020 goal of eliminating racial disparities in birth outcomes in Milwaukee. The ZIP codes are: shown on the map below. Additionally, the Collaborative recognizes that within ZIP codes there can be significant variation and pockets of both needs and assets. It is therefore recommended that the applicants for implementation grants fully describe in their proposals the geographic focus of their approach within the area the Collaborative has identified for this plan. The description should build on the work of the Collaborative but include natural neighborhoods, assets and informal support networks.



By defining the targeted area and asking implementing organizations to further specify and elaborate on the geographic area of focus, Milwaukee LIHF is following a place-based strategy common in the Obama administration's efforts with Promise Neighborhoods (Department of Housing and Urban Development and Choice Neighborhoods (Department of Education). Place-based strategies leverage investments by focusing resources in targeted places and drawing on the compounding effect of well-coordinated action. The core principles of place-based strategies are that change comes from the community level and often through partnership and that complex problems require flexible, integrated solutions. The Harlem Children's Zone and the Best Baby Zone work now being done by Dr. Michael Lu are also examples. This approach helps assure the sustainability of the effort as well.

Community-driven efforts give control of decisions and resources to the members of the impacted population. Community-driven collaboratives often work in partnership with support organizations and service providers including local government, the private sector and nonprofits. The impacted population is not viewed as the target of the effort but rather the impacted population and their institutions are viewed as assets and partners in the process. The advantages of a community-driven approach are that it improves efficiency and effectiveness, allows efforts to be taken to scale, makes solutions more inclusive of the interests of the impacted population and enhances sustainability. This approach has been a cornerstone of the Milwaukee effort beginning with the establishment of the African American Task Force, their delineation of the effort's Guiding Principles, the vetting of the domain task force recommendations, and the established priority of increasing father involvement in African American families. The role of the African American Task Force is clearly defined in the Operational policies of the Collaborative. The recommendation that implementation funds focus on grass roots or nontraditional organizations where African Americans compose the majority of board and staff leadership as well as constituency reinforces this approach.

Lessons Learned

1. The impact of racism must be acknowledged. By definition, the Milwaukee LIHF planning process involved a dimension that is often present but seldom acknowledged in collaborations: racism. From the very beginning, participants and staff recognized that the project would need to address the topic of racism head on. Dollars from the planning budget were allocated to bring experts from the New Orleans-based People's Institute on Racism and Beyond to Milwaukee in spring 2011.

2. Ensuring a community-driven process is the key to sustainability. A truly community-driven approach includes the genuine ownership, leadership and involvement of the impacted population.[2] Milwaukee LIHF meeting times (early evenings) and locations (in the central city, close to bus lines) were carefully chosen to make it as easy as possible for the impacted population to attend. Stipends for meeting attendance and transportation were built into the budget, as was money to pay for babysitting and food during meetings. At least one co-chair for each task force was a member of the impacted community.

3. Creating a common agenda requires leveraging resources. Milwaukee LIHF created a community-wide agenda through leveraging existing resources, for example: publicizing major events run by others like the City's infant mortality summit; engaging with the Milwaukee Journal Sentinel as it ran a year-long series of articles on the city's black-white infant mortality gap; meeting with the Donor's Forum of Wisconsin; partnering with youth groups such as Public Allies; and working with the Women's Fund of Greater Milwaukee to create a bus shelter campaign about Milwaukee LIHF.

4. It takes time to establish trust and shared vision. Everyone involved in the Milwaukee LIHF planning process learned to weather the changes that are inevitable in a lengthy project. Issues around personal/family health, child welfare, domestic violence, interpersonal disagreements, employment changes, educational pressures and even death had an impact on the evolution of the collaboration. Over the 18-plus months of the project, such changes created continuity challenges but with patience, the trust and shared vision necessary for a successful collaborative began to emerge.

5. Ongoing, honest and clear communication is a necessity. Avoiding jargon, making documents available well in advance of meeting dates, and distributing documents in a format that worked best for all involved were important ways of keeping all Milwaukee LIHF participants "in the loop." Also, Milwaukee LIHF created a virtual space (http://milwaukee-lihf.wikispaces.com/) and regularly provided project updates via monthly e-newsletters. Keeping a complex initiative such as Milwaukee LIHF open, straightforward and transparent was not always easy. The lesson was to always keep the channels of communication open and listen, listen, listen.

6. Clarity in responsibilities and representation is necessary for continuity. It is important to have a common understanding by all main interest groups of the planning approach that will be used. In particular, clarity around the issue of representation is crucial when dealing with difficult issues (such as racism) or fear. Having clear rules and responsibilities in place before any dispute arises—and revisiting them often—can help avoid needless conflict.

7. A trusted convener is critical. A community-driven planning process involving a large number of interested individuals and groups benefits immensely from the services of a trusted, local convener.

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[2] Impacted population was defined as "African American families who have been impacted by infant mortality."

Budget & Sustainability

The Milwaukee LIHF Collaborative has chosen the YWCA of Greater Milwaukee to be the fiscal agent for any WPP funds that are designated to Milwaukee for implementation of the Community Action Plan. While the precise number of dollars WPP intends to allocate to the Milwaukee plan are unknown at the time of this writing, the Collaborative is recommending that WPP direct approximately $750,000 per year for the five-year period to the Milwaukee initiative. This recommendation is based on the assumption of the original $10,000,000 commitment for four sites over the five-year period. It also assumes that the planning phase has adequately demonstrated that the complexity and depth of the problem in Milwaukee necessitates additional resources going to this community.

The Collaborative further recommends that 60% of the WPP dollars allocated to Milwaukee be dedicated to programs that promote the following identified priorities aimed at increasing father involvement in African American Families:

a. Engage, partner with and fund grassroots and informal efforts in the development of a comprehensive network of fatherhood resources and supports. Recommended strategies include reaching out to black men thru grassroots, non-traditional social networks, building social capital at the community level, recognizing the importance of churches and directly fund and build capacity for organizations where a majority of board, staff and population served is African American.

b. Increase relationship-building skills and self-worth for African American men and their families in ways that are culturally appropriate and community-driven. Recommended strategies include changing female and male perceptions that men are not needed to raise children

c. Increase the role that dads play in the community, including helping ex-felons understand when they can and cannot vote.

This recommendation was made by the African American Task Force and confirmed by the Collaborative as a way to best leverage existing resources and target existing gaps. Thus if Milwaukee's implementation dollars are set at $750,000 per year, it is recommended that $450,000 of that amount focus on strategies that promote strengthening father involvement in African American families and that the balance ($300,000) go to support the recommendations for improving healthcare for African American women and reducing poverty among African American families.

Until such time as the WPP implementation funds are received, the Collaborative will continue to work on a variety of tasks including: continuing to build public awareness and support of the Community Action Plan; refining membership and structure of the Collaborative; building capacity of the Collaborative; conducting outreach to potential grantees; participating in WPP training; and working with WPP on media and evaluation activities.

A plan is not an end in itself, but rather the means to an end. The Milwaukee LIHF Collaborative will ensure that its Community Action Plan is disseminated to the public at large, that it is integrated with other city initiatives working toward similar goals, and that it is used as a guide for decision making and action by all sectors of the community. In early 2012, specific sectors of the Milwaukee community will be asked to commit to specific actions they can take that will help end the disparities between black and white birth outcomes by 2020.

TABLE OF CONTENTS

I. Mission, Vision and Values Statement

[Black babies] are dying from being born prematurely. They are dying from questionable pre-natal care. They are dying from the stress of living in unstable conditions. They are dying because of the economic conditions in Milwaukee, especially for black Milwaukeeans.

– Dr. Patricia McManus in Milwaukee Community Journal 7/22/10

The Milwaukee LIHF Collaborative acknowledges that the disparity between black and white infant mortality in this community has existed for decades, and cannot be solved overnight. The Collaborative has developed a theory of change that takes a long-term view of how the gap between black and white infant mortality can be eliminated.

In the short term (one to five years), Milwaukee LIHF will focus on creating a collaborative for infant mortality, educating Milwaukeeans about infant mortality disparities, and implementing evidence-based programs and promising practices that have the potential to reduce these disparities. Activities will be based on the Lifecourse Model as articulated in the literature, in particular by Dr. Michael Lu (see section I.E.).

The intermediate (five- to ten-year) outcome Milwaukee LIHF wishes to achieve is that Milwaukee will be a community where:

- Residents love, trust and respect each other;
- Healthy lifestyles across the lifecourse are promoted; and
- Family supports, education and other resources are available.

The long-term (ten- to twenty-year) vision of Milwaukee LIHF is that all African-American families in Milwaukee will have less stress and healthy birth outcomes. Milwaukee LIHF has set as its goal eliminating racial disparities in infant mortality in Milwaukee by the year 2020.

In pursuit of these goals, Milwaukee LIHF will be guided by the wisdom of the impacted community as represented by the African American Task Force. This task force established guiding principles which state that all strategies undertaken by Milwaukee LIHF should:

a. Be culturally appropriate;
b. Be community-driven;
c. Be family-centered;
d. Recognize the unique role of African American organizations;
e. Address racism;
f. Integrate the concept of the Lifecourse; and
g. Work toward fulfilling the project vision of reducing stress and improving birth outcomes.

II. Background

Infant mortality is the ultimate misery index.
– Milwaukee Journal Sentinel, 11/12/11

A. Infant Mortality and Morbidity Data

The most recent Milwaukee Health Department Fetal Infant Mortality Review (FIMR) documents that of the 807 infant deaths and stillbirths that occurred in the City of Milwaukee during 2005-2008, 85% of were of infants of color.[1] The report also shows that the overall infant mortality rate for the city in 2008 was 10.79 per 1000. During this same time the white infant mortality rate in the city was 5.49 per 1000, while that for African Americans was 13.85 per 1000. This infant mortality rate for African American babies in Milwaukee is worse than the rate in Jamaica, Ukraine, Costa Rica, Ecuador, Malaysia and 56 other countries.[2]

These numbers have not improved in the years since the last FIMR report. There were 217 infant deaths in 2009 and another 217 infant deaths in 2010. As of early December 2011, there were 75 total infant deaths in Milwaukee according to data being compiled by the Milwaukee Journal Sentinel. The newspaper qualified this data, saying that the "State Department of Health Services will not validate and reconcile 2011 numbers until December 2012. The Journal Sentinel is tracking and mapping deaths reported to the county medical examiner. However, not all infant deaths must be reported there, so the actual number is much larger."[3]

The death of even one infant causes intense pain and suffering for the families involved; the loss of so many promising lives is an unacceptable loss for the community at large. Infant mortality is one of the most important indicators of the health of a community, as it is associated with other important factors including maternal health, quality and access to medical care, socioeconomic conditions, and public health practices. As Geoffrey Swain, medical director of the Milwaukee Health Department explains it, "The infants are like the canary. . . They are the most vulnerable. They are the first to drop off when conditions are bad."[4]

A National Issue

Infant mortality and poor birth outcomes are major public health issues in the United States that disproportionately affect African American families. While there has been a general decline in the US infant mortality rate during the 20th century, from 2000-2005 there was no significant decline. In 2005, the US infant mortality rate was 6.86 deaths per 1,000 live births, which did not differ significantly from the rate of 6.89 in 2000. The 2006 infant mortality rate of 6.71 per 1,000 live births, did represent a 2% decrease from 2005. However, even this slight decrease was 50% above the Healthy

[1] City of Milwaukee, Health Department. (2010). *Fetal Infant Mortality Review Report: Understanding and Preventing Infant Death and Stillbirth in Milwaukee*. Retrieved from: http://www.milwaukee.gov/FIMR2010

[2] US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Healthy Start National Evaluation. (2006). *Evidence of Trends, Risk Factors, and Intervention Strategies.* Retrieved from: ftp://ftp.hrsa.gov/mchb/OriginalfilesEvidence.pdf

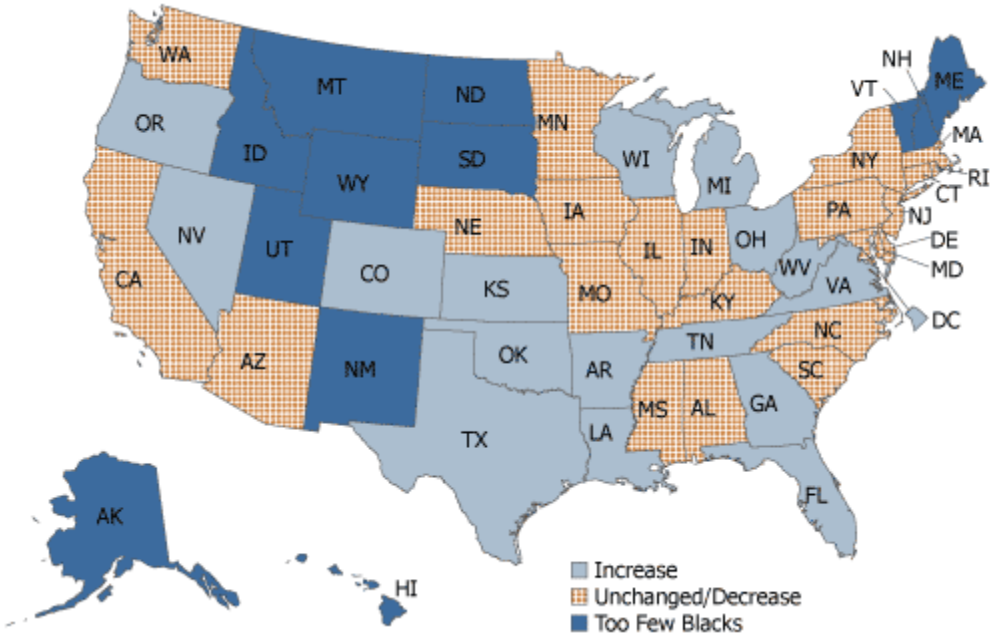
[3] Boulton, G., Karon, A., Poston, B., Stephenson, C., Yount, E. Mapping Milwaukee's Infant Mortality Crisis. *Milwaukee Journal Sentinel*. Data compiled from U.S. Census Bureau, Milwaukee Health Department, Milwaukee County Medical Examiner's Office, Wisconsin Department of Health Services, Center for Urban Population Health, Journal Sentinel research. Accessed 12/11/11 from: http://www.jsonline.com/news/130456803.html

[4] Schmid, J. (2011 November 12). Where city factories, and now babies, die. *Milwaukee Journal Sentinel*. Retrieved from: http://www.jsonline.com/features/health/economic-decline-elevated-infant-mortality-go-handinhand-in-53210-zip-code-mh2kv7l-133758368.html

People 2010 target goal for US infant mortality of 4.5 deaths per 1,000 live births.[5] The Healthy People 2020 target goal has been adjusted to a more attainable 6.0 deaths per 1,000 live births, aiming for a 10% improvement in infant mortality rates.[6] Compared to other developing countries the US ranking for infant mortality has been steadily falling from a ranking of 12th in 1960 to 23rd in 1990 to 29th in 2004 to an all-time low of 33rd in 2007. The US now ranks behind countries such as Cuba, Poland and Slovakia for infant mortality.[7]

Despite the tremendous gains in maternal and child health that have occurred in the past twenty years, racial disparities in adverse birth outcomes persist in the United States, with African Americans shouldering the greatest burden of infant death, preterm delivery and low birth weight infants. During the 1990s, there were signs of improvements in the health of black infants in the 39 states with enough blacks for a reliable analysis (at least 20 black infant deaths during a given period). All of those states except Iowa and Oklahoma saw their black infant mortality rates decline between the 1989-1991 and 1998-2000 periods. However, recent data show a partial reversal of this trend.[28] Sixteen of the 39 states experienced rising black rates between the 1998-2000 and 2002-2004 periods, as shown in the map below.

Change in Infant Mortality Rate of Blacks in U.S. States, 1998-2000 to 2002-2004[9]



Source: National Center for Health Statisics, *Health, United States, 2006.*

[5] MacDorman, M.F. & Matthews, T.J. (2008 October). *Recent Trends in Infant Mortality in the United States*. (NCHS Data Briefs No. 9). Centers for Disease Control and Prevention, National Center for Health Statistics. Retrieved from: http://www.cdc.gov/nchs/data/databriefs/db09.pdf

[6] US Department of Health and Human Services, Healthy People 2020. Maternal Infant and Child Health (MICH) Objective 1.3. Retrieved from: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=26

[7] MacDorman. (2008).

[8] Eckholm, E. (2007 April 22). In Turnaround, Infant Deaths Climb in South. *New York Times*. Referenced by Saenz, R. (2007 October). *The Growing Color Divide in US Infant Mortality*. Population Reference Bureau. Retrieved from: http://www.prb.org/Articles/2007/ColorDivideinInfantMortality.aspx

[9] Saenz, R. (2007 October). *The Growing Color Divide in US Infant Mortality*. Population Reference Bureau. Retrieved from: http://www.prb.org/Articles/2007/ColorDivideinInfantMortality.aspx

The disparity in birth outcomes between African Americans and whites can be partially explained by the disproportionately high rates of preterm birth and low birth weight infants in African Americans. In 2002, the rate of preterm delivery among African Americans was 17.5% compared to 11.1% in whites, while the rates of low birth weight were 13.3% and 6.8%, respectively. Although the large proportion of low birth weight and preterm deliveries among African Americans helps explain the disparity in infant mortality, paradoxical evidence has shown a survival advantage at younger gestational ages and low birth weights in African American newborns compared with whites. As medical advancements reduce overall rates of infant mortality, the apparent survival advantage for African American infants compared with whites is disappearing as these advances have favored survival of white infants, leading to a widening in racial disparity in infant mortality.[10]

Disparities in birth outcomes between whites and African Americans exist at all levels of socioeconomic status, even after controlling for health behaviors, and have been shown to increase with higher levels of education. Furthermore, a growing body of work provides evidence for the deleterious effects of maternal stress on birth outcome. It has been hypothesized that the higher rate of preterm delivery among African American women is related not only to stress exposures during pregnancy, but more importantly is a result of a stress response that has been patterned by lifelong exposures to chronic and repeated stress, including racism.[11]

Infant Mortality in Wisconsin

While the racial disparity in infant mortality rates in the US is high at 2.5 to 1, the situation in Wisconsin is more striking with a black to white infant mortality ratio exceeding 3 to 1. Wisconsin's black infant mortality rate compared to other states has deteriorated in national ranking from the third best ranking in 1979-1981 to third worst in 1999-2001 to now an all-time low of second worst in 2003-2005.[12] [13] From 1999-2001 the rates of both preterm birth and low birth weight infants in blacks were twice that of white infants in Wisconsin. Not only are the rates of preterm birth and low birth weight infants higher in blacks, but these black infants are also have a 5.2 fold greater risk of dying from these conditions than their white counterparts.[14] The second leading cause of black infant deaths is SIDS, with black infants having a 5-fold greater risk of dying from SIDS than white infants. Even after controlling for variables such as maternal age, maternal education, marital status, weight gained during pregnancy, smoking status, prenatal care, trimester that prenatal care began, region of the state resided, birth weight and gestational age, black infants with the same risk profile as white infants still had a two-fold excess risk of death.[15]

Regardless of the region of the state in which a black woman lives, she has a 3-fold greater risk of having an infant death compared to a white woman. The majority of black infant deaths occurred in southeastern Wisconsin, where many of the state's African Americans reside.[16] Approximately 78% of the state's African American population lives in the City of Milwaukee, one of the most segregated cities in the nation. Large black-white gaps in infant mortality have been well documented in highly segregated cities like Milwaukee, which is the most segregated city in the nation.[17]

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[10] Giscombe, C.L. & Lobel, M. (2005 September). Explaining disproportionately high rates of adverse birth outcomes among African Americans: the impact of stress, racism, and related factors in pregnancy. *Psychological Bulletin, 131(5),* 662-683. DOI: 10.1037/0033-2909.131.5.662

[11] Giscombe. (2005).

[12] Salm Ward, T.C., Mori, N., Patrick, T.B., Madsen, M.K. and Cisler, R.A. (2010). Influence of socioeconomic factors and race on birth outcomes in urban Milwaukee. *Wisconsin Medical Journal, 109(5),* 254-260. PMID: 21066930

[13] Byrd, D.R., Katcher, M.L., Peppard, P., Durkin, M. & Remington, P. L. (2007). Infant mortality: explaining black/white disparities in Wisconsin. *Maternal and Child Health Journal, 11(4),* 319-326. DOI: 10.1007/s10995-007-0183-6

[14] Byrd. (2007).

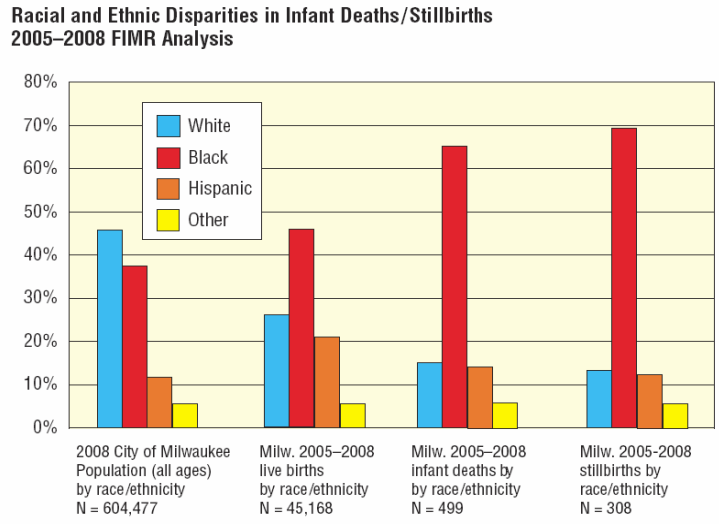
[15] Byrd. (2007).

[16] Byrd. (2007).

[17] Frey, WH. (2010). *Black-White Segregation Indices for Metro Areas*. Analysis of 2005-9 American Community Survey and 2000 US Census. Accessed through University of Michigan, Population Studies Center, Institute of Social Research website: www.psc.isr.umich.edu/dis/census/segregation.html. Retrieved from: www.censusscope.org/ACS/FREYAcsBLK100MetroSeg.xls

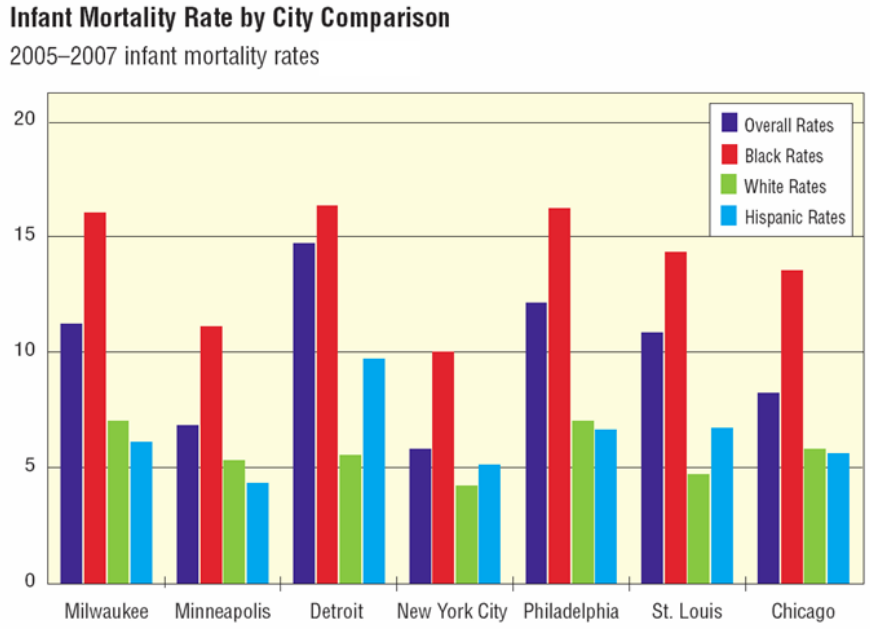
Infant Mortality in Milwaukee

For the period 2005-2008 in the City of Milwaukee, the black infant mortality rate was 15.7, nearly three times higher than the rate of 6.4 for white infants, and of the 807 infant deaths and stillbirths during this period, 686 or 85% were infants of color.[18]



Source: City of Milwaukee Health Department. 2010 City of Milwaukee FIMR Report

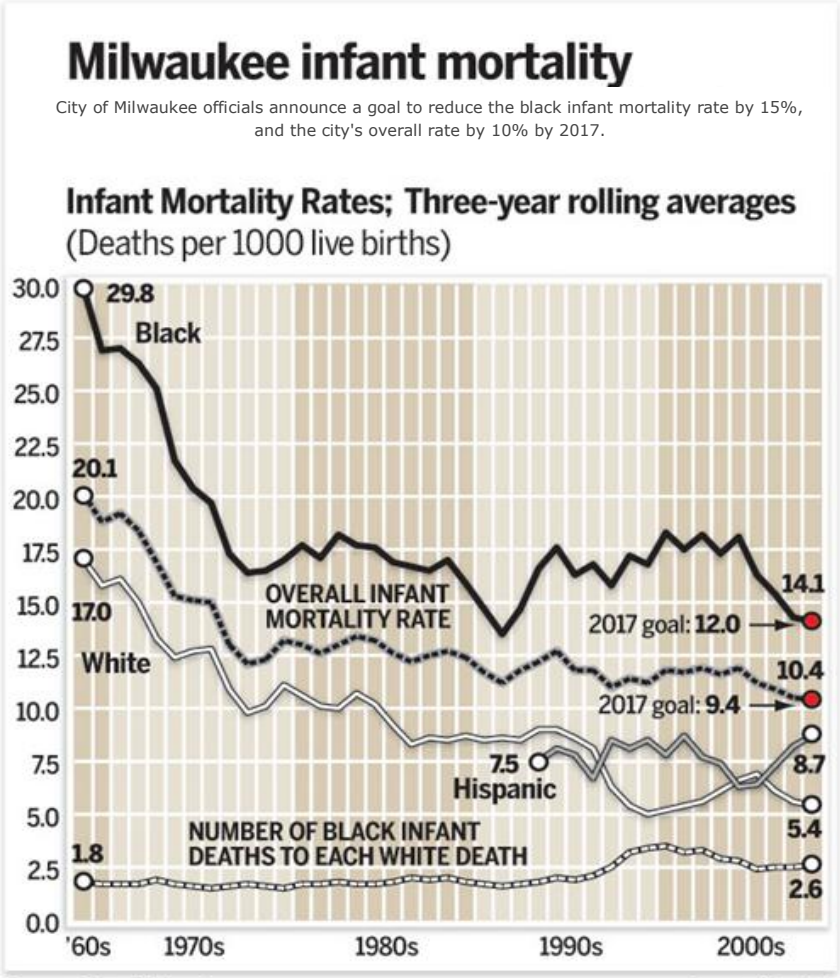
Milwaukee's infant mortality rate is worse than the rate in large US cities such as New York and Chicago. While the city of New York's population is 13 times that of Milwaukee, Milwaukee's overall infant mortality rate is 80% worse.



Source: City of Milwaukee Health Department. 2010 City of Milwaukee Fetal Infant Mortality Review Report

[18] City of Milwaukee, Health Department. (2010).

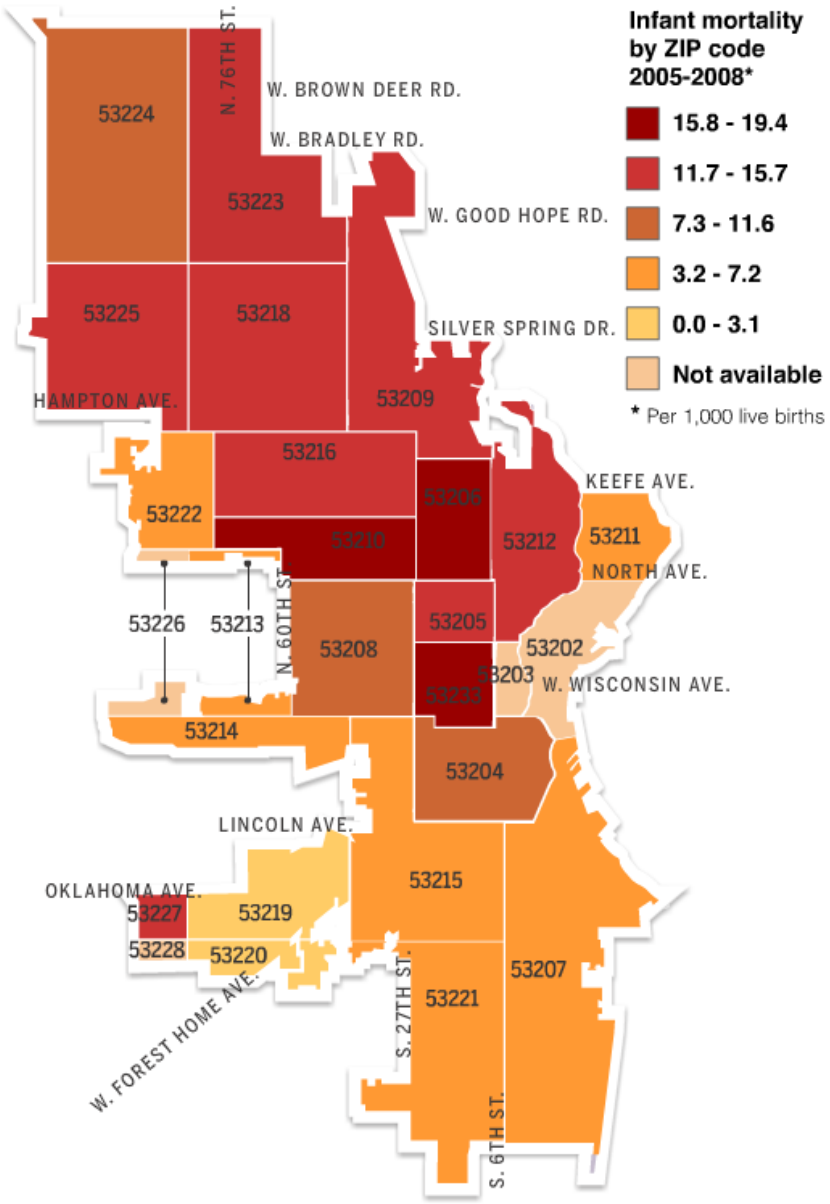
While infant mortality rates in Milwaukee for all racial groups have dropped over the decades, the disparity between black and white infant mortality rates has actually worsened over the same period, as represented in the chart below.[19]



[19] Herzog, K. (2011 November 08). Milwaukee sets goal to reduce infant mortality. *Milwaukee Journal Sentinel*. Retrieved from: http://www.jsonline.com/features/health/milwaukee-sets-goal-to-reduce-infant-mortality-st2vff2-133504268.html

Milwaukee infant deaths are concentrated in a few predominantly African American ZIP codes clustered within the central and near-northwest portions of the city, as seen in the map below, which analyzes data for the four-year period from 2005-2008. Residents of these ZIP codes are more likely to experience poverty, joblessness and other socioeconomic challenges,[20] realities that impact residents' opportunities to initiate or sustain healthy choices.

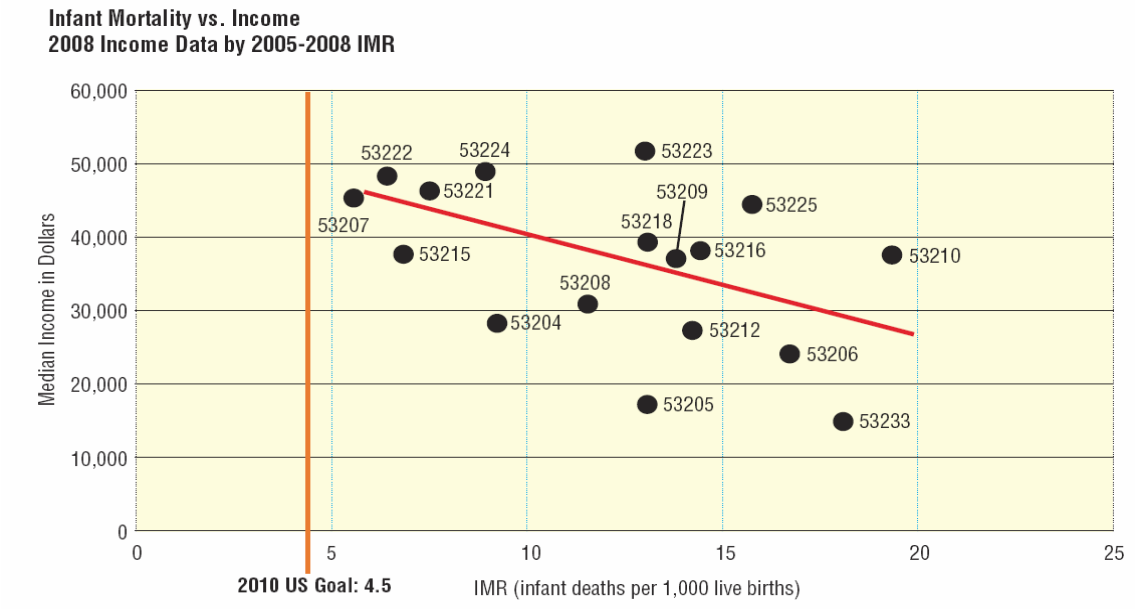
Infant mortality by ZIP code, 2005-2008



Sources: *2010 City of Milwaukee Fetal Infant Mortality Review; Milwaukee County Medical Examiner's Office, 2000 U.S. Census; Wisconsin STD Program.* Map published 2011 by Milwaukee Journal Sentinel. Retrieved from http://www.jsonline.com/news/milwaukee/113310294.html

[20] City of Milwaukee, Health Department. (2010).

In September 2010, the US Census Bureau reported that Milwaukee is the country's fourth poorest city with over 32% of children living below the poverty level. The chart below shows that ZIP codes with the lowest median income are more likely to have the highest infant mortality rates.



Source: City of Milwaukee Health Department. 2010 City of Milwaukee Fetal Infant Mortality Review Report

Furthermore, in Milwaukee, black women with more education still have higher infant mortality and stillbirth rates than white women who did not graduate from high school.[21]

Disparities in Infant Mortality Rate by Maternal Education

City of Milwaukee **Infant Deaths, N=488***							
Education	Total	Black	White	Hispanic	Black / White Disparity Ratio	Black / Hispanic Disparity Ratio	White / Hispanic Disparity Ratio
Less than High School	13.0	17.1	11.7	8.1	1.4	2.1	1.4
High School Graduate	12.1	15.1	10.5	6.0	1.4	2.5	1.8
More than High School	7.5	14.6	3.5	5.1	4.2	2.9	.69
City of Milwaukee **Stillbirths, N=289***							
Education	Total	Black	White	Hispanic	Black / White Disparity Ratio	Black / Hispanic Disparity Ratio	White / Hispanic Disparity Ratio
Less than High School	5.9	7.5	6.6	3.8	1.1	2.0	1.7
High School Graduate	9.5	13.5	5.4	4.6	2.5	2.9	1.2
More than High School	3.9	6.8	3.5	5.0	1.9	1.4	.70

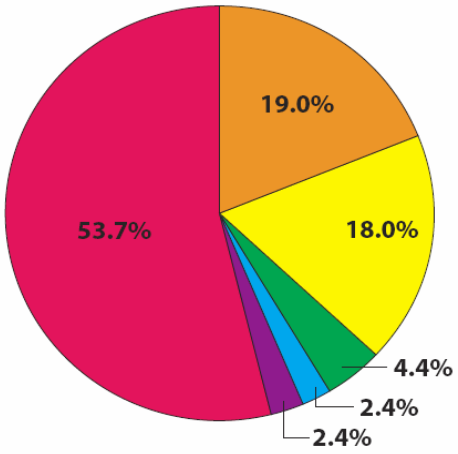
*Mothers of 11 infants and 19 stillbirths had no recorded education information.

Source: City of Milwaukee Health Department. 2010 City of Milwaukee Fetal Infant Mortality Review Report

[21] City of Milwaukee, Health Department. (2010).

Premature birth - birth before 37 weeks of pregnancy - is the No. 1 reason babies die in Milwaukee (54%), followed by congenital abnormalities (19%) and SIDS/overlays/accidental suffocation (18%).[22]

All Milwaukee Infant Deaths, 2005-2008



Causes of Infant Death in Milwaukee, 2005-2008

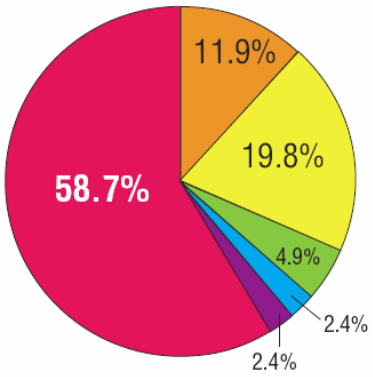
Cause of Death	Key	Black	Hispanic	White
Complications of Prematurity		193 (58.7%)	35 (49.3%)	32 (41.0%)
Congenital Abnormalities and Related Complications		39 (11.9%)	26 36.6%)	23 (29.5%)
SIDS, Overlay, Accidental Suffocation		65 (19.8%)	4 (5.6%)	16 (20.5%)
Infections		16 (4.4%)	2 (2.8%)	4 (5.1%)
Homicide		8 (2.4%)	2 (2.8%)	1 (1.3%)
Other		8 (2.4%)	2 (2.8%)	2 (2.6%)

Source: City of Milwaukee Health Department. 2010 City of Milwaukee Fetal Infant Mortality Review Report

Milwaukee's black-white disparity in premature births is worse than the disparity in overall infant mortality between the two groups. Black infant deaths and stillbirths are five times more likely to be premature than among whites.[23]

Black Infants

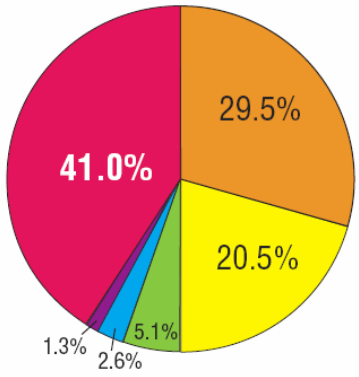
The major causes of 2005-2008 Black infant death were **complications of prematurity, SIDS, overlay or accidental suffocation**, and **congenital abnormalities.**



N = 329

White Infants

The major causes of 2005-2008 White infant death were **complications of prematurity, congenital abnormalities**, and **SIDS, overlay, or accidental suffocation.**

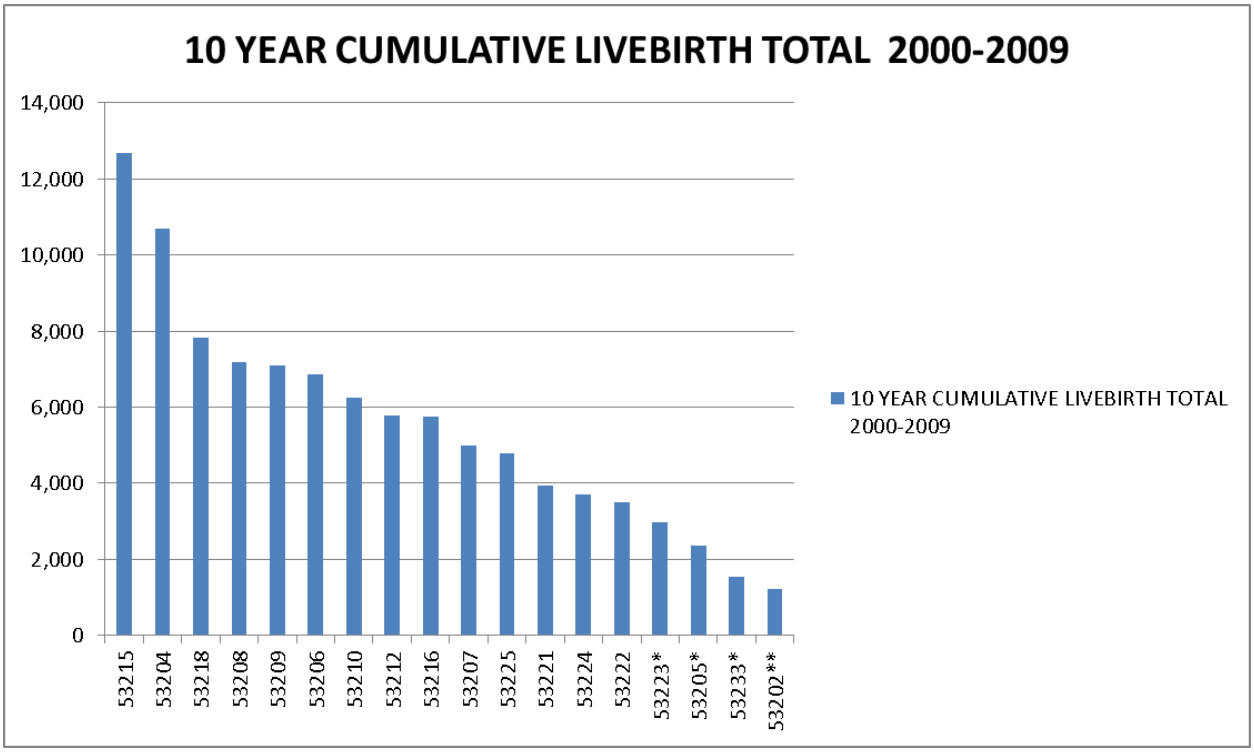


N = 78

Source: City of Milwaukee Health Department. 2010 City of Milwaukee Fetal Infant Mortality Review Report

[22] City of Milwaukee, Health Department. (2010).
[23] City of Milwaukee, Health Department. (2010).

The Milwaukee LIHF Collaborative further analyzed infant mortality rates over a ten-year period from 2000- 2009 by ZIP code to determine where to concentrate its efforts. On the following graphs created by the Milwaukee Health Department for Milwaukee LIHF, only ZIP codes with enough births or deaths in a year to produce a statistically significant number are presented. When examining the ten-year cumulative live birth totals, it can be seen that 53215, 53204, and 53218 have the greatest number of live births, with 53208, 53209, and 53206 all similar and vying for 4th place.

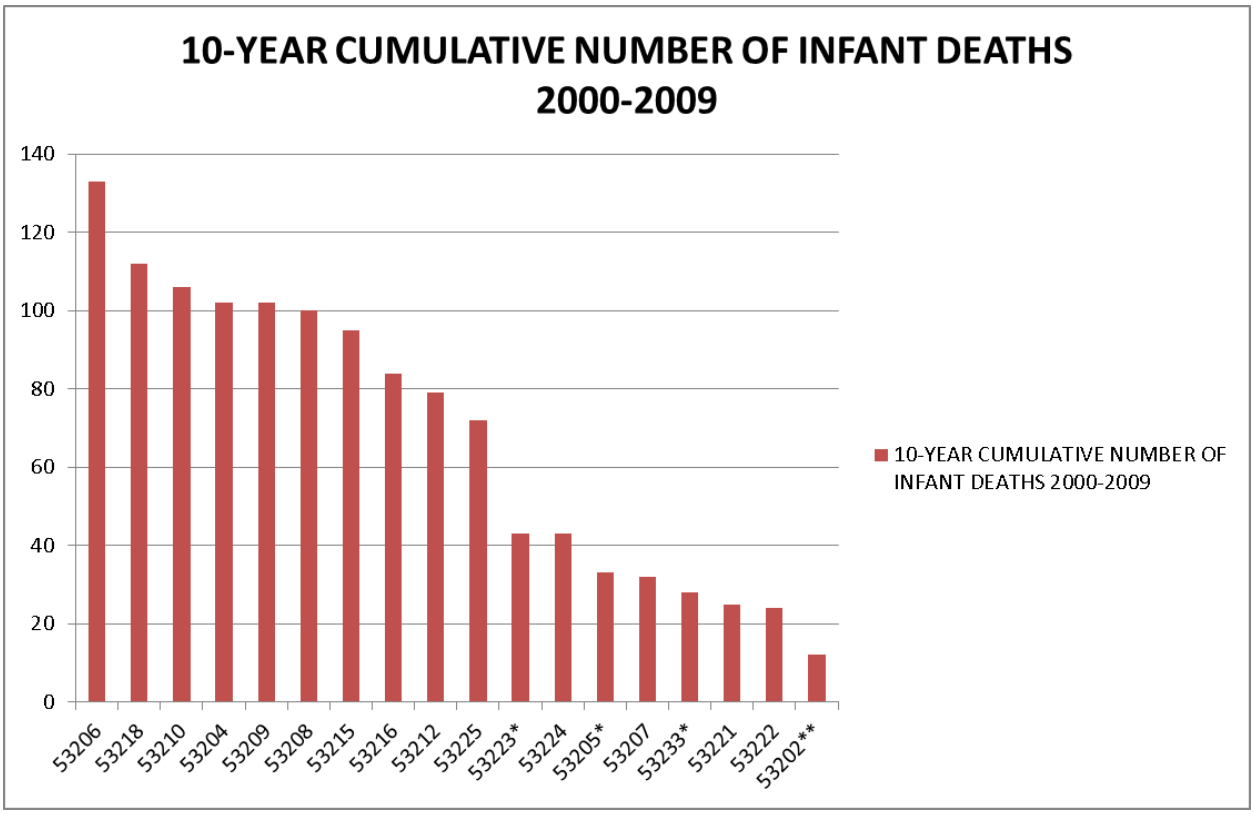


Source: Milwaukee Health Department, 2011

* *Rates and totals for zip codes with between 150-300 live births per year on average (1500-2999 births per 10 years), and may have some inherent statistical instability over time.*

** *Rates and totals for zip codes with between 100-150 live births per year on average (1000-1499 births per 10 years), and are likely to have inherent statistical instability over time.*

However, the ZIP codes with the greatest number of infant births (53215, 53204 and 53218) are not where the greatest number of infant deaths occur. As shown below using data provided to Milwaukee LIHF by the Milwaukee Health Department, the ZIP codes with the greatest number of infant deaths over a ten-year period are 53206, 53218 and 53210.

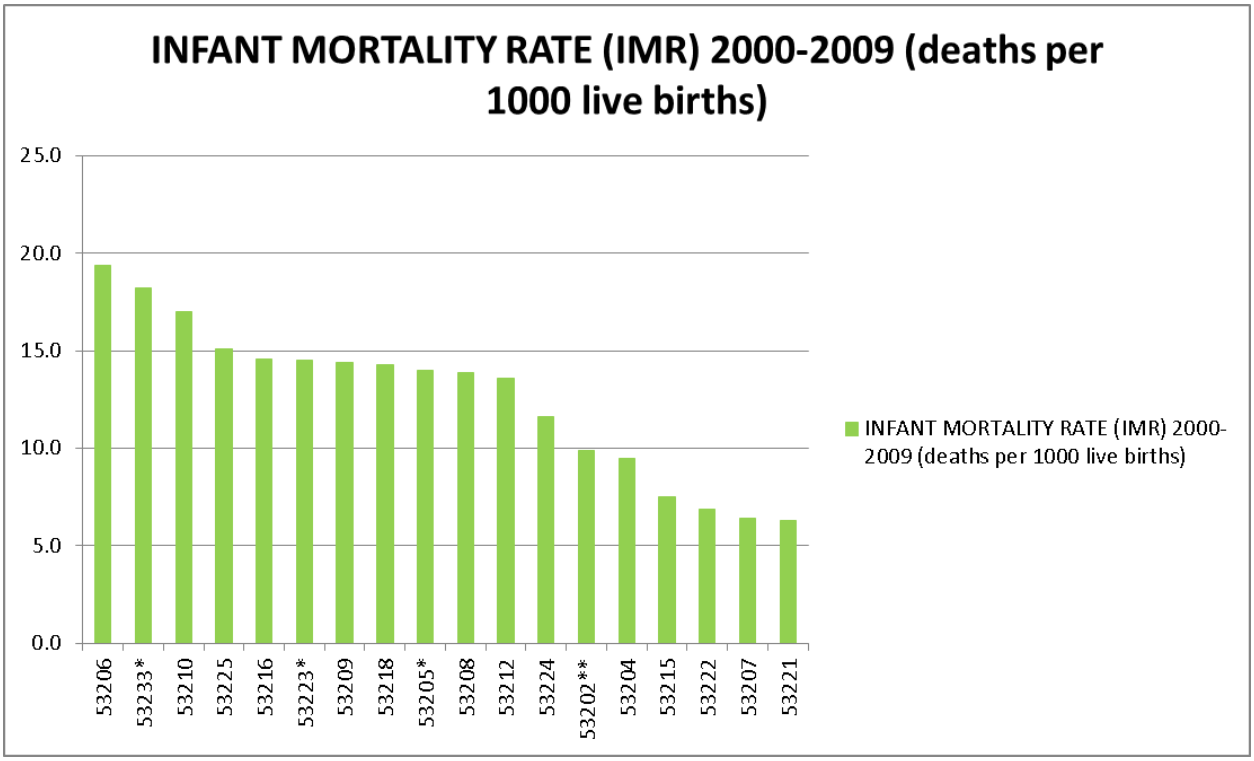


Source: Milwaukee Health Department, 2011

* *Rates and totals for zip codes with between 150-300 live births per year on average (1500-2999 births per 10 years), and may have some inherent statistical instability over time.*

** *Rates and totals for zip codes with between 100-150 live births per year on average (1000-1499 births per 10 years), and are likely to have inherent statistical instability over time.*

Taking into consideration those ZIP codes with the highest infant mortality rates over the ten-year period under consideration, that is the number of deaths per 1000 live births, the ZIP codes that stand out are 53206, 53210, 53225, and 53216 (53233 was not taken into consideration due to the potential for statistical instability).

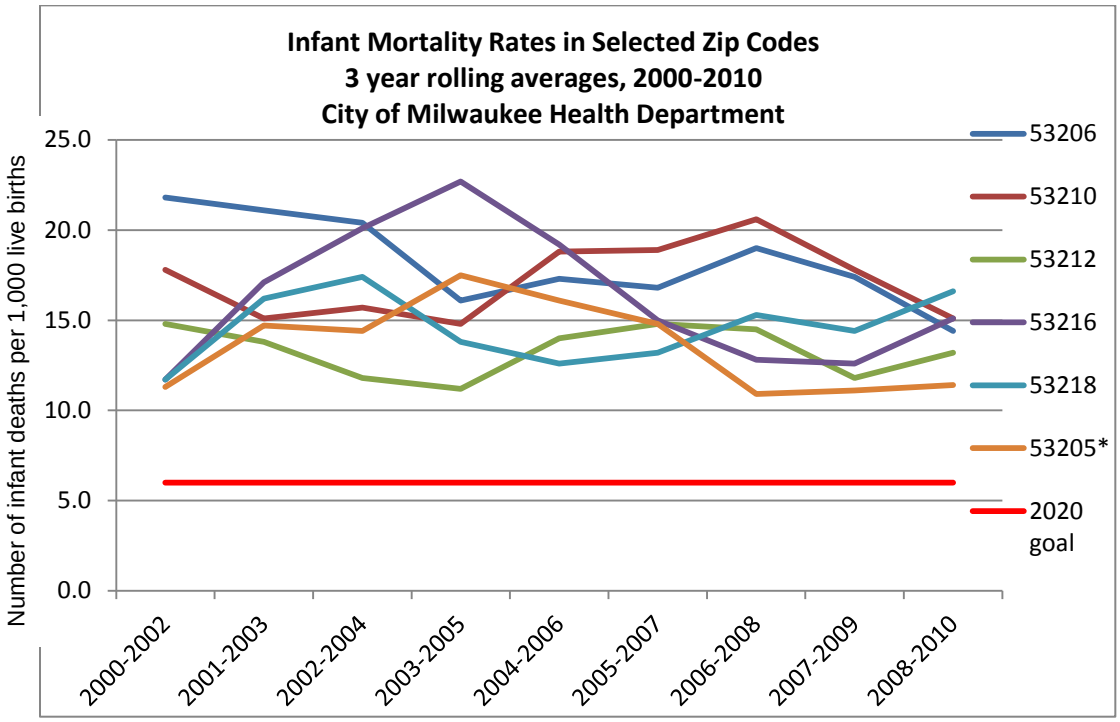


Source: Milwaukee Health Department, 2011

* *Rates and totals for zip codes with between 150-300 live births per year on average (1500-2999 births per 10 years), and may have some inherent statistical instability over time.*

** *Rates and totals for zip codes with between 100-150 live births per year on average (1000-1499 births per 10 years), and are likely to have inherent statistical instability over time.*

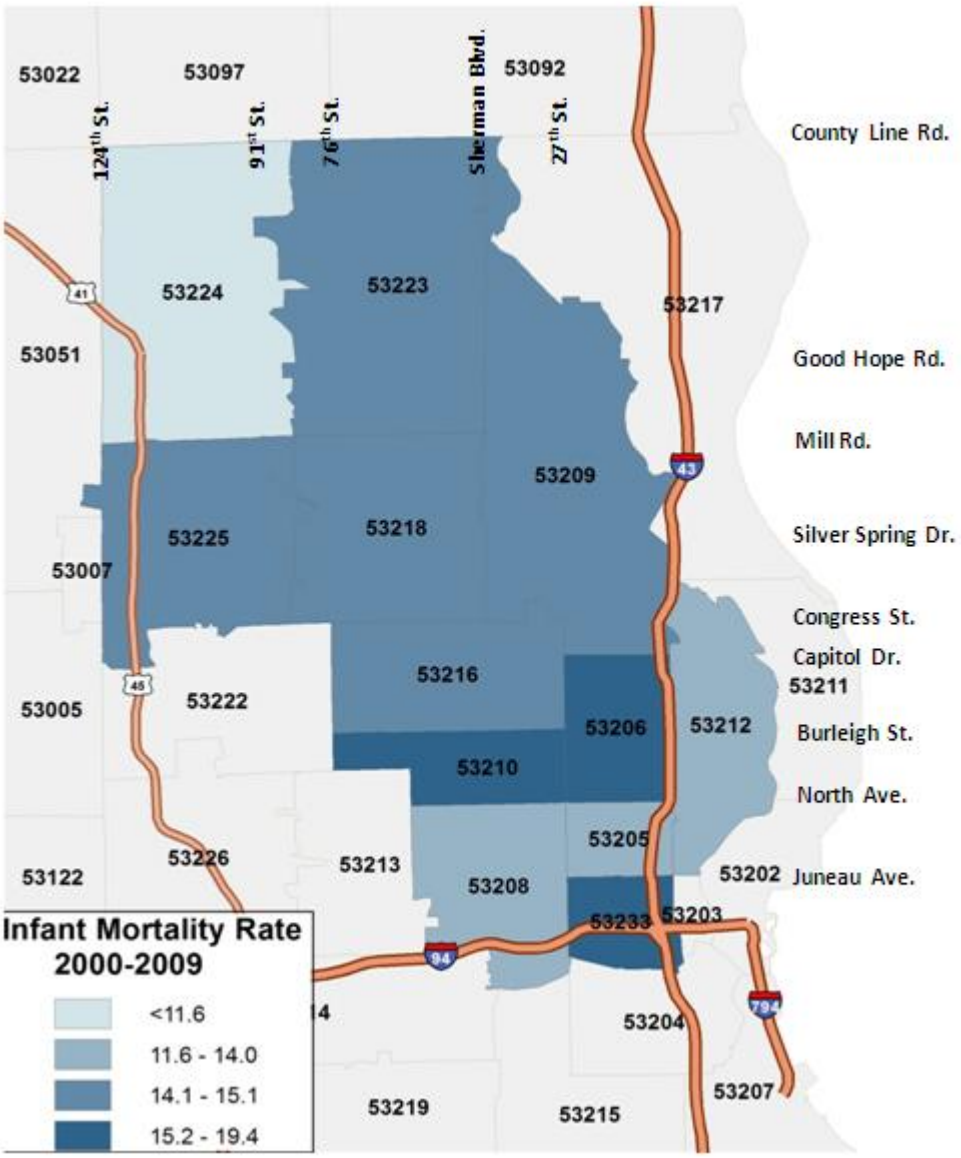
Lastly, Milwaukee LIHF looked at how all these ZIP codes trended over the ten-year period. While the highs and lows are significant, it is important to look at the overall trend from where the ZIP codes started in 2000 to where they ended in 2009. The Collaborative noted that while the infant mortality rate in some ZIP codes such as 53210 and 53206 appears to be decreasing, it is still quite high.



** Zip code with high infant mortality rate but <300 live births per year*

CITY OF MILWAUKEE INFANT MORTALITY RATES – MOST HIGHLY IMPACTED ZIP CODES

2000 – 2009



Throughout the past 20 years great advances have been made in caring for premature infants and in reducing the incidence of preterm labor, two of the major risk factors for infant mortality. Despite these advances, the disparity in infant mortality among black and white infants has continued to grow as implementing single-focus programs, such as improved prenatal care and educational programs, for the entire population have been found to differentially benefit white women. Focusing solely on prenatal care ignores the socioeconomic contexts in which women live, medicalizes a problem that is socially and historically complex, and thus contributes to the illusion that there is a "medical policy bullet" that can provide a comprehensive and efficacious solution.[24] Additionally many interventions reflect a lack of culturally sensitive messages, culturally competent delivery and variations in health literacy, and reveal differences in the quality of care delivered. Even access to greater formal education for black women is unlikely to overcome a life of high stress due to poverty and racism.[25]

Since neither advances in technology nor implementation of single-focus programs has been able to reduce the racial disparity in infant mortality between blacks and whites, a different approach is needed. Improving maternal and infant health will likely require the "re-conceptualization of prenatal care as part of a longitudinally and contextually integrated strategy to promote optimal development of women's reproductive health not only during pregnancy, but over the life course".[26] In order to begin this process of re-conceptualization a focus on upstream factors such as racism, income, education, urban planning, and policies regarding housing and employment will be critical to the improvement of the health of Milwaukee as well as to the reduction of health disparities.[27]

To this end the Lifecourse Initiative for Healthy Families (LIHF) is currently working on addressing the issue of racial disparities in infant mortality in the cities of Milwaukee, Kenosha, Beloit and Racine. LIHF is employing the lifecourse perspective as a framework for addressing the issue of infant mortality.

It is nearly impossible for Wisconsin as a whole to be healthy if Milwaukee is not, and Milwaukee as a whole cannot be healthy when an entire group of its citizens is losing infants at a greater rate than many third world countries. It is hoped that by using a 'whole-person, whole-family, whole-community systems approach' instead of the current single intervention approach, racial disparities in infant mortality in Milwaukee can be eliminated. The process will not be easy, and it will take collaboration between health care systems, public health professionals, businesses, community groups, residents and policymakers, to attend to the necessary upstream social and economic causes of the disparity in infant mortality rates[28], but it is a necessary process to ensure the health of future generations of Milwaukeeans of all races.

[24] Ford, B.C., Dalton, V.C., Lantz, P.M., Lori, J., Rodseth, S.B., Ransom B.M., and Siefert, K. (2005). *Racial disparities in birth outcomes: poverty, discrimination, and the life course of African American women*. University of Michigan. Retrieved from: http://www.rcgd.isr.umich.edu/prba/perspectives/fall2005/ford.pdf
[25] Byrd. (2007).
[26] Ford. (2005).
[27] Vila, P.M, Swain, G.R., Baumgardner, D.J., Halsmer, S.E., Remington, P.L., & Cisler, R.A. (2007). Health disparities in Milwaukee by socioeconomic status. *Wisconsin Medical Journal, 106(7),* 366-372.
[28] Vila. (2007).

B. Health of African American Women over the Lifespan

Overview of the Health of African American Women

Many people tend to think of poverty, limited education, poor personal health behaviors, and limited access to health care as the main factors accounting for the disparities in overall health that exist between white and black Americans. However, these variables do not fully account for the disproportionately high rates of adverse birth outcomes in African Americans. As was discussed in the previous section of this report, disparities in birth outcomes between whites and African Americans exist at all socioeconomic levels, even after controlling for health behaviors.

One of the leading theories that attempts to explain these disparities is the lifecourse perspective. Briefly, the lifecourse perspective points to broad social, economic and environmental factors as underlying causes of persistent inequalities in health. It emphasizes that today's experiences and exposures influence tomorrow's health, and that there is a cumulative impact of multiple stresses over time that directly impact health and development. There is also an emphasis on critical time periods (fetal development, early childhood and adolescence) at which adverse events and exposures have the greatest impact on a person's health, and the idea that the broader community environment (biologic, physical and social) strongly affects an individual's capacity to be healthy.[29] This theory is explained in further detail in Section II.E.

Researchers working within the lifecourse theory have created a growing body of evidence that the deleterious effects of maternal stress—accumulated over an entire lifetime—may be causing the unusually high rate of negative birth outcomes among African Americans.[30]

Maternal stress can have a direct impact on birth outcomes by altering physiological functioning and indirectly through the influence of negative health behaviors.[31] A variety of psychological stresses have been found to increase risk for decreased birth weight. These include the death of mother or sister of a pregnant woman during gestation, neighborhood safety, stressful life events, living in a neighborhood with high crime and deprivation, general or pregnancy-related anxiety, poverty and racism.[32] [33] These cumulative stressors cause stress responses and changes in health behaviors that result in preterm delivery. In a study of 104 African American women, the experience of racial discrimination, specifically, was found to be an independent risk factor for preterm birth.[34]

Racism is an additional form of stress that African Americans encounter simply because of the color of their skin. Experiencing racism can negatively affect a person's psychological and physiological functioning, independent of general stress variables, likely because it is undeniably negative, demeaning, and provokes a threatening reaction to an immutable personal characteristic. Perceived racism across the lifetime, especially during childhood, predicts birth weight in African Americans and helps to account for racial differences in birth weight, after controlling for medical and sociodemographic risk factors. It is thought that racism experienced during childhood is most predictive of having a low birth weight baby due to the initiation of a heightened threat perception,

[29] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2010 October). *Rethinking MCH: The Lifecourse Model as an Organizing Framework: Concept Paper.* Retrieved from: http://mchb.hrsa.gov/lifecourse/rethinkingmchlifecourse.pdf

[30] Giscombe. (2005).

[31] Dailey, D. (2009). Social stressors and strengths as predictors of infant birth weight in low-income African American women. *Nursing Research, 58(5),* 340-347. PMID:19752674

[32] Dailey. (2009).

[33] Gennaro, S., Shults, J., & Garry, D.J. (2008 September). Stress and preterm labor and birth in black women. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 37(5),* 538-544. DOI: 10.1111/j.1552-6909.2008.00278.x

[34] Gennaro. (2008).

which triggers a chronic state of hyperarousal beginning in childhood and continuing throughout the lifecourse. For each significant event of perceived racism experienced during childhood there was found to be a 167.85 g decrease in birth weight, resulting in an African American baby weighing, on average, 340.55 g (0.75 lbs) less than their white counterparts, even at term. While this may seem like a trivial reduction in birth weight, this difference has important clinical implications including: decreases in cognitive function, ocular development, and school performance.[35]

Not only does racism experienced during childhood negatively affect birth outcomes, but racism experienced during pregnancy is also detrimental. When previous pregnancies, late or no prenatal care, social support, tobacco, alcohol, and drug use are controlled for, the odds of an African American giving birth to a very low birth weight (<1500g) infant if she has experienced racism during the pregnancy is 3.3 times higher than if she did not experience racism during her pregnancy. Not surprisingly, the more domains in which an African American woman experiences racism (i.e. school, medical care, service at a restaurant/store, work and housing) increases her odds of delivering a very low birth weight infant. Additionally, there is a 1.4 fold increased risk of spontaneous preterm birth among African American women who experience high levels of racism throughout their lifecourse, compared to those who report no experiences of racism. This effect is independent of the association of preterm birth with pregnancy-related anxiety and negatively appraised life events, suggesting that effects of racial discrimination are distinct from other forms of prenatal stress.[36]

This chronic stress experienced by African American throughout their lives leads to physiologic changes in the body that contribute to preterm birth and low birth weight infants, thereby increasing the incidence of infant mortality. It has been proposed that psychological stress may decrease birth weight by altering mechanisms in place during normal pregnancy to protect the fetus from stress-related hormones, such as corticotrophin releasing hormone (CRH). Maternal stress can increase the release of CRH, thereby precipitating the biologic cascade that leads to the onset of preterm labor.[37] Fetal CRH normally increases over gestation, but preterm babies have been found to have much higher levels than is normal for their gestational age.[38]

The impact of maternal stress on vascular functioning is another proposed explanation for disparities in birth outcomes between African Americans and whites. African Americans are more likely to have exaggerated cardiovascular reactivity to stress compared with whites. Current and past exposure to racism have been found to influence cardiovascular reactivity and hypertension, predicting higher blood pressures throughout pregnancy. Additionally, in the United States both nonpregnant and pregnant African American women have higher rates of hypertension than do white women at all ages. In one study, African American women were found to be twice as likely as white women to enter their pregnancies with preexisting hypertension. This increased blood pressure reactivity to stress in pregnancy results in vasoconstriction, causing a decrease in uterine blood flow and fetal hypoxia, which leads to elevations in CRH and increased risk for preterm delivery. Uteroplacental vascular insufficiency related to hypertension during pregnancy may also result in intrauterine growth retardation and subsequent low birth weight.[39]

Another hypothesized effect of maternal stress on poor birth outcomes is related to immune function during pregnancy. Normally, pregnancy is accompanied by an overall decrease in immune function

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[35] Dominguez, T.P., Dunkel-Schetter, C., Glynn, L.M., Hobel, C., & Sandman, C.A. (2008 March). Racial differences in birth outcomes: the role of general, pregnancy and racism stress. *Health Psychology, 27(2),* 194-203. PMID: 18377138

[36] Giscombe. (2005).

[37] Lu, M.C. & Chen, B. (2004 September). Racial and ethnic disparities in preterm birth: the role of stressful life events. *American Journal of Obstetrics and Gynecology, 191(3),* 691-699. PMID: 15467527

[38] Holland, M.L., Kitzman, H., & Veazie, P. (2009 November). The effects of stress on birth weight in low-income, unmarried black women. *Women's Health Issues, 19(6),* 390-397. PMID: 19879453

[39] Giscombe. (2005).

and for African American women their immune function is further compromised due to the additional reduction in immunity from chronic stress. These reductions in immunity leave African American women more susceptible to infections during pregnancy and thus increase the probability of having a poor birth outcome. High levels of chronic stress during pregnancy have been shown to be associated with urogenital infection, increasing women's risk for adverse birth outcomes, even after adjusting for sociodemographic and behavioral risk factors. Urogenital infections during pregnancy are associated with amniotic infections, premature rupture of membranes, and subsequent preterm delivery. African American women have a disproportionately higher prevalence of urogenital tract infections even after statistically controlling for possible confounders, such as sexual behavior, number of partners, and hormonal status. A recent study compared pregnant women with differing levels of perceived stress to their risk of having bacterial vaginosis during pregnancy. They found that compared to the women in the low stress group the risk of having bacterial vaginosis was 2.4-fold higher in the high stress group, 2.5-fold higher in the moderate-to-high stress group, and 1.4-fold higher in the low-to-moderate stress group. The results from this study provide evidence that chronic maternal stress is significantly and independently associated with urogenital infection, specifically bacterial vaginosis (a urogenital infection associated with an increased risk of preterm delivery), even after controlling for maternal age, marital status, SES, ethnicity, and behavioral practices, such as douching, drug use, and sexual activity.[40]

In order to effectively reduce poor birth outcomes in African Americans, interventions need to consider the interactions among stressful life events, susceptibility to these stressful life events and the contextual factors that increase exposures to stress. The greater risk of African American women to preterm delivery, and thus increased infant mortality, is linked to increased exposures to stressful life events not only just before and during pregnancy but also to early life stressors and the accumulation of these stresses over the lifecourse.[41] The most efficacious interventions to decreasing racial disparity in birth outcomes will need to address ways to reduce the chronic stress that African American women face throughout their life, beginning in childhood.[42]

[40] Giscombe. (2005).
[41] Lu. (2004).
[42] Dailey. (2009).

C. General Description of Social Determinants of Health

The World Health Organization (WHO) defines the social determinants of health as the conditions in which people are born, grow up, live, work and age.[43] These conditions influence a person's opportunity to be healthy, his/her risk of illness and life expectancy. In simpler terms, it is the concept that socioeconomic factors can determine profoundly different levels of health and disease in a community. A person's health is determined by the health and social services they receive, and their ability to obtain quality education, food and housing, among other factors. Contrary to the assumption that people have personal control over these factors, these living conditions are often imposed by the quality of the communities, housing situations, work settings and employment opportunities, access to healthcare facilities, social service agencies and programs, and educational institutions in the community.[44] [45]

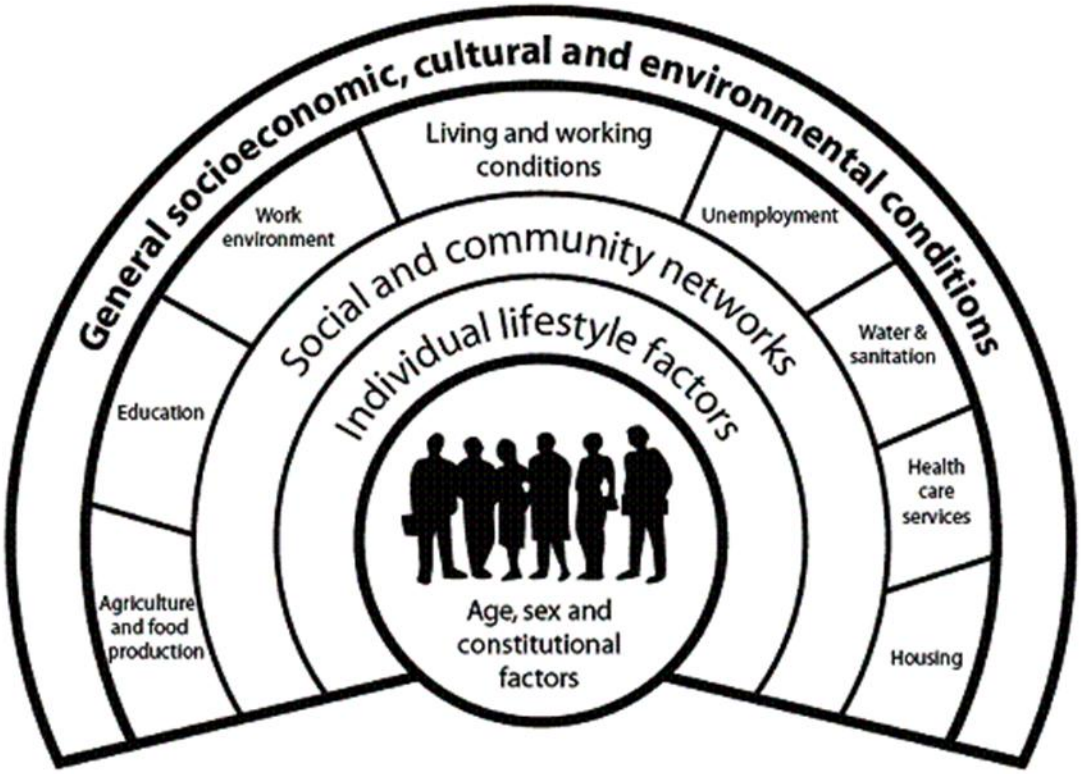


Fig1: **Dahlgren and Whitehead Socioecological Model of Determinants of Health 1991.**[46] The socioecological model recognizes that the social and economic conditions in which individuals live their lives have a cumulative effect upon their probability of developing disease in the future.

[43] World Health Organization. Social Determinants of Health. Retrieved from: http://www.who.int/social_determinants/en/.
[44] Marmot, M. (2005 March). Social determinants of health inequalities. *Lancet, 365(9464)*, 1099-104. DOI:10.1016/S0140-6736(05)71146-6
[45] Marmot M. (2001 November). Economic and social determinants of disease. *Bulletin of the World Health Organization, 79(10)*, 988-9. PMID: 11693982
[46] Dahlgren, G. & Whitehead, M. (1991). Policies and strategies to promote social equity in health. Stockholm: Institute for Future Studies. Retrieved from: http://www.hiaconnect.edu.au/healthy_public_policy.html

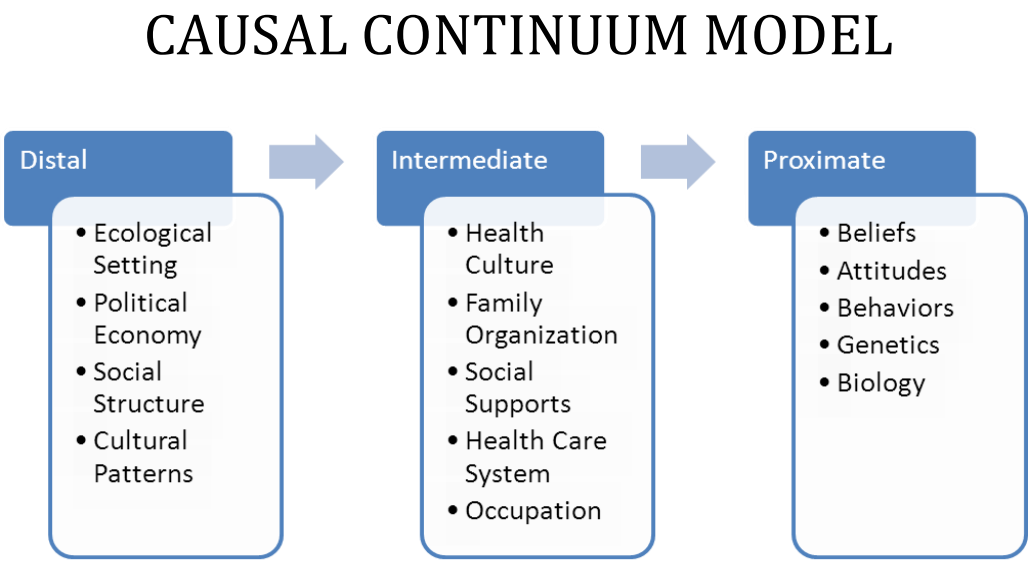
In the socioecological model of health, intrapersonal influences are at the core of the model and include biological and physical factors such as personality, cognition or genetics. Personal behaviors and ways of living that can promote or damage health are also considered at this level.

The second layer of the model takes into account interpersonal processes and relations with primary social groups such as the home, family or peer groups. These influences can provide mutual support for members of the community in unfavorable conditions.

The third layer recognizes the importance of institutional factors such as work and school settings, civic associations and health care organizations. Other factors such as ethnicity, social class, social capital, public facilities and the built environment also play a role.

At the most general level the model acknowledges public policy, cultural values, economics, and education as macro influencers of health across the population.

A framework related to the socioecological model, the Causal Continuum, further classifies risk factors as distal, intermediate or proximate to highlight the relative directness of their effects.[47] There are several complex, multilevel schema, such as the "web of causation," but for simplicity a more straightforward model is shown in Figure 2.



Source: Coreil, J. Social and behavioral foundations of public health. 2010.

The social determinants of health for the population of interest to the Milwaukee LIHF project, African American women living in the City of Milwaukee, are discussed at length in other parts of this report, however two of these risk factors are explained below in general terms to acquaint the reader with the model.

[47] Coreil, J. (Ed.). (2009). *Social and Behavioral Foundations of Public Health*. Los Angeles: Sage Publications. P 46-47.

At the interpersonal and community level, education is a socioeconomic determinant of health that is often examined by researchers. Many studies show that people with less education experience poorer health outcomes. For instance, some researchers have found that an individual's health is correlated with their social position, and success in school helps to determine social status in adulthood.[48] Others have found that the first years of a child's life are crucial in establishing learning, literacy and adaptive behaviors that will sustain physical and mental health[49] Positive early experiences have been found to impact development of neural systems and expression of genetics factors that influence the individual's reaction to stress[50] Other studies show that parents with low levels of education tend to do poorly as well if there are not programs in place to help, concluding that child resilience and adult health are influenced by home and school.[51]

Another determinant of health that is often studied is social support networks, in which support from family, friends and communities are generally believed to influence health. Cultural also plays an important role, with beliefs of the family and community shown to have an effect on the health of the individual.[52] A sense of "belonging" in a social network protects health and helps those involved feel valued. Individuals with social support have less risk of mortality from certain diseases and recover more quickly from sickness.[53]

[48] Ross, C.E., & Wu, C.L. (1996). Education, age, and the cumulative advantage in health. *Journal of Health & Social Behavior, 37(1),* 104-120. PMID: 8820314
[49] Kuh, D., Ben-Shlomo, Y., Lunch, J., Hallqyist, J., & Power, C. (2003). Life course epidemiology. *Journal of Epidemiology & Community Health, 57,* 778-783. DOI: 10.1136/jech.57.10.778
[50] Evans, R.G., Barer, M.L., & Marmor, T.R. (1994). *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations.* Piscataway, NJ: Aldine Transaction Press.
[51] Werner, E.E. (1993). Risk, resilience, and recovery: perspectives from the Kauai Longitudinal Study. *Development & Psychopathology, 5(4),* 603-515. DOI:10.1017/S095457940000612X
[52] World Health Organization, Health Impact Assessment. (2011). WHO-The Determinants of Health. *Retrieved from:* http://www.who.int/hia/evidence/doh/en/
[53] Taylor, S. E. (1990). Health psychology: The science and the field. *American Psychologist, 45(1),* 40-50. DOI: 10.1037/0003-066X.45.1.40

D. Background of the Milwaukee LIHF project and planning process

The Wisconsin Partnership Program (WPP) of the University of Wisconsin School of Medicine and Public Health provided funding from spring 2010 through summer 2011 for four communities to carry out a planning process to close the black-white gap in infant mortality. The four communities were: Milwaukee, Beloit, Racine, and Kenosha. The process was to be guided by the Lifecourse Model as described by Dr. Michael Lu, thus the name Life-course Initiative for Healthy Families (LIHF). The goals of the planning process were to build LIHF collaboratives in each target community and to create community action plans to address infant mortality.

In Milwaukee, the LIHF planning process was guided by a steering committee and several task forces whose members represented multiple sectors, including African-American Women and Families; Health Care Providers & Health Care Systems; Federally Qualified Community Health Centers; Medicaid & BadgerCare State Contracted HMOs; Wisconsin Department of Health Services, Division of Public Health; Local Health Departments; Prenatal Care Coordinators & Medicaid Case Management; WIC Programs; Zilber Neighborhood Initiative Project Staff; Local Infant Mortality Experts; Local Health Coalitions; Government & Policy Makers; Business; Faith; Community-Based Organizations; Education; Academics; and Philanthropic Organizations.

The Milwaukee LIHF planning process was organized around three task forces corresponding to the three Lifecourse domains:

- Improving Healthcare for African-American Women;
- Strengthening African-American Families and Communities; and
- Addressing Social Determinants.

In addition, Milwaukee LIHF created an African American task force to provide input and feedback to the domain task forces and take the lead on developing the vision for this action plan. African Americans across generations, including fathers, the faith community, students, funders, and the general public also provided input via listening sessions and attendance at citywide Milwaukee LIHF events.

Approximately 120 community members from a range of sectors and systems attended taskforce and/or steering committee meetings during the Milwaukee LIHF planning process, forming the core membership of the project. An extended circle of more than 400 additional key individuals and organizations signed on as LIHF Supporters, receiving periodic updates, electronic newsletters and invitations to Milwaukee LIHF events, thus broadening the project's community input and ownership. A community kickoff event held in October 2010 to launch the project in Milwaukee was attended by 130 community members, and a mid-term plenary session drew a crowd of nearly 100 individuals in April 2011.

Participation by members of the impacted community not attending as a part of a job responsibility was encouraged by holding most meetings after 5:30 pm, selecting meeting locations on bus lines, offering free child care, and distributing small stipends. As a result of these efforts, 70% of planning process participants were African American.

Two nonprofit organizations—the Planning Council for Health and Human Services and the Women's Fund of Greater Milwaukee—served as co-conveners of the Milwaukee LIHF planning process. The methodology employed by the conveners during the planning process involved having each task force review the life-course strategies in their respective domains through the following lenses:

- What strategies work?
- Which strategies are most effective with the target population?

- Which of these are already operating in Milwaukee?
- Which are most needed in Milwaukee?

Some of the activities pursued by Milwaukee LHF members during the planning process included:

- Viewing the video "Unnatural Causes" at the Community Kickoff Event;
- Viewing the video "Race: The Power of an Illusion" at the Lifecourse Model trainings;
- Learning about data on infant mortality from the Fetal and Infant Mortality Review team;
- Examining conditions in areas of the City of Milwaukee with high infant mortality rates;
- Learning about the Life-course 12 Point Plan to decrease the black-white gap in infant mortality;
- Becoming familiar with evidence-based and promising practices that have the potential to impact the goal areas selected by the task forces;
- Participating in online surveys to prioritize policies; and
- Selecting strategies for eventual inclusion in the final Milwaukee LIHF community action plan.

Another important objective of the Milwaukee LIHF planning process was to engage the larger public around the crisis of infant mortality. Over the course of the 13-month planning process, there were several major events in Milwaukee that centered on infant mortality (Aurora Family Service's Annual Summit, the Women's Fund Social Change Exchange, the Milwaukee Fatherhood Initiative, and the City of Milwaukee's Infant Mortality Summit, to name only a few) which, while not initiated by Milwaukee LIHF, boasted large attendance due in part to the collaborative's publicity efforts. Even more importantly, in January of 2011 the Milwaukee Journal Sentinel began running a yearlong series of articles on the city's black-white infant mortality gap. These articles have been featured on the front page of several Sunday editions, and have included tie-in articles and opinion pieces during the week. Volunteer leaders of Milwaukee LIHF, along with Planning Council and Women's Fund staff associated with the project, were interviewed for these stories. Additionally, Milwaukee LIHF created a virtual space (http://milwaukee-lihf.wikispaces.com/) to provide easy public access to information, conducted radio and television interviews, and regularly provided different community groups with project updates.

To engage emerging leaders, medical students and other young people, Milwaukee LIHF worked in partnership with Public Allies, the Medical College of Wisconsin's Urban and Community Health service learning program, Alverno College's Nursing Program, and the University of Wisconsin Madison School of Medicine and Public Health's TRIUMPH program. Public Allies, in particular, did an outstanding job, presenting the video "Unnatural Causes" to 140 individuals at seven community sites in diverse neighborhoods.

Another important aspect of the work done during the planning process involved collaborating with the WPP LIHF Senior Program Leader and other academic partners, as well as the other LIHF communities in the region and other state and national experts. The commitment of the WPP to a new way of grantmaking, to the regionalized effort, and to staying open to suggestions from the field, made this a unique opportunity for all involved.

Milwaukee LIHF successfully organized a well-structured collaborative with the ongoing and dedicated participation of representatives including health care systems, the City of Milwaukee Health Department, the Medical College of Wisconsin, the Women's Fund, the Fatherhood Initiative, the YWCA, the Black Health Coalition, the Greater Milwaukee Committee, United Way, the Zilber Foundation, the Faith Partnership Network and, importantly, African American families who have been directly affected, people *are* working together. The conversation is deeper and broader; the collective impact more certain.

E. Description of Life-Course Theory and 12-Point Plan

The Life-Course Model recognizes that socioeconomic status, race and racism, healthcare, disease status, stress, nutrition and weight status, birth weight, and a range of behaviors affect health outcomes over a person's lifespan. According to Dr. Michael Lu—an obstetrician and public health professor at the University of California, Los Angeles, who has been at the forefront of studying the differences in birth outcomes for African-American women—inequities that accumulate even before women get pregnant can affect their lifecourse:

> "I was looking at factors that had always been proposed to explain the disparities, such as differential access to prenatal care, socioeconomic differences, and none seemed to explain very much. That's when my colleagues and I applied the life course perspective. The whole idea is that each stage of life is influenced by all the life stages that preceded it. The disparities in birth outcomes therefore are not just simply differential exposures during pregnancy, but really all the inequities that accumulated even before (women) get pregnant." [54]

Life-course theory helps explain health and disease patterns—particularly health disparities—across populations and over time. Early studies in Norway and the UK showed that areas with high infant mortality in the early 20th century correlated strongly with coronary heart disease mortality rates 70 years later.[55] This kind of relation between chronic diseases and socioeconomic deprivation through the life course of an individual has been demonstrated in several other longitudinal studies that have followed individuals over a lifetime.[56]

Based on growing and converging scientific evidence from reproductive health sciences, developmental and neurosciences, and chronic disease research, life-course theory offers several key concepts: [57] [58] [59]

Pathways or Trajectories – Health pathways or trajectories are built—or diminished—over the lifespan. While individual trajectories vary, patterns can be predicted for populations and communities based on social, economic and environmental exposures and experiences. A life course does not reflect a series of discrete steps, but rather an integrated continuum of exposures, experiences and interactions.

Early Programming – Early experiences can "program" an individual's future health and development. This includes prenatal programming (i.e. exposure in utero), as well as intergenerational programming (i.e., the health of the mother prior to conception) that impact the health of the baby and developing child. Adverse programming can either result directly in a disease or condition, or make an individual more vulnerable or susceptible to developing a disease or condition in the future.

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[54] Ghose, Tia. (2011 April 18). Fighting disparities in infant mortality. *Milwaukee Journal Sentinel.* Retrieved from: http://www.jsonline.com/features/health/120032294.html

[55] Forsdahl, A. (2002). Observations throwing light on the high mortality in the county of Finnmark: Is the high mortality today a late effect of very poor living conditions in childhood and adolescence? *International Journal of Epidemiology, 31(2),* 302-8. DOI: 10.1093/ije/31.2.302

[56] Barker, DJ. & Osmond C. (1986 May). Infant mortality, childhood nutrition, and ischaemic heart disease in England and Wales. *Lancet, 327(8489),* 1077-81. DOI:10.1016/S0140-6736(86)91340-1

[57] Lynch, J. & Smith, GD. (2005). A life course approach to chronic disease epidemiology. *Annual Review of Public Health, 26,* 1-35. DOI: 10.1146/annurev.publhealth.26.021304.144505

[58] Lu, MC. & Halfon, N. (2003 March). Racial and ethnic disparities in birth outcomes: A life-course perspective. *Maternal & Child Health Journal, 7(1),* 13-30. PMID: 12710797

[59] U.S. Department of Health and Human Services. (2010). *Rethinking MCH.*

Critical or Sensitive Periods – While adverse events and exposures can have an impact at any point in a person's life course, the impact is greatest at specific critical or sensitive periods of development (e.g., during fetal development, in early childhood, during adolescence, etc.).

Cumulative Impact – Cumulative experiences can also "program" an individual's future health and development. While individual episodes of stress may have minimal impact in an otherwise positive trajectory, the cumulative impact of multiple stresses over time may have a profound direct impact on health and development, as well as an indirect impact via associated behavioral or health service seeking changes. (This concept of cumulative impact is also referred to as "weathering" or "allostatic load").

Risk and Protective Factors – Throughout the lifespan, protective factors improve health and contribute to healthy development, while risk factors diminish health and make it more difficult to reach full developmental potential. Thus, pathways are changeable. Further, risk and protective factors are not limited to individual behavioral patterns or receipt of medical care and social services, but also include factors related to family, neighborhood, community, and social policy. Examples of protective factors include, among others: a nurturing family, a safe neighborhood, strong and positive relationships, economic security, access to quality primary care and other health services, and access to high quality schools and early care and education. Examples of risk factors include, among others: food insecurity, homelessness, living in poverty, unsafe neighborhoods, domestic violence, environmental pollution, inadequate education opportunities, racial discrimination, being born low birthweight, and lack of access to quality health services

Stated more simply, key life course concepts can be summarized as follows:

- Today's experiences and exposures influence tomorrow's health. (Timeline)
- Health trajectories are particularly affected during critical or sensitive periods. (Timing)
- The broader community environment–biologic, physical, and social –strongly affects the capacity to be healthy. (Environment)
- While genetic make-up offers both protective and risk factors for disease conditions, inequality in health reflects more than genetics and personal choice. (Equity)

The life-course model suggests the need to:

- Refocus resources and strategies for a greater emphasis on early ("upstream") determinants of health; incorporate earlier detection of risks coupled with earlier intervention
- Interventions that promote protective factors while reducing risk factors at the individual, family and community levels can change the health trajectory of individuals and populations
- Develop integrated, multi-sector service systems that become lifelong "pipelines" for healthy development.

During the planning phase, the Milwaukee LIHF Collaborative worked on the LIHF health outcomes in the three domains identified by Dr. Michael Lu in his description of the Life-course approach.[60] These domains encompass broad areas of intervention within which Dr. Lu made twelve specific recommendations that constitute a comprehensive strategy to eliminate racial and ethnic disparities in birth outcomes. This "12-Point Plan" addresses many of the factors identified in the Life-course Health Development Model and serves as the basis of the Wisconsin Partnership Program's Community Action Planning Grants, the primary funder of the Milwaukee LIHF planning process.

[60] Aronson, RA. (2008 February 8). *Elimination of Racial and Ethnic Disparities in Birth Outcomes in Wisconsin.* White Paper for Wisconsin Partnership Program, Special Funding Initiative. Retrieved from: http://www.med.wisc.edu/files/smph/docs/community_public_health/partnership/targeted_initiative/partnership_elimination_of_disparities.pdf

- **To improve health care for African American women over the lifespan**
  1. Provide interconception care to women with prior adverse pregnancy outcomes
  2. Increase access to preconception care for African American women
  3. Improve the quality of prenatal care
  4. Expand healthcare access over the life-course

- **To strengthen African American families and communities**
  5. Strengthen father involvement in African American families
  6. Enhance service coordination and systems integration
  7. Create reproductive social capital in African American communities
  8. Invest in community building and urban renewal

- **To address 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

Following consideration and examination of the relevant strategies of the 12-point plan and their current status in the City of Milwaukee, members of each domain task force identified the most promising strategy in each domain as follows:

- Expand healthcare access over the life-course;

- Strengthen father involvement in African American families; and

- Reduce poverty among African American families.

These recommendations were disseminated to multiple stakeholders for input and review (see Section IV.B.2. for a full description of the vetting process) and final approval by the Steering Committee.

Focusing the task forces on the LIHF domains and related strategies familiarized members to the Life-course model and allowed them to examine how the Life-course model applied to the Milwaukee community.

III. Community Description

***We cannot ignore the effect of environmental issues in Milwaukee city neighborhoods on black infant mortality*.**
– Participant at a Milwaukee LIHF task force meeting, 2010

A basic tenet of the Life-course model is that community-level factors, such as ethnicity and socioeconomic status, are important factors that need to be taken into consideration when framing an understanding of the health status of individuals within the community. This section of the report will examine a few of the most important community-level factors in Milwaukee both historically and currently.

A. Community Conditions, Assets and Gaps

1. Basic Demographics and other health and social descriptors

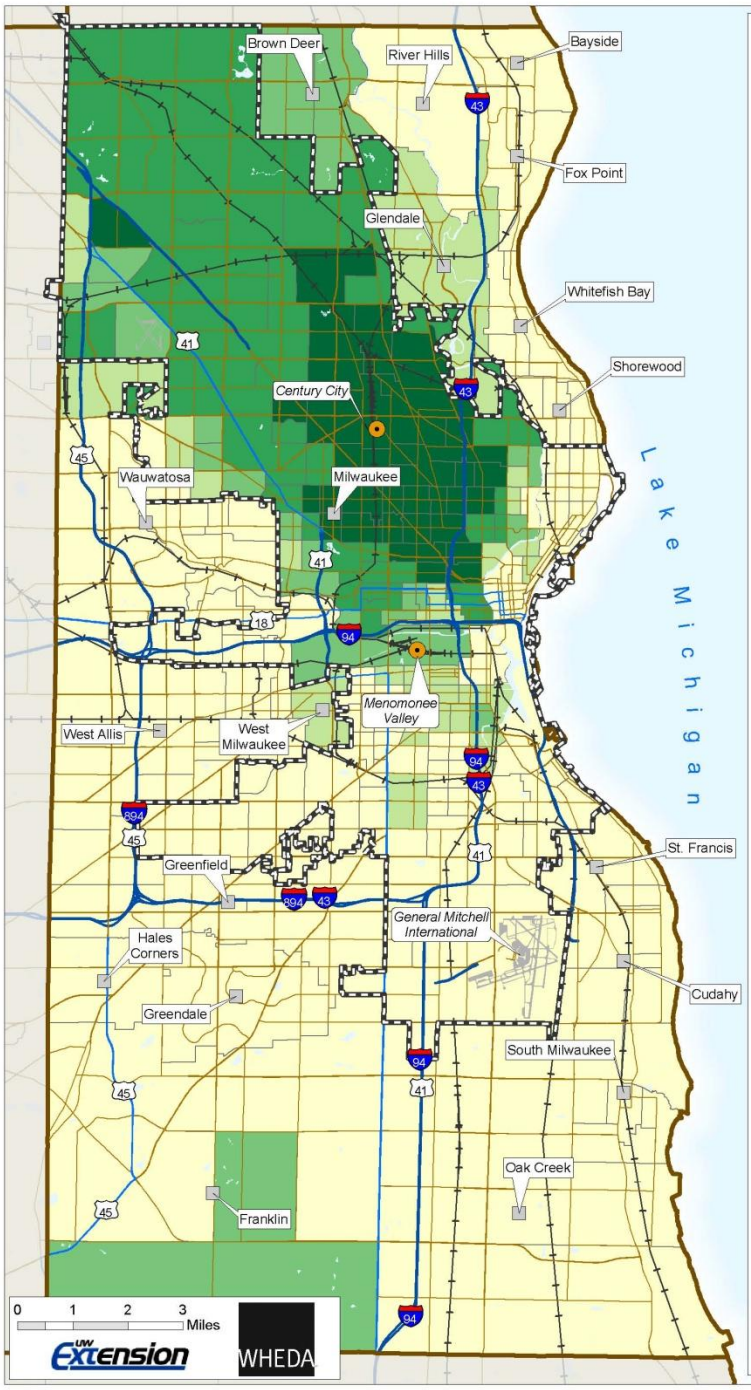
Milwaukee is the largest city in the state of Wisconsin, with an estimated 603,338 residents. Nearly half of the population is white (48.8%) and more than one-third is black or African American (37.5%).[61] The median age of Milwaukeeans is 31 years. Eight percent of residents are children under the age of five (8.3%); for African Americans this percentage increases to nearly one in ten (9.9%).[62] Since 1990, the city's population has been trending downward, and its minority population has been increasing, so that during the 1990's, it became a majority-minority city. According to a recent UWM study, the city's white population fell from 61 percent of the city's total population in 1990 to 40 percent in 2008 (the largest percentage decline in white population during this time period of any city in the study).[63]

The Milwaukee LIHF Collaborative, upon examination of a variety of indicators, has decided to focus its efforts on certain central city ZIP codes. These ZIP codes contain the highest concentration of African American population in the city. The data, which will be detailed in subsequent sections of this report, show these ZIP codes have larger numbers of total residents, higher rates of infant mortality, lower average household incomes, higher male unemployment, and (where data is available) higher numbers of residents that are involved in the corrections system. Maps of the city and of these ZIP codes are included on the following pages.

[61] US Census Bureau. American Community Survey 2005-2009.
[62] US Census Bureau. American Community Survey 2005-2009.
[63] Rast, J. (2010 December). *The Economic State of Milwaukee, 1990-2008*. Retrieved from University of Wisconsin-Milwaukee, Center for Economic Development website: http://www4.uwm.edu/ced/publications/milwecon_2010.cfm

Black or African American Residents as a Percent of Total Population

2010 Census Figures by Census Tract



Black or African American Residents as a Percent of Total Population (2010)

- 0.0% to 10.0%
- 10.1% to 20.0%
- 20.1% to 40.0%
- 40.1% to 80.0%
- 80.1% to 96.3%

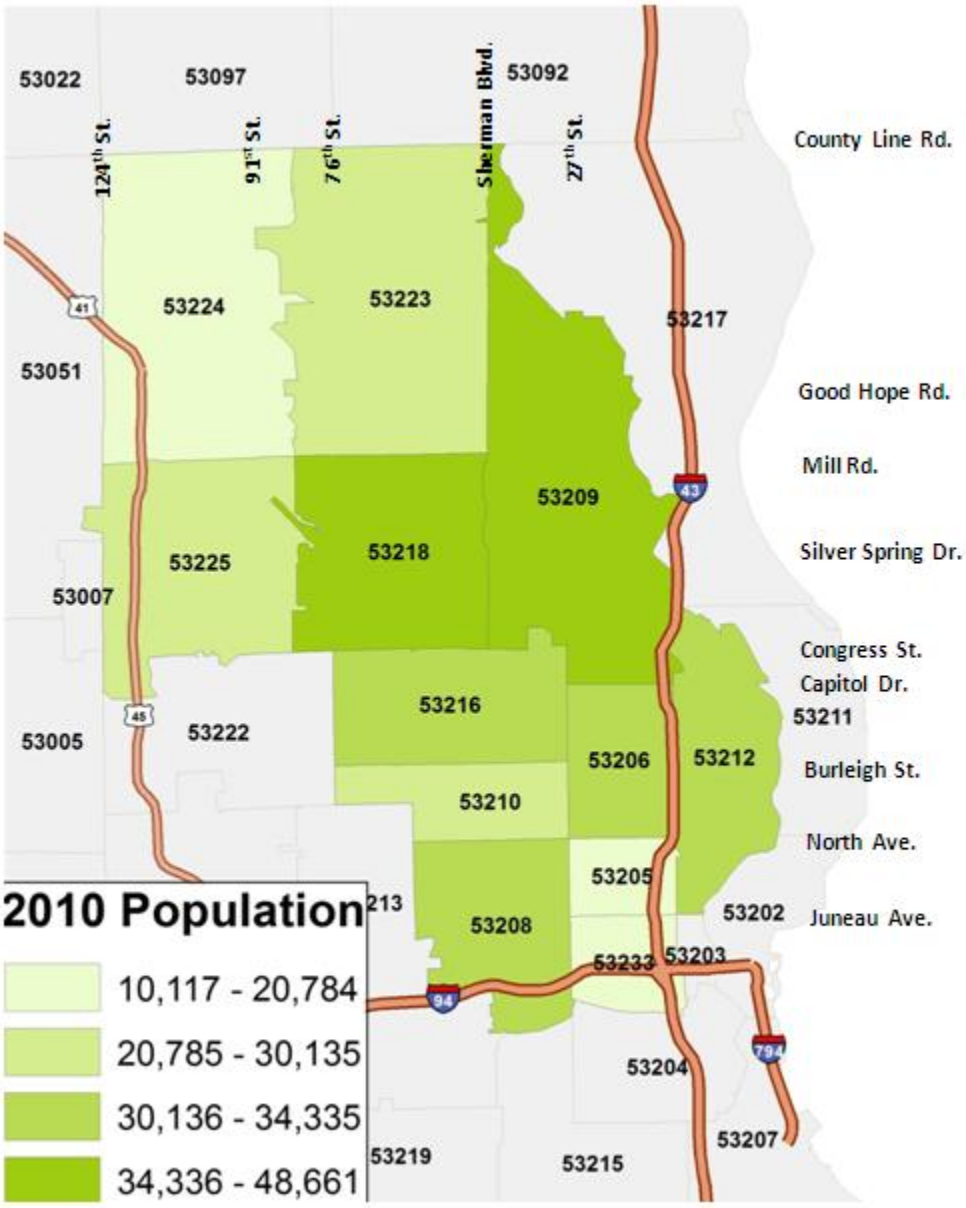
Other Features

- Limited Access Highway
- Other Highway
- Major Road
- Railroad
- City of Milwaukee Boundary
- County Border
- City or Village Centroid

Area	Percent Black or African American
City of Milwaukee	40.0%
State of Wisconsin	6.3%
United States	12.6%

Data Sources: U.S. Census Bureau, 2010 Census and University of Wisconsin-Extension
Center for Community & Economic Development
Map Production: December 2011

Milwaukee's Total Population, Selected ZIP Codes – 2010

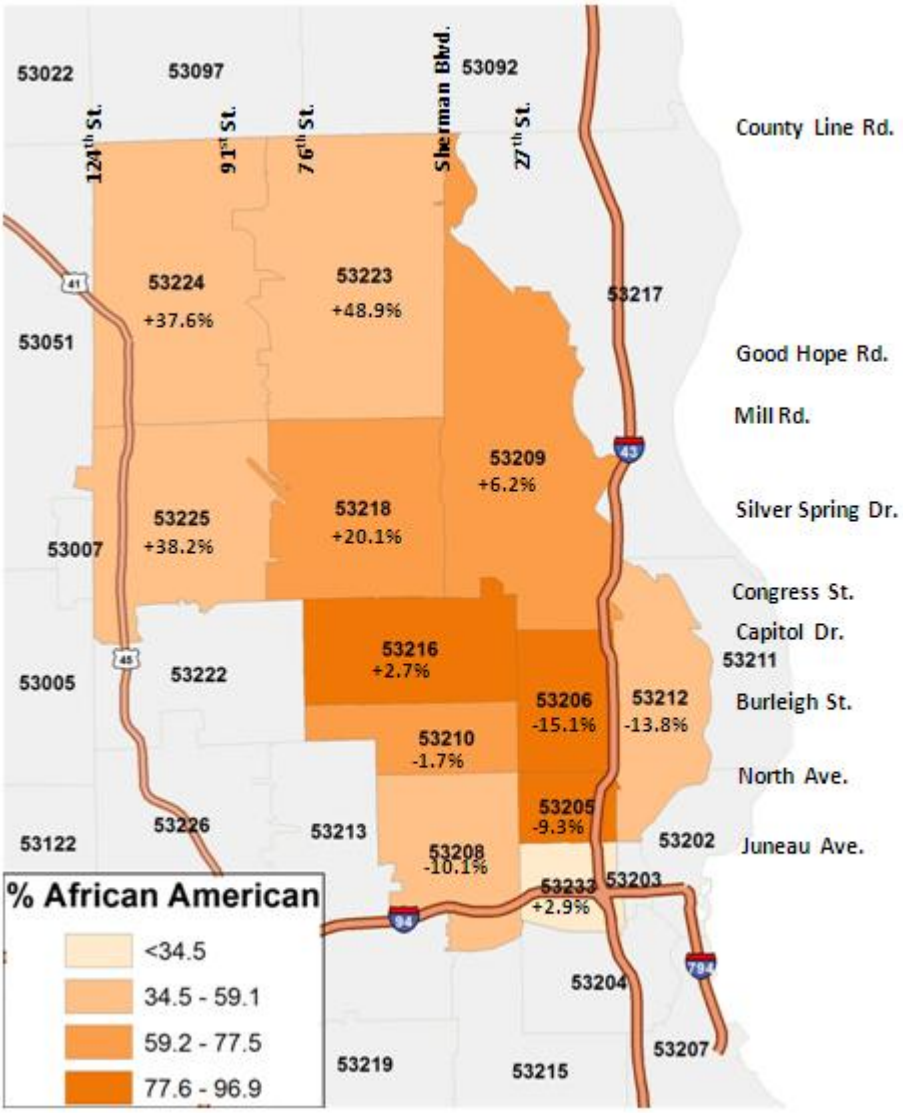


Population data retrieved from www.zip-codes.com on October 11, 2011.

Milwaukee's African American Population – Selected ZIP Codes

2010

The number below each zip code represents the percent increase or decrease in the African American population for that zip code since the 2000 Census.

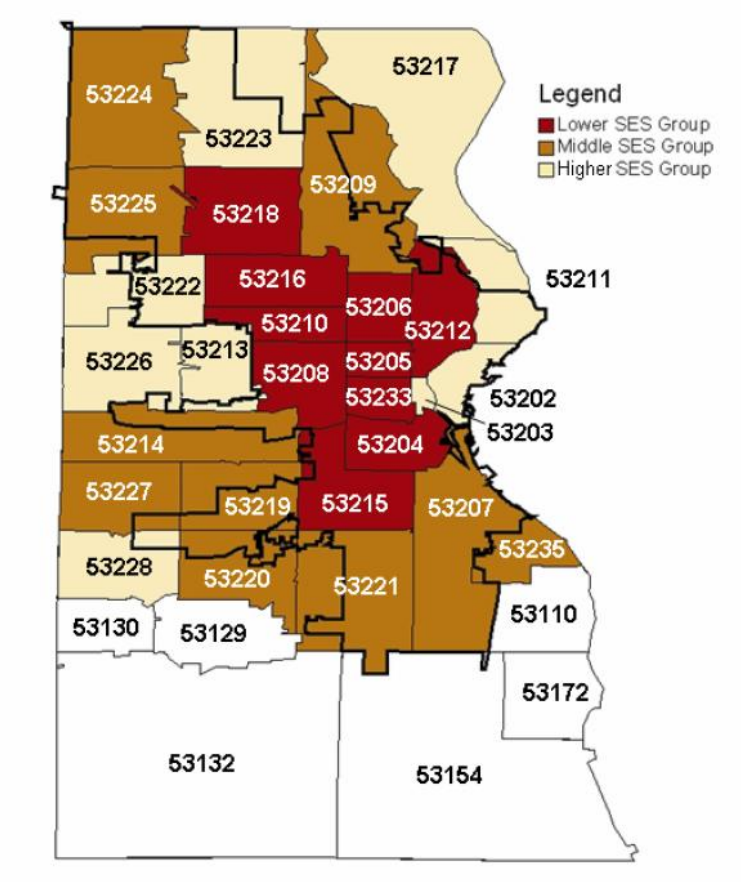


Population data retrieved from www.zip-codes.com on October 11, 2011.

Percent change based on 2000 and 2010 U.S. Census Data (Single Race Reported) retrieved on November 6, 2011 http://factfinder2.census.gov

Milwaukee is highly segregated along socioeconomic lines, as shown in the most recent Milwaukee Health Report, which annually examines city health measures and stratifies the data into three groups by lower, middle and higher socioeconomic status (SES). The researchers note in the 2011 report that the ZIP codes in the lower SES group are all clustered within the central and near-northwest portions of the City of Milwaukee, while the higher SES group was found along the outer edge of the city, as seen in the following graphic and table. These two pieces further demonstrate the extreme segregation of the community, showing large disparities in the distribution of education level, age, race/ethnicity, education, housing, and other SES-related measures between the ZIP code groups. And while race is not an indicator of socioeconomic status, the report shows that in Milwaukee, nearly half (48.3%) of individuals living in the lower SES ZIP codes are African American, versus less than one in ten (8.5%) individuals in the higher SES ZIP codes.[64]

Map of the City of Milwaukee by ZIP Code and SES Group[65]



[64] Chen, H-Y., Baumgardner, D.J., Galvao, L.W., Rice, J.P., Swain, G.R., & Cisler, R.A. (2011). *Milwaukee Health Report 2011: Health Disparities in Milwaukee by Socioeconomic Status.* Milwaukee WI: Center for Urban Population Health. Retrieved from http://www.cuph.org/mhr/2011-milwaukee-health-report.pdf

[65] Chen. (2011).

Sociodemographic Characteristics of the City of Milwaukee by SES Group[66]

Characteristics	Milwaukee			Wisconsin	US
	Lower SES group	Middle SES group	Higher SES group		
Population					
Total Population	303,929	285,459	194,584	5,573,578	300,876,796
Square Miles	35.8	72.2	52.2	54,310	3,537,438
Population Density	8,492	3,952	3,728	103	85
Age (years)					
Median Age	27.3	37.2	37.5	36.1	35.3
0 - 17 (%)	32.9	24.0	19.5	25.9	25.9
18 - 64 (%)	59.2	60.3	64.9	61.5	62.2
> 65 (%)	7.9	15.7	15.6	12.6	11.9
Gender (%)					
Male	48.2	47.6	48.1	49.7	49.4
Female	51.8	52.4	51.9	50.3	50.6
Race (%)					
White	31.2	73.7	84.7	88.3	73.0
Black	48.3	18.4	8.5	5.3	12.1
Asian	4.1	2.1	3.3	1.9	4.3
Other Races	16.3	5.8	3.5	4.5	10.6
Hispanic Ethnicity (%)	21.1	6.2	3.3	4.5	15.0
Education (%)					
Less than High School	30.9	15.6	7.6	12.9	17.1
High School	29.7	33.7	18.4	33.5	27.7
Some College	20.9	24.4	20.6	21.9	22.5
Associate Degree	5.1	6.8	5.9	7.7	6.5
College	9.1	13.6	29.5	16.4	16.8
Graduate Degree	4.2	5.7	18.1	7.6	9.4
Language Speaking (%)					
Speaks English	79.3	91.6	91.1	93.9	82.6
Speaks Spanish	16.5	4.2	2.6	3.6	11.6
Income ($)					
Household Income, Median	29,066	45,405	55,935	52,048	49,565
Household Income, Average	38,356	53,988	74,836	64,034	66,816
Housing (%)					
Occupied by Renters	58.2	42.2	45.6	30.1	32.2
Household					
Average Size	2.7	2.2	2.0	2.4	2.5
Parkland as % of Total Land[2]	3.4	3.4	5.6	4.7	N/A

[66] Chen. (2011).

a. Community health indicators & health care access

Wisconsin, and the Milwaukee area in particular, face significant challenges related to the health of the people who make the area their home. Rates of binge drinking, obesity and chronic disease much higher than the national average[67] are facts of life that negatively impact the health of the citizenry of the state.

At the state level, "health disparities" as well as "social, economic, and educational factors that influence health" have been named by the Department Of Public Health as the "overarching focus areas" for the Healthiest Wisconsin 2020 plan. However, there may not be adequate funding available to address many of the goals of this plan, since public health services in Wisconsin are heavily dependent on federal funding and the local tax levy (which together make up 75 percent of the funding[68]). Quoted below are some of the challenges and inherent problems associated with heavy reliance on these two funding sources according to a Healthiest Wisconsin 2020 profile on public health funding in the state:

- *All federal revenue is categorical: if priorities and appropriations change at the federal level, it directly affects the capacity of Wisconsin public health programs and the workforce needed to provide health protection and health intervention for serious health disparities that affect the quality of life for all people in Wisconsin. Such changes affect Wisconsin's ability to rapidly respond to current and emerging threats to the health of the public.*
- *If significant decreases in federal funding occur, which is likely given the national economic picture, state and local health departments will need to drastically reduce the services they provide. For example, reductions in the Maternal and Child Health Block Grant during the last presidential administration (years 2000 -2008) made it more difficult for the state and local health departments to meet the health needs of mothers and infants in Wisconsin.*
- *Because state and local funding for public health is small, and decreasing, governmental public health departments and their public health system partners are finding it difficult to fulfill effectively their mission to improve health in Wisconsin. Gains made in the past may be lost*.[69]

Within the state, Milwaukee County is one of the least healthy counties. In the 2011 County Health Rankings (produced by the UW Population Health Institute in collaboration with the Robert Wood Johnson Foundation), Milwaukee County ranked 69th out of the 72 Wisconsin counties in overall health outcomes (mortality and morbidity), and 70th in overall health factors (health behaviors, clinical care, social and economic, and physical environment factors)[70]. Breaking these health factors into their component parts, it can be seen that while there is more access to care in Milwaukee County than in many other areas of the state (although this varies significantly within the county based on the person's SES), socioeconomic factors such as low high school graduation rates and high unemployment rates make the county a very unhealthy place to live for many people.

[67] United Health Foundation. *America's Health Rankings 2010.* Retrieved from http://www.americashealthrankings.org/
[68] Wisconsin Department of Health Services, Focus Area Strategic Team. (2010 July). *Equitable, Adequate, and Stable Public Health Funding.* Retrieved from http://www.dhs.wisconsin.gov/hw2020/pdf/funding.pdf
[69] Wisconsin Department of Health Services. (2010).
[70] County Health Rankings Collaboration. (2011). Wisconsin Overall Rankings. Retrieved from http://www.countyhealthrankings.org/wisconsin/overall-rankings

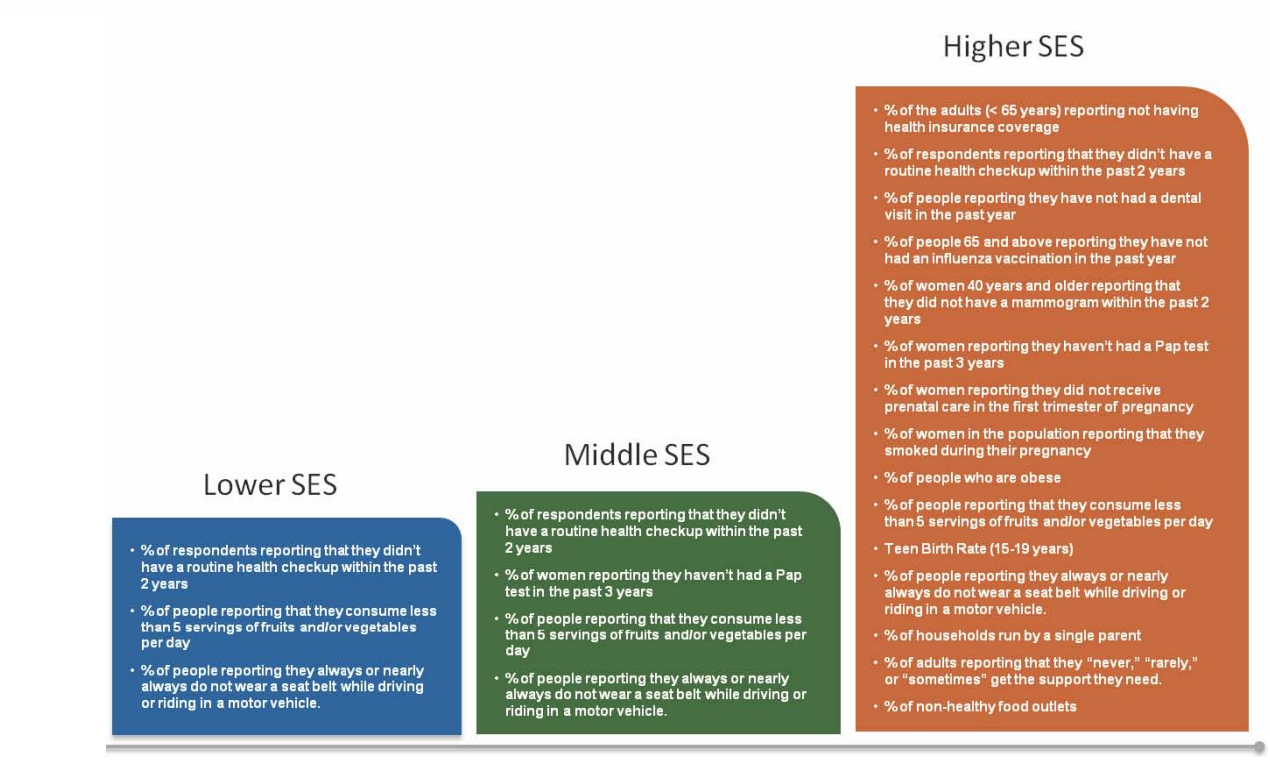
- *Health behaviors include measures of smoking, diet and exercise, alcohol use, and risky sex behavior: Milwaukee County Rank – 64 out of 72*
- *Clinical care includes measures of access to care and quality of care. Milwaukee County Rank – 35 out of 72*
- *Social and economic factors include measures of education, employment, income, family and social support, and community safety. Milwaukee County Rank – 71 out of 72*
- *The physical environment includes measures of environmental quality and the built environment. Milwaukee County Rank – 57 out of 72*[71]

In the City of Milwaukee, large health disparities exist, as detailed in the Milwaukee Health Report, which annually examines a wide variety of city health measures stratified by SES as discussed in section 1a above. Overall, the 2011 report found that "dramatic health disparities by socioeconomic status exist—and persist—within Wisconsin's largest city."[72] The full report contains extensive information on community-level health indicators including mortality and morbidity, access to care, health behaviors, socioeconomic factors and physical environment factors, nearly all of which are worse for residents in the lower SES, as shown in the graphic on the next page.

[71] County Health Rankings Collaboration. (2011). Retrieved from http://www.countyhealthrankings.org/wisconsin/health-factors-rankings
[72] Chen. (2011).

Summary of Milwaukee Community-Level Health Indicators[73]

Indicators that are better than WI and US average, by SES



[73] Chen. (2011).

LIHF
THE LIFECOURSE INITIATIVE for HEALTHY FAMILIES
Supporting Healthy Pregnancies for Healthy Babies
Project of the Wisconsin Partnership Program
University of Wisconsin School of Medicine and Public Health

Summary of Milwaukee Community-Level Health Indicators[74]

Indicators that are worse than WI and US average, by SES

Lower SES

- Premature Death (Years of Potential Life Lost)
- Infant Mortality
- % of people reporting that they feel they are in poor or fair health
- average number of days people reported that their physical health was not good.
- average number of days people reported that their mental health was not good.
- % of live births for which the infant weighed less than 2,500 grams
- % of live births born less than 37 completed weeks of gestation.
- % of adults (,65) reporting not having health insurance coverage
- % of people reporting they have not had a dental visit in the past year
- % of people 65 and above reporting they have not had an influenza vaccination in the past year
- % of 65 years or older respondents reporting that they have never had a pneumonia vaccination
- % of women 40 years and older reporting that they did not have a mammogram within the past 2 years
- % of women reporting they haven't had a Pap test in the past 3 years
- % of women reporting they did not receive prenatal care in the first trimester of pregnancy
- % of people reporting that they currently smoke.
- % of people reporting levels of activity that do not meet the recommended levels of moderate or vigorous physical activity
- % of people who are obese
- Chlamydia Rate
- HIV Infection Rate
- Teen Birth Rate (15-19 years)
- % of households run by a single parent
- % of adults reporting that they "never," "rarely," or "sometimes" get the support they need.
- % of houses that were built before the year 1940
- % of reported cases of childhood lead poisoning
- % of non-healthy food outlets

Middle SES

- Premature Death (Years of Potential Life Lost)
- Infant Mortality
- % of people reporting that they feel they are in poor or fair health
- average number of days people reported that their mental health was not good.
- % of live births for which the infant weighed less than 2,500 grams
- % of live births born less than 37 completed weeks of gestation.
- % of reporting binge drinking
- % of people who are overweight
- % of people 65 and above reporting they have not had an influenza vaccination in the past year
- % of women reporting they did not receive prenatal care in the first trimester of pregnancy
- % of people reporting that they currently smoke.
- % of people reporting levels of activity that do not meet the recommended levels of moderate or vigorous physical activity
- % of people who are obese
- Chlamydia Rate
- Teen Birth Rate (15-19 years)
- % of households run by a single parent
- % of adults reporting that they "never," "rarely," or "sometimes" get the support they need.

Higher SES

- Premature Death (Years of Potential Life Lost)
- % of people reporting that they feel they are in poor or fair health
- average number of days people reported that their physical health was not good.
- % of people reporting that they currently smoke.
- % of people reporting binge drinking
- Chlamydia Rate
- % of houses that were built before the year 1940

[74] Chen. (2011).

Many people in Milwaukee do not receive needed medical and dental treatment. In a recent door-to-door survey of people living within Milwaukee's central city, one-quarter of respondents said there were adults in their household who had not had a medical check-up in the past year. Nearly half (45%) said there were adults in their household who had not had a dental checkup in the past year. This same survey found that children fared slightly better than the adults: 93% of respondents said that all the children in their household had a medical check-up in the past year, and 74% said that all the children in their household had a dental check-up in the past year. Ninety-one percent indicated that all of the children in their household were current with required immunizations. [75]

Quality of care is another concern for Milwaukee's central city residents. In the door-to-door survey, residents reported they were often unhappy with the quality of the care they received. Nearly one in five of those surveyed with chronic or long-term health issues were not satisfied with the treatment available to them, and one out of four who needed medical equipment or supplies were not satisfied, as detailed in the following table.

Prevalence of Medical Issues and Treatment/Service Satisfaction[76]

	Yes	No	Don't Know	IF YES	Yes	No	Don't Know
Chronic or long-term health issues	38%	61%	2%	Satisfied with the medical treatment available?	79%	19%	2%
Need for medical equipment or supplies	31%	78%	2%	Satisfied with the supplies received?	70%	28%	2%

Many of the individuals who are not getting health care, or not getting quality care, may be experiencing a lack of access to care. In fact, more than one-quarter (26%) of respondents to the central city door-to-door survey indicated that they had difficulty navigating the health care system.[77] The reasons why Milwaukeeans lack access to quality care are many, and include financial, personal and structural barriers.

Financial barriers to health care access, such as having no health insurance or being underinsured, affect a large number of Milwaukeeans. Nearly one in five adults (17.9%) in the City of Milwaukee was uninsured in 2010 and this rises to 22.2% for those in the lowest SES.[78] According to the 2009 Milwaukee Community Health Survey Report, African Americans were more likely than white respondents to say they were not covered by health insurance in the past 12 months (28% vs. 18%).[79] The door-to-door survey of central city residents found higher rates of coverage for children: 89% of respondents with children living in their household indicated that all the children in their household had health insurance.[80]

[75] Kovari, J. & Davis, GS. (2010 February). *CSBG Community Needs Assessment - Chapter I.2: Door-to-Door Survey of Milwaukee County Residents.* University of Wisconsin-Milwaukee, Center for Urban Initiatives & Research, and the Social Development Commission. Retrieved from: http://www.cr-sdc.org/DefaultFilePile/PolicyandResearch/Door-to-DoorSurveyReport.pdf
[76] Kovari. (2010).
[77] Kovari. (2010).
[78] Chen. (2011).
[79] JKV Research. (2010). Milwaukee Community Health Survey Report 2009. Report Commissioned by Aurora Health Care. Retrieved from: http://www.aurorahealthcare.org/yourhealth/comm-health-reports/art/2009-milwaukee-health-survey.pdf
[80] Kovari. (2010).

There are also personal barriers to health care access, such as literacy, cultural and language differences that make it hard for some to navigate the health care system.

- Health literacy is defined as "the degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions and services needed to prevent or treat illness."[81] Low health literacy, more prevalent among minority populations and people of low socioeconomic status, can contribute to more emergency room visits and a lower rate of preventive care such as flu shots or mammograms.[82]

- Cultural competency refers to "the ability of health care providers to deliver culturally appropriate services to members of different ethnic and linguistic groups."[83] The degree to which this concept is embraced by health care providers can vary from simply showing patients empathy, to becoming competent about the dominant social and cultural systems in which patients live, to examining the providers' own cultural and organizational background and the assumptions that guide their work.[84] Increasing the cultural competency of health care providers could go a long way toward eliminating health disparities by allowing patients and doctors to come together and talk about health concerns without cultural differences hindering the conversation.[85]

Healthcare access can be further restricted due to structural barriers, including a lack of nearby facilities, health care professionals, services during non-work hours, or public transportation options.[86] Such structural access has been declining for decades in Milwaukee.

> *Since 1977, nine hospitals have closed in Milwaukee, including the 1995 closing of the county-owned John Doyne Hospital, which had long served as a safety net for the uninsured. Initially, these losses were tied to the city's population decline, but the most recent closings – Northwest General in 2000 and St. Michael's in 2006 – occurred despite a stabilization of the city's population during the past decade.*[87]

This movement of hospitals out of Milwaukee's central city contributes to the statistic that 31% of central city residents surveyed said that there is a lack of doctors or medical clinics in their area. An even higher 38% said there is a lack of dentists or dental clinics in their area.[88]

Where people go to access health care is thought to be important to their overall health. Evidence shows that having a medical home can produce better health, lower the cost of care and reduce disparities in health. "It is clear that, for most aspects of care and health outcomes, identification of a particular practitioner provides better services than mere

[81] US Department of Health and Human Services, Health Resources and Services Administration. About Health Literacy. Retrieved from: http://www.hrsa.gov/publichealth/healthliteracy/healthlitabout.html
[82] Fox, M. (2011 March 28). Low Health Literacy Equals Poor Results, Study Finds. *National Journal*. Retrieved from: http://www.nationaljournal.com/healthcare/low-health-literacy-equals-poor-results-study-finds-20110328
[83] Coreil, J. (2009). p. 169.
[84] Coreil, J. (2009). p. 171.
[85] US Department of Health and Human Services, Office of Minority Health. What is Cultural Competency? Retrieved from: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11
[86] Chen. (2011).
[87] Peterangelo, J. (2011 August 30). *Escalating health challenges for inner city Milwaukee*. Public Policy Forum blog post: http://milwaukeetalkie.blogspot.com/2011_08_01_archive.html
[88] Kovari. (2010).

identification of a particular place . . ."[89] However, according to the 2009 Milwaukee Community Health Survey Report, nearly one-third of Milwaukeeans do not go to a doctor's or nurse practitioner's office when they are sick or need health advice, as shown in the following table.

When you are sick or need advice about your health, to which one of the following places do you usually go?[90]

Place	Percent of Respondents
Doctor's or nurse practitioner's office	67
Hospital emergency room	10
Public health clinic or community health center	8
Urgent care center	7
No usual place	5
Hospital outpatient department	3
Some other kind of place	<1
Not sure	<1

The report shows that African Americans are less likely to report going to a doctor's or nurse practitioner's office when they are sick or need health advice (64%) compared to white respondents (78%).

A lack of health care professionals is affecting the accessibility of dental care in Milwaukee. A recent Milwaukee Journal Sentinel investigation into the availability of dental care to people enrolled in BadgerCare found that of the 55 dental clinics in the city listed on the state's website, only eight were accepting new adult BadgerCare patients.[91] This lack of access to dental care is of particular concern for pregnant mothers, since several studies have found that pregnant women with periodontal disease are more likely to have a preterm or low birth-weight baby[92], which is itself the number one risk factor for infant mortality. According to the article, "dentists say the low participation is due to the state's Medicaid reimbursement—which, at about 40% of the billed amount, ranks fifth-lowest in the country and often does not cover a dentist's costs. The amount is less for those in a managed care organization, as are more than 90% of BadgerCare Plus patients in Milwaukee County."[93]

[89] Starfield, B. & Shi, L. (2004, May). The Medical Home, Access to Care, and Insurance: A Review of Evidence. *Pediatrics, 113(4),* 1493 -1498. PMID: 10617723. Retrieved from: http://pediatrics.aappublications.org/content/113/Supplement_4/1493.full
[90] JKV Research. (2010).
[91] Caron, A. (2011 August 31). In pain, mom-to-be found only dentist wait list. *Milwaukee Journal Sentinel.* Retrieved from: http://www.jsonline.com/watchdog/watchdogreports/128720683.html
[92] Caron (2011).
[93] Caron (2011).

Mental Health and Stress

The effects of mental health and stress on overall wellbeing are particularly important to take into consideration for a project such as Milwaukee LIHF, which is based on the Lifecourse model. This model posits that the cumulative effects of risk factors and stressors—like continual exposure to racism over the lifetime—can have a "weathering" effect on an individual, making them more vulnerable to negative outcomes like giving birth to a low birthweight baby.

Three recent reports show that the mental wellbeing of Milwaukeeans and their access to mental health services are problematic. According to the Milwaukee Health Report 2011, when asked the question "thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" Milwaukeeans reported more average days than the average for Wisconsin (4.2 days for Milwaukee vs. 3.0 days for Wisconsin overall). Within the city, residents' reported mental health differed based on SES, with those in the lowest SES saying their mental health was "not good" an average of 4.9 days while those in the highest SES reporting a much lower 3.3 days.[94]

Another recent report authored by the Human Services Research Institute (HSRI) looked at Milwaukee's adult mental health care delivery system and found a high level of need for mental health services in the county. In Milwaukee, low-income uninsured and individuals served by public insurance primarily receive mental health crisis services through the Milwaukee County Behavioral Health Department (BHD).

> *The County's BHD comprises the second-largest budget of all organizational units in Milwaukee County government ($172 million in 2009). The BHD also is the second largest county organizational unit in terms of its number of employees, with 859 full-time equivalent employees in the 2009 budget. Behavioral health is one of the County's largest functions in terms of individuals served. For example, the 2009 budget estimated BHD would handle more than 4,000 inpatient and 13,000 PCS admissions, provide services to more than 2,000 individuals in Targeted Case Management (TCM) or the Community Support Program (CSP), and provide community-based substance abuse services to more than 4,500 individuals.*[95]

Also included in the HSRI report is state-level data from the Long Term Care Functional Screen* on frequency of mental illness. These data "show that 38.5% of Family Care** members have serious mental illnesses such as schizophrenia, bi-polar disorder, psychosis, or depression. Additionally, 24% have personality disorders, anxiety disorders, or other mental health problems, and 5.4% have substance abuse disorders." [96]

* *The Wisconsin Functional Screen is a web-based application used to collect information about functional status, health and need for assistance for various programs that serve the frail elderly and people with developmental or physical disabilities*

** *Family Care is a managed care program (MCO) that provides long term care services for adults with physical disabilities or developmental disabilities and older adults.*

[94] Chen. (2011).

[95] Human Services Research Institute. (2010 October). *Transforming the adult mental health care delivery system in Milwaukee County.* Retrieved from: http://www.hsri.org/files/uploads/publications/Milwaukee_Mental_Health_System_Redesign_Final_Report.pdf

[96] Human Services Research Institute. (2010).

In its door-to-door survey of residents of Milwaukee's central city, the Community Relations-Social Development Commission found that 14% of respondents indicated that someone in their household was experiencing a mental health issue, and 7% said someone in their household was experiencing an alcohol or drug problem. Respondents further indicated a high level of dissatisfaction with the services being received for these problems, as indicated in the table below.

Prevalence of Medical Issues and Treatment/Service Satisfaction[97]

	Yes	No	Don't Know	IF YES	Yes	No	Don't Know
Mental health issues	14%	84%	3%	Satisfied with the services available?	54%	42%	5%
Alcohol or drug abuse problems	7%	90%	3%	Satisfied with the services available?	20%	51%	27%

Such high rates of mental health challenges are of concern, but high rates of stress can also be a risk factor for poor health outcomes. There is not a lot of data on the stress levels experienced by Milwaukeeans in particular, but when the Community Relations-Social Development Commission recently asked key stakeholders about the problems they believed most affected people living in poverty in Milwaukee, several respondents said that "people in poverty are faced with a sense of hopelessness or heavy stress, which can often lead to problems in other areas of life."[98] Bevan Baker, the Health Commissioner for the City of Milwaukee, made the connection between living and poverty and stress in a recent opinion piece in the Milwaukee Journal Sentinel, saying:

> *"People living in poverty often work low-wage jobs with no health insurance, and low educational status makes it hard to move up the ladder. Further, engaging in healthy behaviors is much tougher, because healthy food is less available and affordable and because it's harder to access health clubs or even safe neighborhoods in which to exercise or play."*[99]

A recent Milwaukee Journal article summed up the negative effects of stress on the body:

> *When faced with a dangerous situation - witnessing domestic violence, for example - a part of the brain called the hypothalamus sends out a chemical signal that tells the body to produce cortisol, the stress hormone. That sets the heart racing, the body sweating, and creates that jolt known as the "fight or flight" response. . . . [according to] Calvin Hobel, an obstetrician/gynecologist at Cedars-Sinai Medical Center in Los Angeles who has studied the effect of stress on birth outcomes, "people who have chronic stress, throughout the day, your heart rate goes up, your cortisol goes up, but it doesn't come down." This chronic stress leads to permanent changes in the body's heart rate and cortisol levels, he said.* [100]

An increase in these stress hormones can have many effects on pregnant women and their fetuses, from lessened blood flow to the baby, deprivation of nutrition to the baby, a tendency for the mother to get sick more easily, and even the initiation of early labor.[101] The effects of stress on African American women over the lifespan are further explored in Section II b of this report.

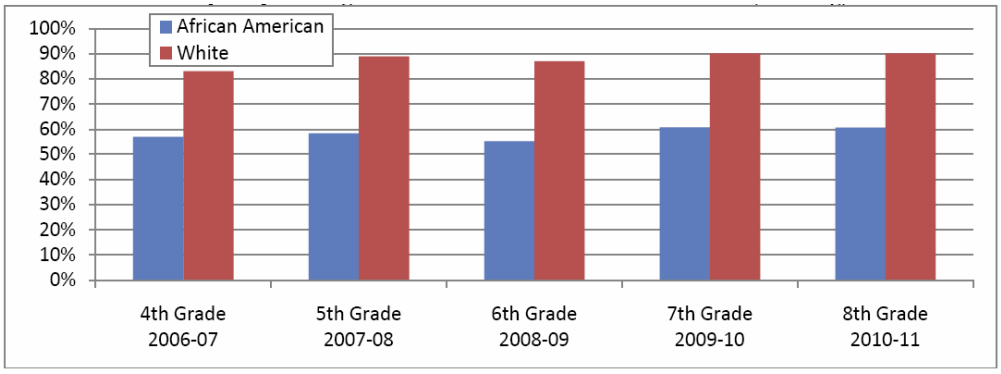
[97] Kovari. (2010).
[98] Kovari. (2010).
[99] Baker, B. (2011 March 31). The state of our health, and health of our state. *Milwaukee Journal Sentinel*. Retrieved from: http://www.jsonline.com/news/opinion/119023554.html
[100] Johnson, M. (2011 April 16). Is stress to blame for preterm births? *Milwaukee Journal Sentinel*. Retrieved from: http://www.jsonline.com/features/health/119987024.html
[101] Johnson (2011).

b. African American families & communities

The typical African American family in Milwaukee is headed by a single mother (38.4% of African American families), living in a small number of central city ZIP codes and earning $26,513 per year, according to recently released data from the 2010 U.S. Census.[102] This picture is not much changed from that of a decade ago, when fewer than three of ten African American families were headed by married couples. Among the many implications of this situation is the fact that black families headed by a single mother in Milwaukee can expect to earn less than one-third of what a two-parent household would earn. [103]

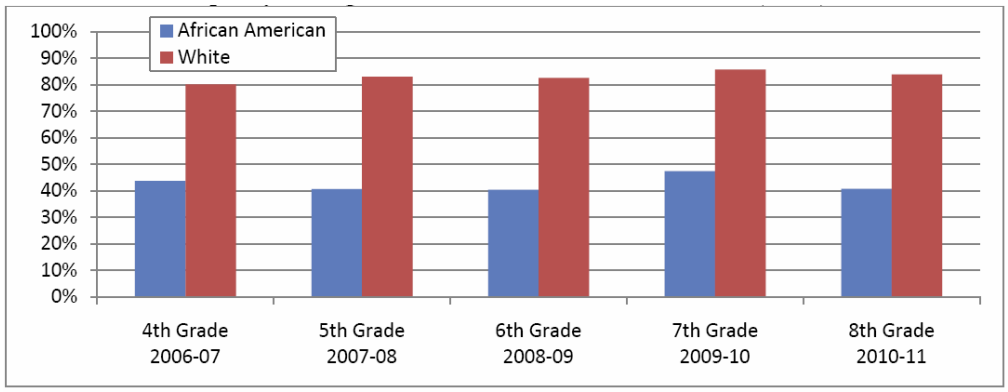
Educationally, blacks in Milwaukee face further discouraging statistics. According to Milwaukee Public Schools, white students graduate at a rate of 77% while black students graduate at a rate of 65%.[104] This low graduation rate is a symptom of other difficulties the school system is having educating black students. The charts below detail the persistent gaps in reading and math skills between black and white students in southeastern Wisconsin schools.

Racial disparity among southeast Wisconsin student cohort (reading)[105]



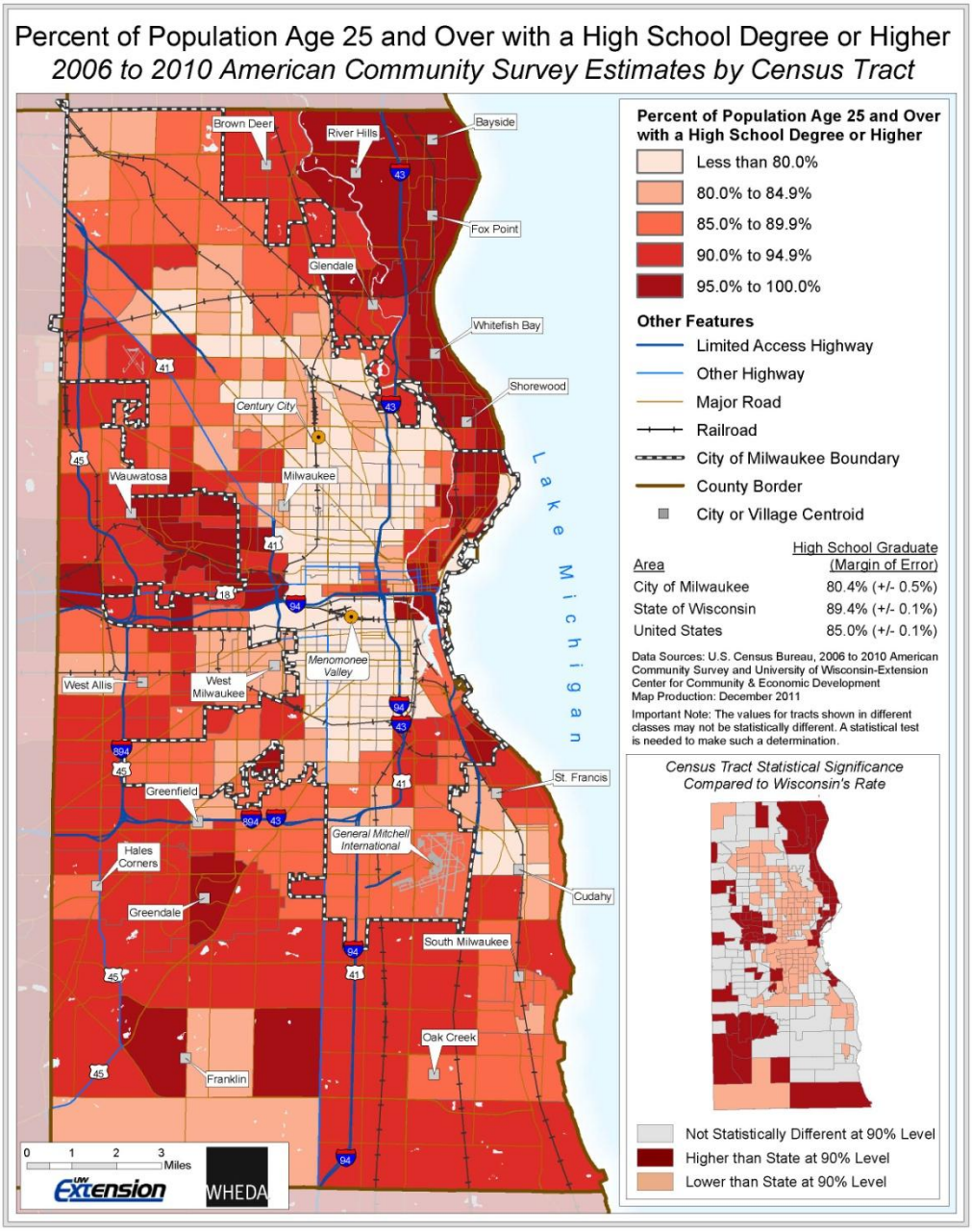
Racial disparity among southeast Wisconsin student cohort (math)[106]

[102] US Census Bureau, American Community Survey 2008-2010.
[103] McNeely, RL. (2011 June). *Milwaukee Today: An Occasional Report of the Milwaukee NAACP*. Executive Summary retrieved from the NAACP website: http://www.milwaukeenaacp.org/#!occ-report
[104] Milwaukee Public Schools, Division of Research & Assessment. (2009). *2008-9 District Report Card*. Retrieved from: http://www2.milwaukee.k12.wi.us/acctrep/0809/2009_district.pdf
[105] Dickman, A. (2011 September). *Public schooling in southeast Wisconsin.* Public Policy Forum. Retrieved from: http://www.publicpolicyforum.org/pdfs/2011SchoolingReport.pdf
[106] Dickman. (2011).



One result of the challenges facing the Milwaukee Public School system is the large percentage of African American residents of the city who lack high school degrees. Lack of education is an indicator of other negative life trajectories. For instance, high school dropouts on average earn only half as much as those with technical college, community college, or junior college associate degrees.[107]

[107] McNeely. (2011).


Percent of Population Age 25 and Over with a High School Degree or Higher
2006 to 2010 American Community Survey Estimates by Census Tract
Brown Deer
River Hills
Bayside
Fox Point
Glendale
Whitefish Bay
Shorewood
Century City
Wauwatosa
Milwaukee
Lake Michigan
West Allis
West Milwaukee
Menomonee Valley
St. Francis
Greenfield
General Mitchell International
Hales Corners
Greendale
Cudahy
South Milwaukee
Oak Creek
Franklin
Percent of Population Age 25 and Over with a High School Degree or Higher
Less than 80.0%
80.0% to 84.9%
85.0% to 89.9%
90.0% to 94.9%
95.0% to 100.0%
Other Features
Limited Access Highway
Other Highway
Major Road
Railroad
City of Milwaukee Boundary
County Border
City or Village Centroid
Area
High School Graduate (Margin of Error)
City of Milwaukee 80.4% (+/- 0.5%)
State of Wisconsin 89.4% (+/- 0.1%)
United States 85.0% (+/- 0.1%)
Data Sources: U.S. Census Bureau, 2006 to 2010 American Community Survey and University of Wisconsin-Extension Center for Community & Economic Development
Map Production: December 2011
Important Note: The values for tracts shown in different classes may not be statistically different. A statistical test is needed to make such a determination.
Census Tract Statistical Significance Compared to Wisconsin's Rate
Not Statistically Different at 90% Level
Higher than State at 90% Level
Lower than State at 90% Level
0 1 2 3 Miles
UW Extension
WHEDA

Violence can be another outcome of the lack of a quality education. Two out of three young African American males without high school diplomas in Milwaukee will spend time in prison.[108] And although comprising just over one-third of the city's population, African Americans make up nearly three-quarters of homicide victims in Milwaukee.[109] In Wisconsin, blacks are incarcerated at 11 times the white rate, making Wisconsin's rate of incarceration of African-Americans the second-highest in the country.[110]

Children with incarcerated fathers have greater problems in school and are nearly six times as likely to be expelled or suspended from school.[111] Children of incarcerated parents also face greater financial difficulties, which has a negative influence on their future economic performance.

> Before being imprisoned, more than two-thirds of male inmates had jobs and more than half were the primary source of financial support for their children, the study shows. …the report points out: "Family income averaged over the years a father is incarcerated is 22% lower than family income was the year before a father is incarcerated. Even in the year after the father is released, family income remains 15% lower than it was the year before incarceration."[112]

Julie Poehlmann, professor at the University of Wisconsin in Madison, says one reason that Milwaukee Public Schools face so many problems with truancy and low graduation rates is incarcerated parents. "There is probably a huge proportion of kids having these problems—the parents are incarcerated—and the school district may never learn of that fact." And the long-term projections are no better. Poehlmann adds, "Children of an incarcerated parent are at least two and a half times more likely to be incarcerated themselves. Just imagine the scale of the crisis in another 10 or 15 years. It's overwhelming."[113]

The problem of the incarceration of black males is inextricably tied up with that of black male unemployment. The cyclical relationship between these two issues is easy to define. While incarcerated, not only are black males unable to work, but they are losing employment experience and thus losing ground when compared with their unincarcerated peers. But the cycle continues even after release, for job applicants with a criminal record find it extremely difficult to get a job.[114]

An analysis carried out by the Milwaukee LIHF Collaborative for the Milwaukee central city ZIP codes with the highest infant mortality rates reinforces the above picture of a community that is greatly impacted by high incarceration rates, as shown in the map on the following page.

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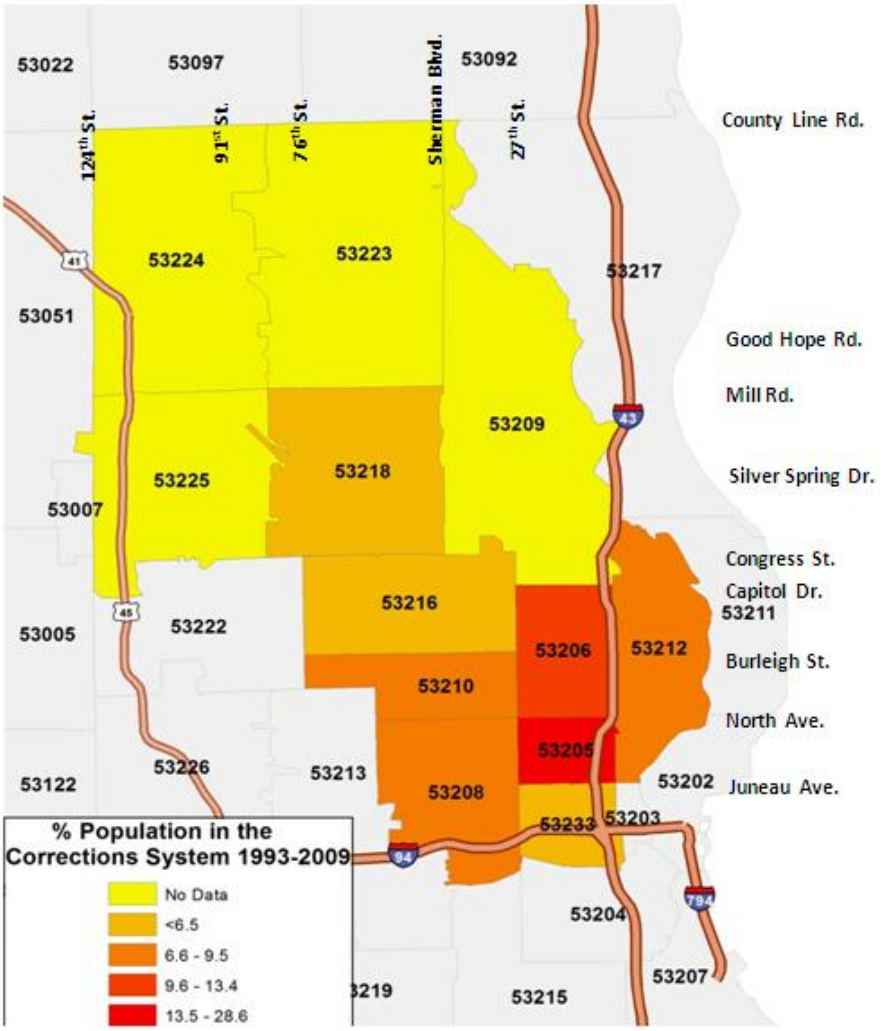
[108] McNeely. (2011).
[109] Milwaukee Homicide Review Commission. (2011). *2010 Homicides and Nonfatal Shootings Data Report for Milwaukee, WI.* Retrieved from: http://city.milwaukee.gov/ImageLibrary/Groups/cityHRC/reports/2011Report2-11-11v1.pdf
[110] McNeely. (2011).
[111] Sanders, B. (2010, October 07). Imprisonment and its legacy. *Milwaukee Journal Sentinel*. Retrieved from: www.jsonline.com/news/opinion/104511754.html Quoting the Pew Charitable Trust's report: *Collateral Costs: Incarceration's Effect on Economic Mobility.*
[112] Sanders. (2010).
[113] Tenenbaum, David. (2010, August 09). *Research by Julie Poehlmann, Ph.D., examines the price of prison for children.* University Communications. Retrieved from: http://www.waisman.wisc.edu/news/stories/2010/PoehlmannSept.html
[114] Celata, D. (2010 June). *Structural issues impacting black male employment opportunities in metro Milwaukee*. Social Development Commission. http://www.cr-sdc.org/DefaultFilePile/StructuralIssuesImpactingBlack.pdf

Percent of Milwaukee's Total Population Involved in the Corrections System 1993-2009

Note that the population is based on the 2010 Census while the data for those in the Corrections System is from 1993 to 2009. As such, the percent shown is not completely accurate. Also note that no Corrections data was available for the zip codes in yellow.



Corrections System data based on number of people either incarcerated, released, or on probation between the years 1993-2009. Retrieved from http://www4.uwm.edu/eti/reports/indypage.htm

The Importance of African American Males

The question of where have all the black males gone is answered, in part, by the high incarceration rates, which are merely a symptom of the many other challenges faced by black men in Milwaukee. Along with high dropout rates, discussed earlier in this report, and high unemployment rates, which will be discussed later, incarceration rates are inextricably linked to the success or failure of the African American male, and consequently, of the black family.

In attempting to understand what it means to be a black male in America, much of the research focuses on the cultural and individual "deficits" of black males, rather than on structural and institutional issues they face. One exception is a recent report done by the Kirwan Institute for the Study of Race and Ethnicity at Ohio State University. This report, entitled the "African American Male Initiative," focused on structural and institutional issues faced by black males in the United States. Some of the report's conclusions are summarized below.

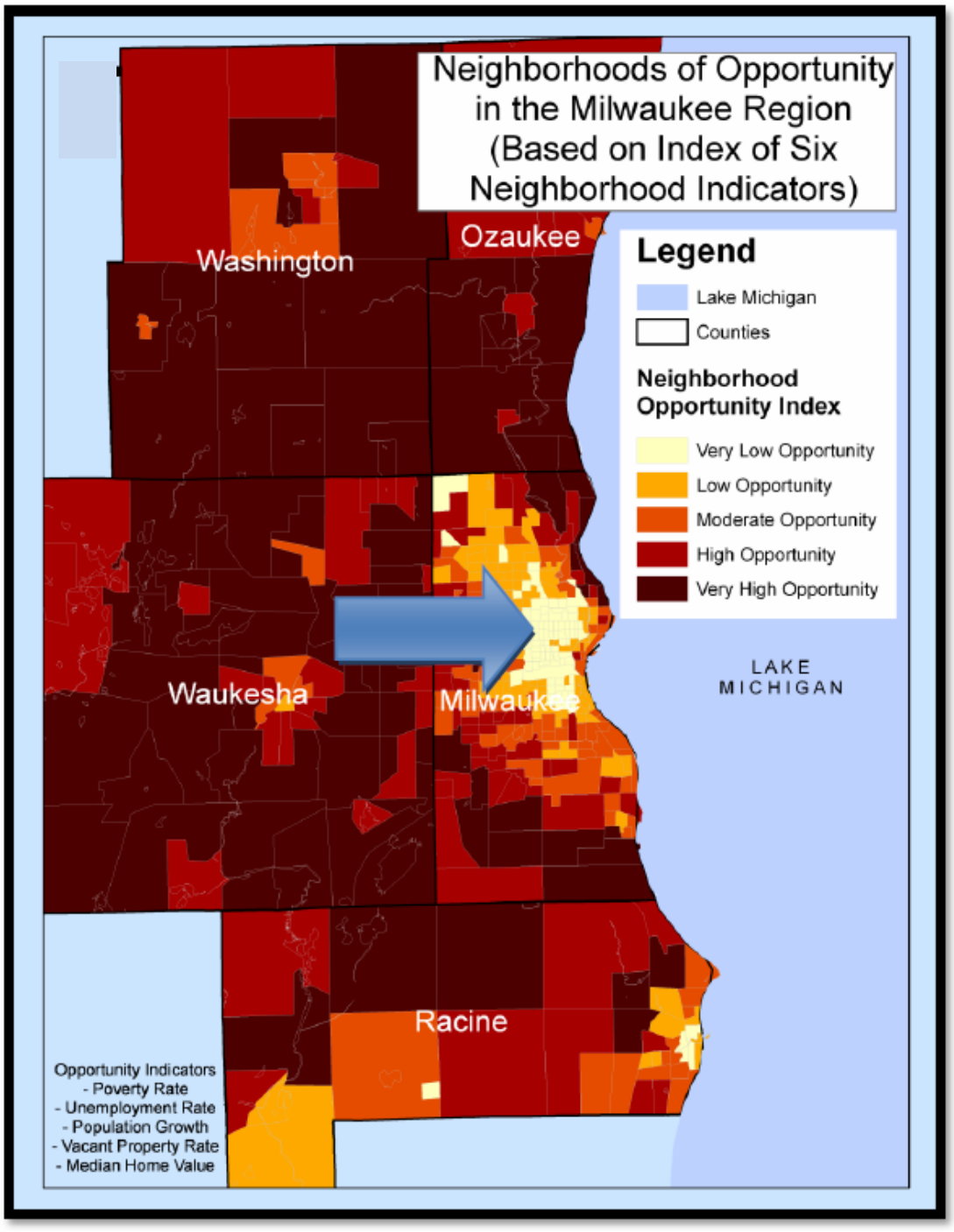
1. Spatial Isolation - Black males are often separated from opportunities geographically, socially and economically.[115] As seen on the map on the follow page, the areas of greatest "opportunity" in the Milwaukee metropolitan area are in the suburban and exurban areas, far from the central city neighborhoods where most African Americans live.

2. Social Marginalization – Social institutions create a number of problems for black males at an early age, beginning at school where "teacher-student cultural differences, racial disparities in suspension rates, and discriminatory practices push young males away from mainstream education and onto a special education track."[116] Additionally, black males are frequently stereotyped with negative and anti-social labels in the media. Academic research also suggests that growing up in the absence of a father is a factor contributing to the negative outcomes experienced by black males.[117]

3. Criminalization – The above factors and the problem of joblessness in combination create the racial disparities in the incarceration rates previously discussed. The cyclical nature of the problem, in which the lack of an education and/or a job increases the likelihood of incarceration, which in turn decreases the likelihood of future employment, is a downward spiral that is hard to get out of once a man is caught up in it. In fact, a study in Milwaukee showed that white job applicants with a criminal record are over three times more likely to receive a call back than their black counterparts. Even black applicants with no criminal record received a lower percentage of call backs than white applicants who disclosed a criminal background.[118]

[115] Trammel, M., Newhart, D., Willis, V., & Johnson, A. (2008 June). *African American Male Initiative.* Ohio State University, Kirwan Institute for the Study of Race and Ethnicity. Prepared for the WK Kellogg Foundation. Retrieved from: http://4909e99d35cada63e7f757471b7243be73e53e14.gripelements.com/publications/AAMaleInitiative_KelloggReport_April2008.pdf
[116] Celata. (2010). Referencing: Trammel. (2008)
[117] Trammel. (2008).
[118] Celata. (2010). Referencing: Pager, D. (2003). *The mark of a criminal record*. The University of Chicago.

Neighborhoods of Opportunity in Metro Milwaukee[119]



[119] Celata. (2010). Referencing: Powell, J. (2007). Ohio State University.

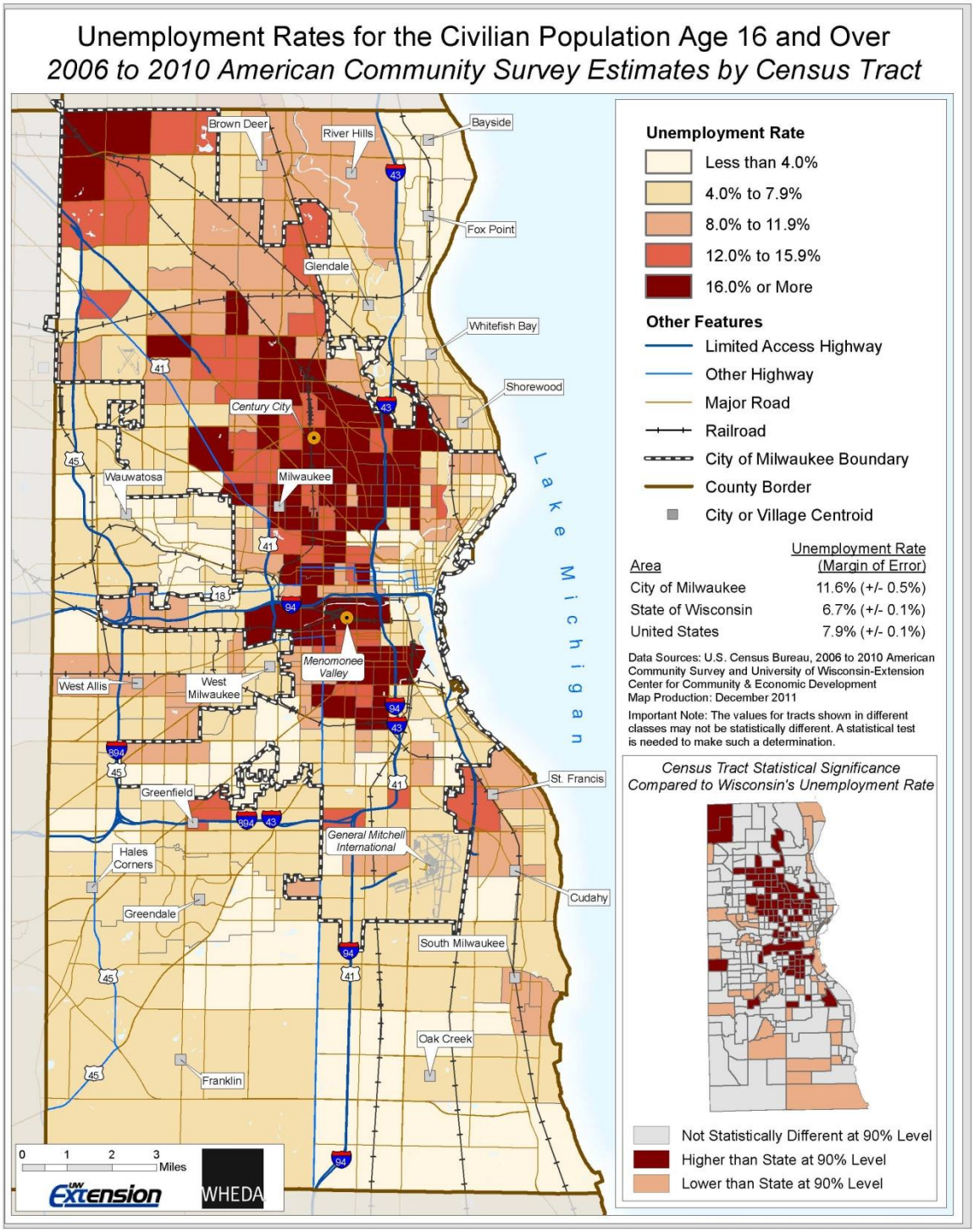
c. Economic and social inequities

For decades, Milwaukee's economy, and its people, thrived in large part due to a successful manufacturing sector that provided many high-paying, blue-collar jobs. As recently as 1970, seven of Milwaukee's top 10 companies were in manufacturing; the other three were brewing companies.[120] But by 2008, four of the city's top ten employers (by number of people employed) were hospitals. Three educational entities—Milwaukee Public Schools, University of Wisconsin-Milwaukee and the Medical College of Wisconsin—were also in the top ten. Rounding out the top ten in 2008 were Milwaukee's city and county governments, and Northwestern Mutual (the insurance company's world headquarters are in Milwaukee). The shift away from manufacturing jobs comes at a price: average pay for jobs in the health/education sector in Milwaukee County is $44,087, and for the public sector it is $51,790, both significantly less than the typical manufacturing job, which pays $56,361.[121]

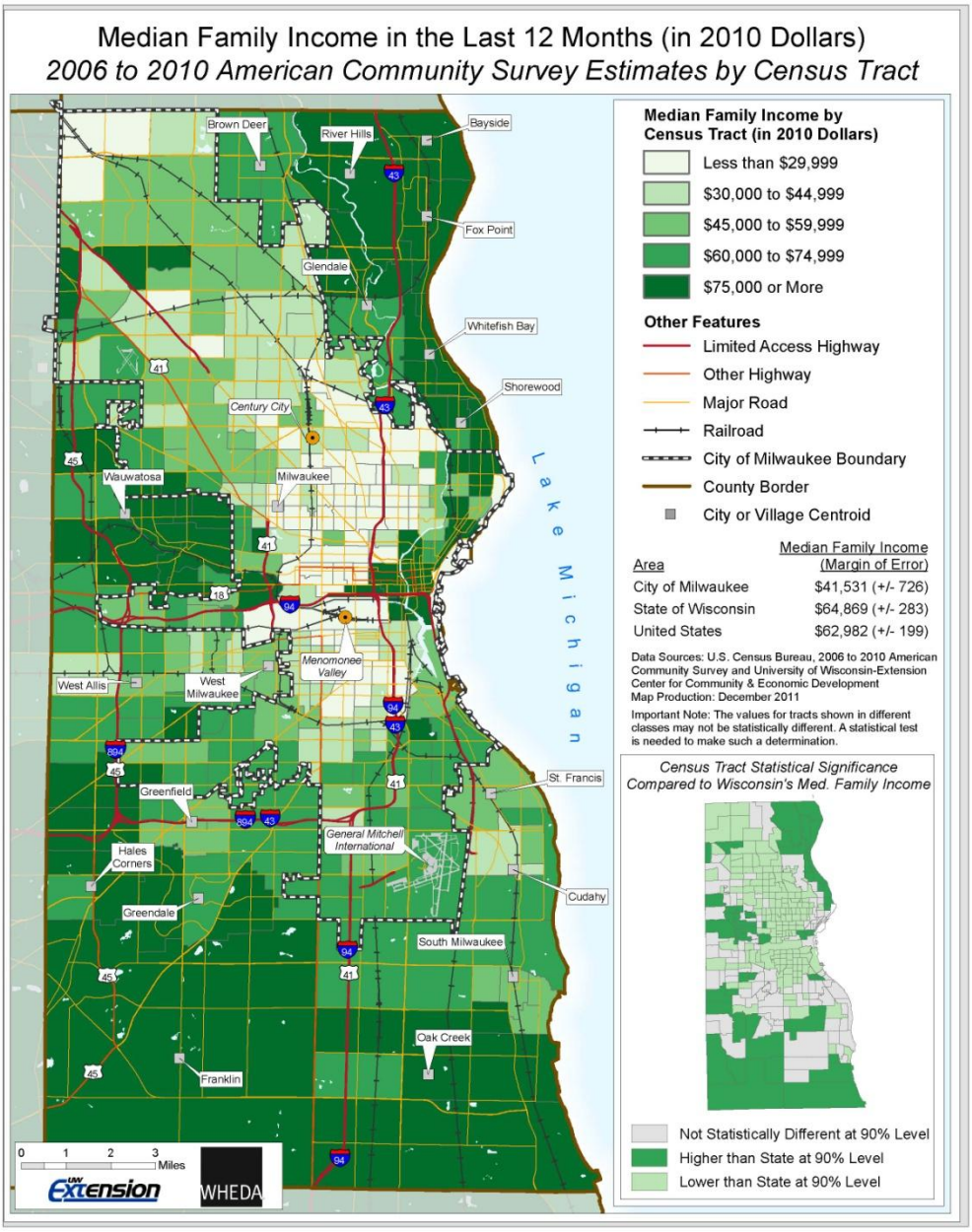
This loss of jobs that pay family-supporting wages helps explain why one-quarter (24.3%) of individuals living in the City of Milwaukee were below the poverty level for the period 2005 - 2009[122]. In the midst of the recession, the 2009 poverty rate for the city increased to 27%, making Milwaukee the fourth poorest city in the nation, behind only Detroit (36.4%), Cleveland (35%) and Buffalo (28.8%) among cities with populations greater than 250,000. That year, nearly 4 in 10 children in Milwaukee were considered poor, meaning an estimated 62,432 children lived in poverty in 2009, up from 49,952 in 2008. [123]

High unemployment rates, particularly in the last few years, have contributed to the increase in poverty in Milwaukee. According to preliminary data from the state, the unemployment rate was 11.6% in the City of Milwaukee in July 2011, the third highest rate in the state after Beloit and Racine.[124] And the most recent data from the US Census American Community Survey confirms that unemployment in Milwaukee continues to be concentrated in central city ZIP codes, as shown on the map on the following page.

[120] Causey, J. (2011 August 13). Recession rocks blacks. *Milwaukee Journal Sentinel*. Retrieved from: http://www.jsonline.com/news/opinion/127621418.html
[121] Falk, B. (2009). *Milwaukee County Workforce Profile 2009.* Wisconsin Department of Workforce Development. Retrieved from http://dwd.wisconsin.gov/oea/county_profiles/current/milwaukee_profile.pdf
[122] U.S. Census Bureau, American Community Survey 2005-2009
[123] Glauber, B. & Poster, B. (2010 September 28). Milwaukee now fourth poorest city in nation. *Milwaukee Journal Sentinel*. Retrieved from http://www.jsonline.com/news/wisconsin/103929588.html
[124] Wisconsin Department of Workforce Development. (2011 August 24). *July local job, employment numbers announced*. Retrieved from http://dwd.wisconsin.gov/dwd/newsreleases/2011/unemployment/110824_july_local.pdf


Unemployment Rates for the Civilian Population Age 16 and Over
2006 to 2010 American Community Survey Estimates by Census Tract
Brown Deer
River Hills
Bayside
Fox Point
Glendale
Whitefish Bay
Shorewood
Century City
Milwaukee
Wauwatosa
West Allis
West Milwaukee
Menomonee Valley
Lake Michigan
St. Francis
Greenfield
General Mitchell International
Hales Corners
Greendale
Cudahy
South Milwaukee
Oak Creek
Franklin
Unemployment Rate
Less than 4.0%
4.0% to 7.9%
8.0% to 11.9%
12.0% to 15.9%
16.0% or More
Other Features
Limited Access Highway
Other Highway
Major Road
Railroad
City of Milwaukee Boundary
County Border
City or Village Centroid
Area
Unemployment Rate (Margin of Error)
City of Milwaukee 11.6% (+/- 0.5%)
State of Wisconsin 6.7% (+/- 0.1%)
United States 7.9% (+/- 0.1%)
Data Sources: U.S. Census Bureau, 2006 to 2010 American Community Survey and University of Wisconsin-Extension Center for Community & Economic Development
Map Production: December 2011
Important Note: The values for tracts shown in different classes may not be statistically different. A statistical test is needed to make such a determination.
Census Tract Statistical Significance Compared to Wisconsin's Unemployment Rate
Not Statistically Different at 90% Level
Higher than State at 90% Level
Lower than State at 90% Level
0 1 2 3 Miles
UW Extension
WHEDA

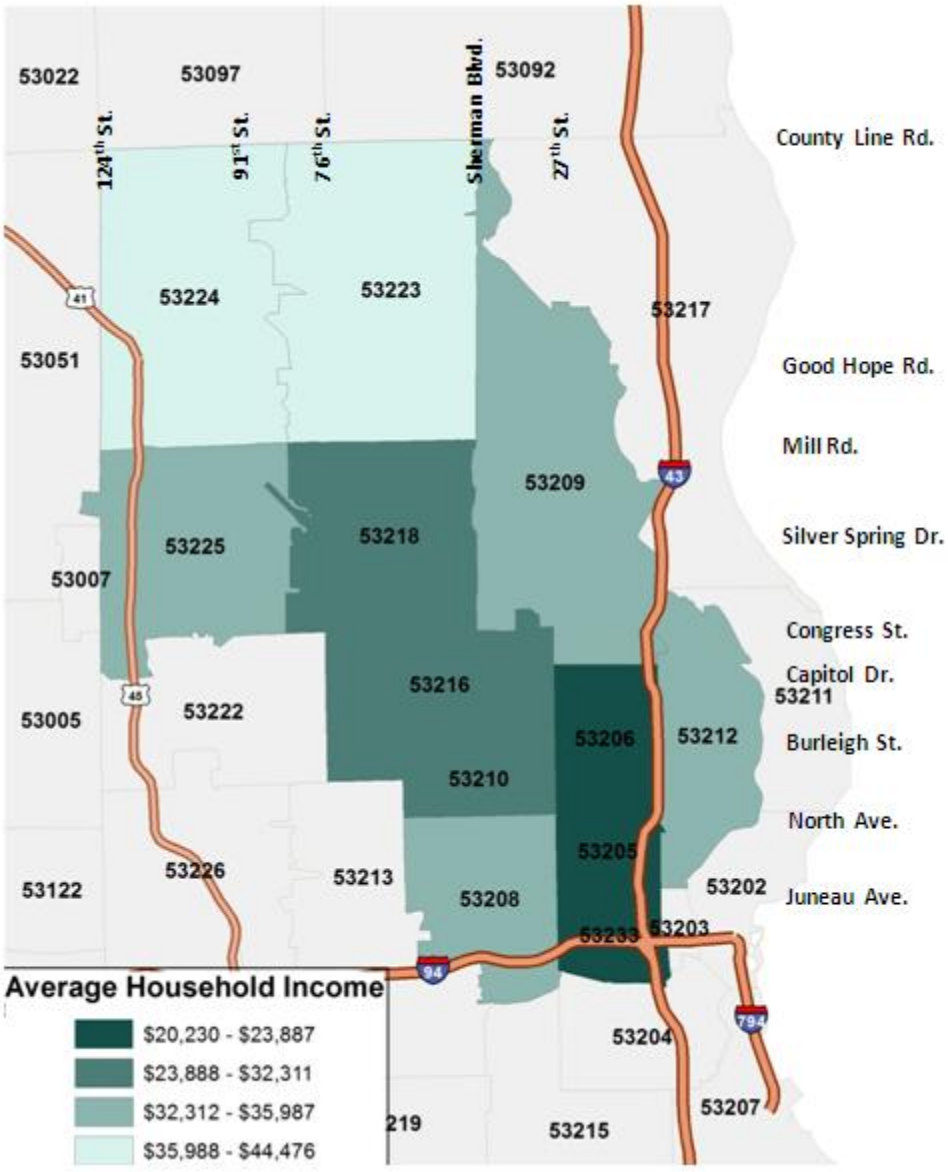
There are also large income and unemployment disparities in Milwaukee. In a recent report on the economic state of the city, UW-Milwaukee researchers found that median household income for African Americans in the Milwaukee region is low compared with other similar cities in the region, due in part to Milwaukee's comparatively small black middle class. The researchers measured black households earning at least $50,000; the percentage of blacks with a 4-year college degree; and the percentage of blacks employed in professional, management, and related occupations. On each of these measures, Milwaukee was consistently in the bottom half of the sample.[125] The following map of American Community Survey data shows median family income is lowest in Milwaukee's central city.



[125] Rast. (2010).

Milwaukee LIHF analyzed average household income for the Milwaukee ZIP codes with the highest infant mortality rates as shown on the map below.

Milwaukee Average Household Income – Selected ZIP Codes - 2011



Average Income per Household – Average Adjusted Gross Income for Working Age Single and Married Tax Filers; data from Milwaukee Drilldown, September 2011, Employment & Training institute, UWM & MAWIB. Retrieved from: http://www4.uwm.edu/eti/2011/Sept2011Drilldown.pdf

As mentioned earlier in this report, joblessness is a particularly intransigent problem for black males in the city. The Economic State of Milwaukee report found that male jobless rates in Milwaukee have risen steadily from 1990 to 2008, and that black male joblessness in the Milwaukee metro area in 2008 was higher than any other region in the sample except Toledo, Detroit, and Buffalo.[126] Statistics compiled by the National Association for the Advancement of Colored People show that in 2009, there were more than 70,000 job seekers in Milwaukee but less than 10,000 job vacancies.[127] A recent study shows that not only does Milwaukee have the 5th highest rate of black male unemployment in the nation, it also has the nation's largest black-white disparity in male joblessness.[128]

2008 Metropolitan Milwaukee Male Joblessness by Race and Location[129]

Age	Black City	Black Suburbs	White City	White Suburbs	Hispanic City	Hispanic Suburbs
All Working Age	47.4%	44.7%	23.1%	16.4%	24.2%	17.0%
Young Adults	70.1%	64.0%	36.8%	35.2%	53.0%	23.8%
Prime Working Age	36.2%	36.2%	16.0%	8.2%	14.6%	11.5%

All working age = 16-64; Young adults = 16-24; Prime working age = 25-54

2008 Metropolitan Milwaukee Male Joblessness by Race and Age[130]

Age Category	Black		White		Hispanic	
	2007	2008	2007	2008	2007	2008
16-24	64.5%	69.6%	37.8%	35.6%	44.4%	43.2%
25-54	43.2%	36.2%	10.4%	10.9%	15.7%	13.8%
55-64	61.8%	53.2%	28.4%	27.2%	25.6%	33.7%

Extensive information on poverty in Milwaukee is available in a 2010 report by the Community Relations-Social Development Commission.[131] This report has information on many indicators that are closely related to poverty including employment, education, food/nutrition, transportation, housing and health. One item of particular interest from this report comes from a door-to-door survey of Milwaukee County residents. The following table shows the biggest problems in looking for work as reported by the 191 respondents who were looking for work.

[126] Rast. (2010).
[127] Causey. (2011 August 13).
[128] Levine, M. (2009). *Research update: Race and male joblessness in Milwaukee: 2008*. University of Wisconsin-Milwaukee: Center for Economic Development.
[129] Levine. (2009).
[130] Levine. (2009).
[131] Anderson, T.J., Davis, G. S., & Hawley, C.B. (2010 March). *CSBG Needs Assessment - Chapter I.3: Existing Data on Various Poverty-Related Indicators for Milwaukee County.* University of Wisconsin-Milwaukee, Center for Urban Initiatives & Research, and the Social Development Commission. Retrieved from: http://www.cr-sdc.org/DefaultFilePile/PolicyandResearch/ExistingDataReport.pdf

Problems with looking for work[132]

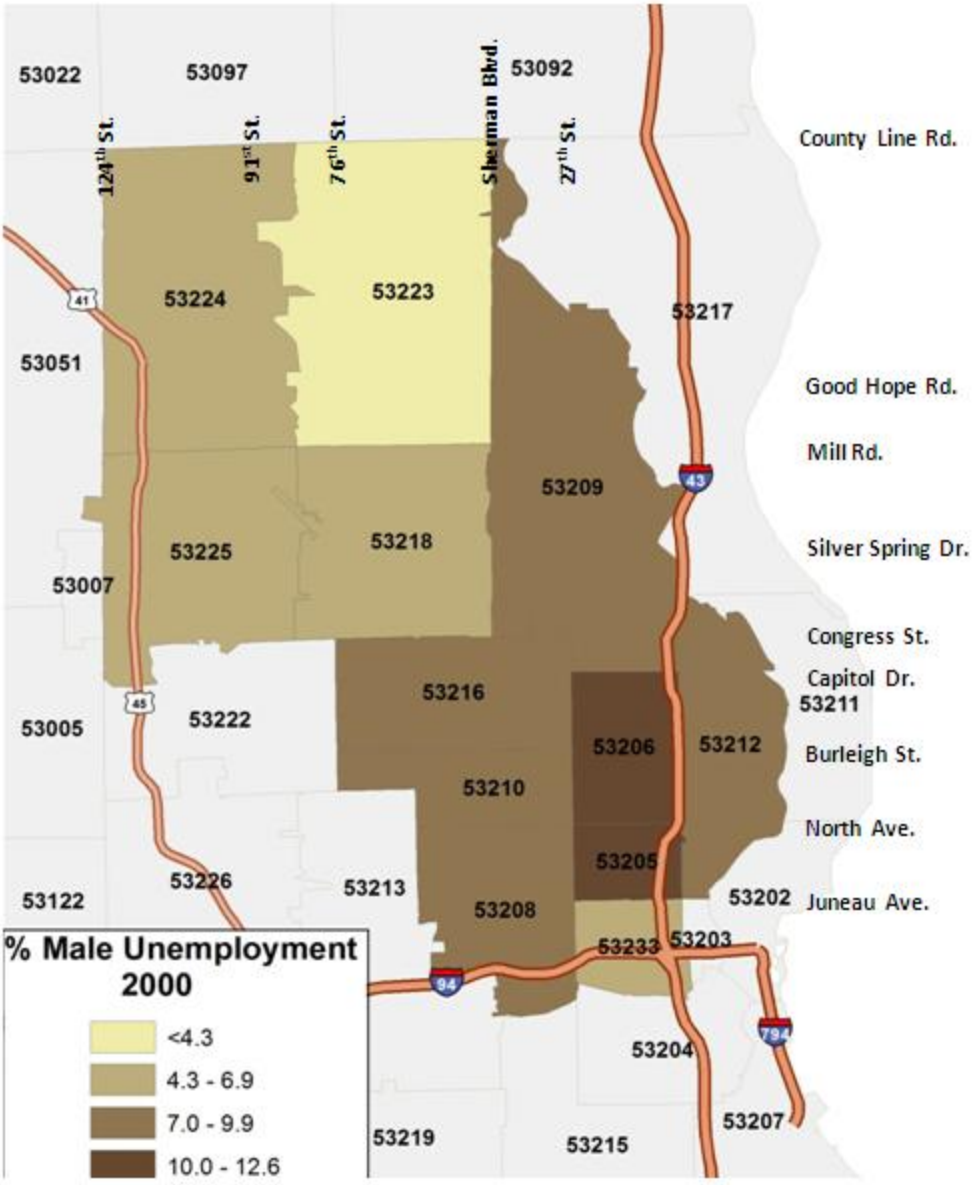
	Count	Percentage
Problems related to JOB AVAILABILITY	**130**	**68%**
• Lack of jobs	112	59%
• Unsatisfactory wages	14	7%
• Too much competition	10	5%
• Too few hours offered	8	4%
• Unsatisfactory benefits	5	3%
Problems related to GETTING HIRED	**35**	**18%**
• Personal discrimination	13	7%
• Do not have necessary education	10	5%
• Do not have necessary skills	6	3%
• Do not have necessary experience	6	3%
Problems related to JOB SEARCH	**23**	**12%**
• Do not have transportation	13	7%
• Have other responsibilities (e.g., kids, current job)	7	4%
• Do not have internet access/proficiency	3	2%
Other	**14**	**7%**

Due to the importance of male joblessness to the overall health of the community, Milwaukee LIHF analyzed male unemployment for the Milwaukee ZIP codes with the highest infant mortality rates. The resulting map is included on the next page.

[132] Kovari. (February 2010).

Percent of Males Unemployed – 2000

With the current economic recession, these percentages are probably higher. African Americans tend to suffer from higher unemployment rates, so current unemployment is also probably higher now in zip codes that have seen a large increase in African American residents, for example 53223.

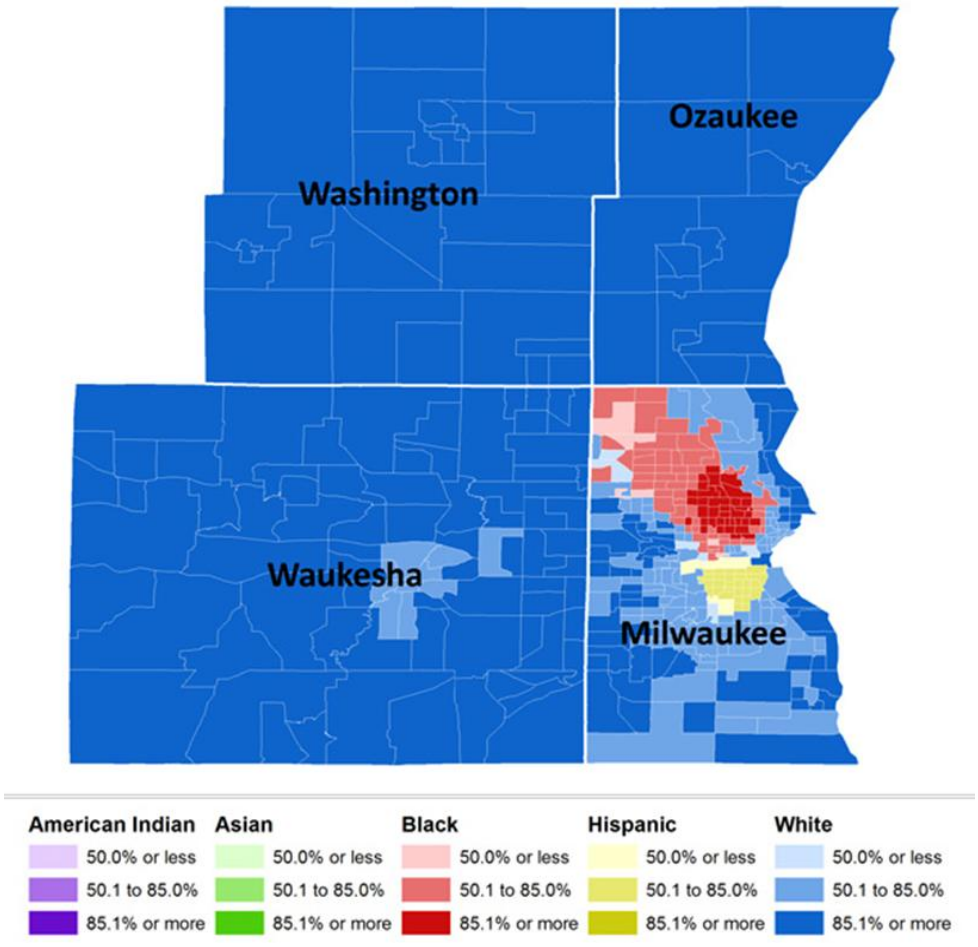


2000 Census data on percent Unemployed (Males 16 and over) was retrieved from http://factfinder.census.gov/ on October 11, 2011. Compare with overall 2000 City of Milwaukee male unemployment rate of 6.6%.

An overview of the socioeconomic reality of Milwaukee would not be complete without a discussion of the segregated housing patterns prevalent in the region. Segregation has been a constant issue in the city and the region, with fewer than one in ten African Americans living in the suburbs in 2008. Using Census 2010 data, CensusScope.org recently ranked Milwaukee as the number one most segregated urban area in the United States (see map next page).[133] It is important to take into account the racial segregation that exists in Milwaukee because decades of research has established an empirical link between segregation and mortality. One study of New York City in the 1940s observed that infant mortality rates, for both blacks and whites, were highest in the most severely segregated black neighborhoods.[134] A more recent study of large- and mid-sized U.S. cities found that white infant mortality rates were essentially unaffected by a city's level of segregation, but black rates were higher in highly segregated cities.[135]

[133] Frey, WH. (2010).
[134] Yankauer, A. (1950). The relationship of fetal and infant mortality to residential segregation. *American Sociological Review, 15(5),* 644-648.
[135] LaViest, T.A. (1989). Linking residential segregation to the infant mortality race disparity. *Sociology & Social Research, 73(2),* 90-94.

Greater Milwaukee: The Number One Most Segregated Metro Area in the United States



Source: Census 2010. www.CensusScope.org. Social Science Data Analysis Network, University of Michigan. www.ssdan.net.

This data is based on Segregation Indices, which are Dissimilarity Indices that measure the degree to which the minority group is distributed differently than whites across census tracts. They range from 0 (complete integration) to 100 (complete segregation) where the value indicates the percentage of the minority group that needs to move to be distributed exactly like whites. The neighborhood composition for average members of a racial group is based on the calculation of exposure indices (each tracts racial composition is weighted by the group's size of each tract). In this analysis all racial groups (whites, blacks, Asians and other races) are non-Hispanic members of those races. Hispanics are shown as a separate category.

2. Community assets (opportunities)

a. Community health and health care access

From antebellum times to the modern period, African American women have been the primary caregivers within their families. Even today, reliance on self-care, family care, advice from friends and neighbors and other sources of help from lay persons constitute important assets that African Americans rely on to maintain their health.

However, over the last century or so, the Western biomedical model has become the dominant system of care, particularly in U.S. cities. In this model white, European values—such as individualism, mastery over nature, future time orientation, "doing" activity orientation, and internal locus of control—predominate. This model also differentiates the physical and the mental, looking at diseases as "entities" within a mechanical body, and is biased toward technological solutions. From the viewpoint of many practitioners of the Western model, other cultural models are often seen as less effective and, at times, are even used to blame the sick person for their own illness.[136]

Some aspects of the Western model are at odds with the belief system of many African Americans, who may come from a cultural paradigm in which the mind and the body are integrated, and where health practices are often handed down from generation to generation. Sometimes called alternative or naturalistic healing models, such practices can complement Western medical approaches and are another asset available to African American families.[137] For instance, for some African Americans, having faith in God and learning to accept God's will are very important in dealing with adversity and disease. While a health care provider with Western values might view these beliefs as unhelpful or fatalistic, a more culturally sensitive provider would recognize strong faith as a worthy goal for a patient who comes from this type of belief system.[138]

Some cultural values and assets frequently available to African Americans[139]

Cultural Value	Culture Care Assets
Extended family networks	Family support readily available; frequent family get-togethers provide mental & spiritual support
Religion valued	Reliance on prayer and song for strength & healing
Interdependence with other African Americans	Concern for "brothers and sisters" expressed through being present (physically) for others
Folk healing modes, foods	Home remedies passed down through generations

[136] Coreil. (2009). 145 – 154.
[137] Andrews, M. & Boyle, J. (Eds.). (2003). *Transcultural Concepts in Nursing Care, 4th Edition.* Philadelphia: Lippencott Williams & Wilkins. 73-88.
[138] Lemelle, A., Reed, W. & Taylor, S. (2011). *Handbook of African American Health*. New York: Springer Publishing. 231.
[139] Freely adapted from Andrews. (2003).

When the alternative healing assets of home remedies and family support cannot adequately address the health needs of African Americans in Milwaukee, they may turn to one of the many health care programs and resources available to them. The following is a short list of some of the programs used most frequently.

BadgerCare is a state program that provides health insurance coverage to children, pregnant women, parents and childless adults. BadgerCare is targeted to the working poor and low-income unemployed; to be eligible, applicants need household incomes of less than $21,780 for an individual and $29,420 for a married couple.[140] Under state law, basic premiums have to support the cost of the program. Those costs have been much higher than planned, therefore the state has stopped taking enrollments in the basic plan and basic plan premiums increased to $325 for coverage beginning with the November 2011 benefit month. 53,000 adults without minor children could be cut from the program in July 2012 if federal permission is not granted by December 31, 2011 for changes sought by the state. Other changes being sought would move 263,000 people in BadgerCare Plus—more than half of them children—into a plan with lower costs for taxpayers but fewer benefits for recipients.[141]

Milwaukee's four federally qualified health centers (FQHCs), which provide primary care services to patients regardless of their ability to pay, fill an important role in serving the city's uninsured. All four centers are expanding their operations and together may be positioned to take on additional patients in the near future. In addition, the downtown AIDS Resource Center of Wisconsin (ARCW) clinic is working to become a fifth primary care FQHC, which would allow it to serve many more patients. These are encouraging signs, but capacity constraints remain a concern at the FQHCs and continue to be a focus of the health system leaders who comprise the Milwaukee Health Care Partnership.[142]

The city of Milwaukee also has more than fifty non-profit and city-run, safety-net clinics providing health care for free or on a sliding scale to those in need. Some are full-service, but many offer only specific services, such as STD clinics or dental clinics.

Those are just a few of the hundreds of health-related programs available to Milwaukee citizens. Of particular interest to Milwaukee LIHF would be the Catalog of Initiatives Addressing Birth Outcomes in Wisconsin, which contains more than 100 different initiatives and agencies that assist with healthier birth outcomes.[143]

Maps of the locations of the FQHCs and safety-net clinics appear on the following pages.

[140] Boulton, G. (2011 March 18). State freezes BadgerCare Basic enrollment. *Milwaukee Journal Sentinel.* Retrieved from http://www.jsonline.com/business/118269999.html

[141] Marley, P., Stein, J. (2011 December 09). Thousands of Wisconsinites could lose health coverage. *Milwaukee Journal Sentinel*. Retrieved from http://www.jsonline.com/news/statepolitics/feds-ok-some-medicaid-changes-but-thousands-could-lose-coverage-iq3clku-135331808.html

[142] Peterangelo. (2011).

[143] Salm Ward, TC. & Bridgewater, F. (2011). *Catalog of Initiatives Addressing Birth Outcomes*. Center for Urban Population Health website: http://www.cuph.org/projects/birth-outcome-disparities-catalog/

Locations of Federally Qualified Health Clinics in Milwaukee, 2011 [144]

Progressive Community Health Centers

1. Lisbon Avenue Health Center, 3522 W. Lisbon Ave.
2. Hillside Family Health Center, 1452 N. 7th St.

Milwaukee Health Services Inc.

3. MLK Heritage Health Center, 2555 N. King Drive
4. Isaac Coggs Heritage Health Center, 8200 W. Silver Spring Drive

Health Care for the Homeless of Milwaukee

5. Administrative and Case Management, 711 W. Capitol Drive
6. Health Care for the Homeless Recovery Health Services, 210 W. Capitol Drive
7. St. Ben's Clinic, 1027 N. 9th St.
8. Walker's Point Community Clinic, 611 W. National Ave.
9. Angel of Hope Clinic, 209 W. Orchard St.
10. Salvation Army Clinic, 1730 N. 7th St.

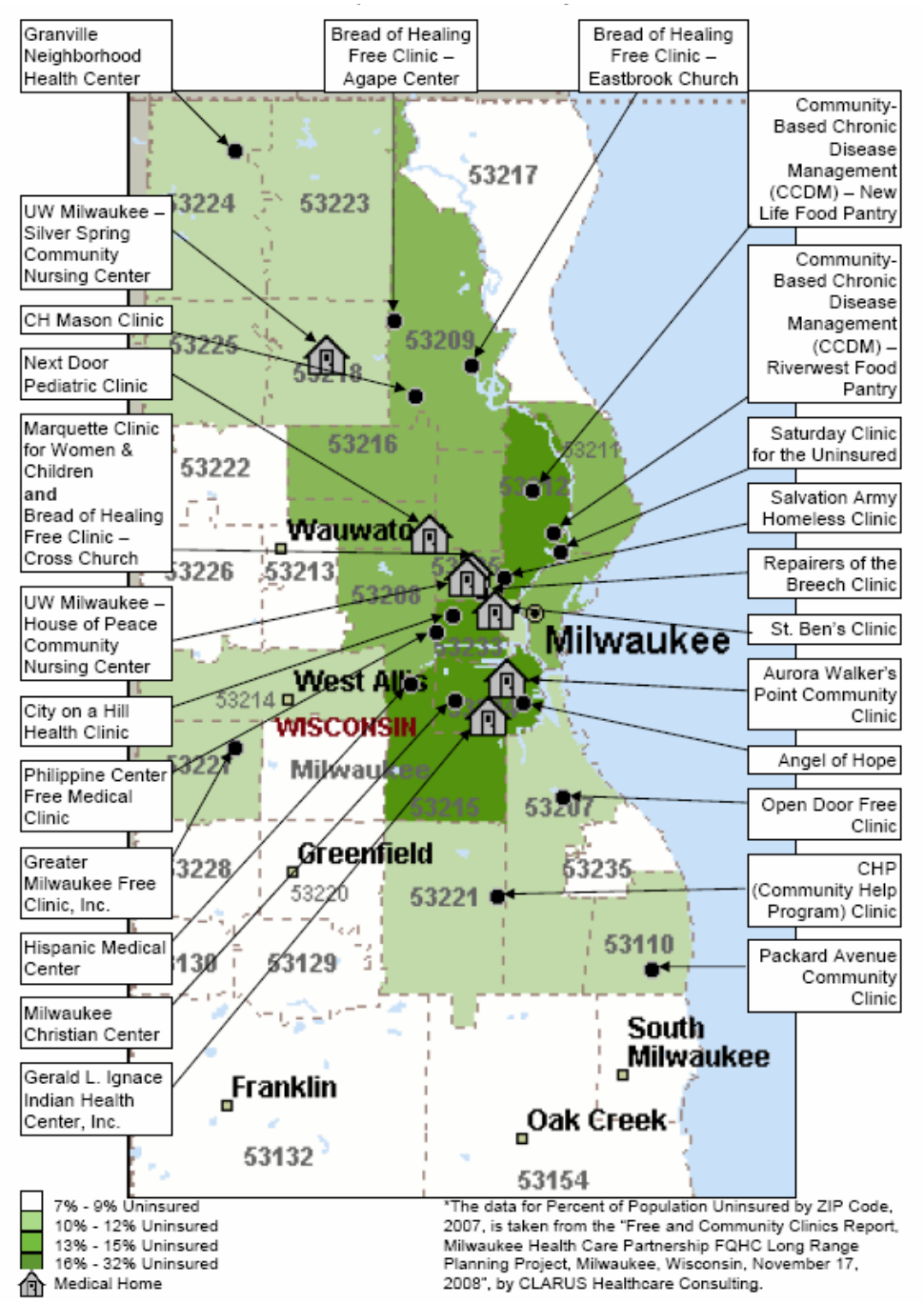
Sixteenth Street Community Health Center

11. Chavez Health Center, 1032 S. Chavez Drive
12. Parkway Health Center, 2906 S. 20th St.
13. Women, Infants & Children Nutrition Program, 1337 S. Chavez Drive

[144] Herzog, K. (2011 August 20). Knowledge is the key to a healthy pregnancy. *Milwaukee Journal Sentinel*. Retrieved from http://media.jsonline.com/images/LITERACY21G2F.jpg

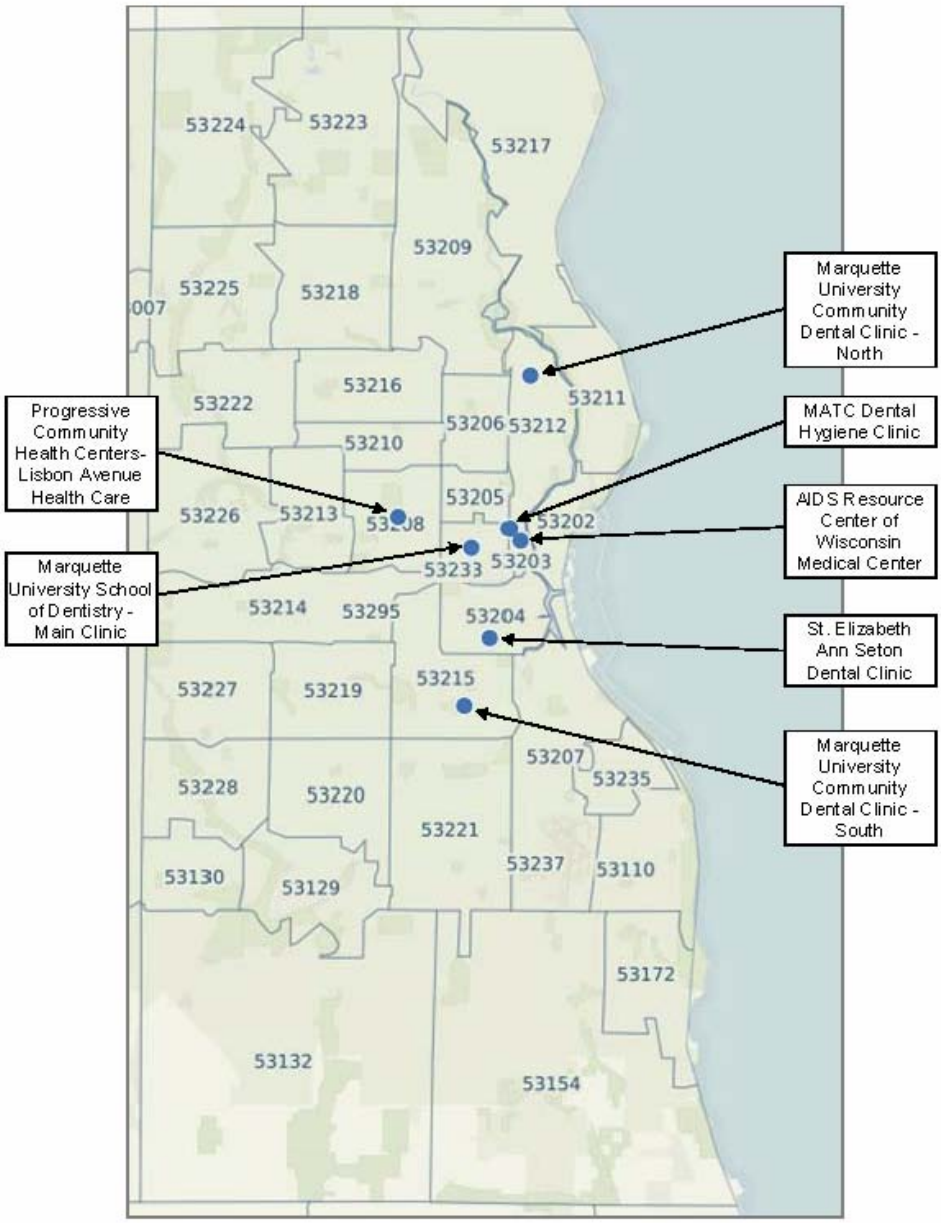
Map of Medical Clinics in Milwaukee County, 2009 [145]

With Percent of Population Uninsured by ZIP Code, 2007*



[145] Planning Council for Health and Human Services, Inc. (2009). *Inventory of Free and Community Clinics in Milwaukee County*. Retrieved from: http://www.planningcouncil.org/PDF/Inventory_of_Free_and_Community_Clinics.pdf

Locations of Dental Clinics in Milwaukee County, 2012 [146]



[146] Planning Council for Health and Human Services, Inc. (2012)., Inventory of Safety Net Clinics.

b. African American families and communities

As discussed earlier in this report, the isolation, marginalization and criminalization of black males is an extremely important determinant of overall outcomes for African American women and families. However, it must be recognized that a significant number of black males manage to overcome the negative influences in their lives. There are many examples of African American men who complete their educations, find good jobs, and raise successful families. Some examples of resiliency and how to build it have been studied and a few are summarized below.

- Parents who used an African American version of authoritative parenting—teaching their male children about cultural heritage and encouraging resiliency despite racial impediments—who were actively involved in monitoring their children's academic progress, and who were active in diminishing their children's counterproductive use of time, were better able to cultivate an environment in which African American males were more likely to succeed in school [147] [148]

- Education is most effective when it promotes positive, school-related growth experiences with particular emphasis on relationships, didactic learning, and emotional support.[149]

- Community resources and academic assistance to children in low-income areas builds character through civic engagement, volunteerism, and sports and improves academic functioning.[150]

- Teaching criteria should measure holistic qualities including: ability to make students feel supported, aptitude for letting students express themselves, and ability to critique students without negatively impacting their self-esteem.[151]

- Students enrolled in Milwaukee's public schools outperform, in both mathematics and reading, students enrolled in voucher schools.[152]

- Prospects for educational achievement are brightest for Milwaukee Public School students who are enrolled in Montessori Schools.[153]

In addition, there are a variety of promising practices related to African American fatherhood listed in Appendix F of this report.

[147] Mandara, J. (2006). The Impact of Family Functioning on African American Males' Academic Achievement. *Teachers College Record, 108(2).* 206-223.
[148] Tolan, PH. & Gorman-Smith, D. (1996 June). Prospects and possibilities: Next steps in sound understanding of youth violence. *Journal of Family Psychology, Vol 10(2).* 153-157. doi: 10.1037/0893-3200.10.2.153
[149] Toldson, I. (2011). *Improving Educational Outcomes for African-American Males by Building Academic Resiliency Skills.* Retrieved from the Scholar Centric website: http://www.scholarcentric.com/events/Webinar%20-%20February%202011.pdf
[150] Toldson. (2011).
[151] Toldson. (2011).
[152] McNeely. (2011).
[153] McNeely. (2011).

c. Economic and social determinants

Certainly, the economic news for everyone, both blacks and whites, during the recession of the late 2000s has been negative. Still, there are some bright spots.

Some employment sectors have experienced significant growth, even in the midst of the recession. In Milwaukee County, the management, education, hospital and social assistance sectors all saw increases in employment between 2007-2008.[154] More recent analyses show continued growth, with the Milwaukee Metropolitan Chamber of Commerce declaring "the trend among the most important indicators – jobs, unemployment, manufacturing – is largely positive," in August of 2011.[155] And the Wisconsin Department of Workforce Development projects that the employment sectors in the following chart will see significant growth in employment by 2016.

High Growth Employment Sectors in Metro Milwaukee[156]

Employment Sector	Number of Positions Added by 2016	Growth Rate by 2016
Healthcare Support	6,400	25.0%
Healthcare Provision	9,520	22.1%
Community & Social Services	2,800	21.6%
Life, Physical, and Social Science	1,000	13.5%
Leisure and Hospitality	8,230	11.7%

Finally, if segregation is a key health determinant and Milwaukee is the most segregated metropolitan area in the United States, then programs and initiatives related to equity, diversity and inclusion will be needed to reduce health disparities in the city. There may be many individuals who are working privately to increase equity in the city, but in terms of large-scale programs, there are only a few. The most noteworthy initiatives include a program run by the Greater Milwaukee Foundation called Milwaukee Mosaic and several YWCA programs.

From 2006-2010, Milwaukee Mosaic matched about 700 participants as partner-pairs across race and ethnicity in an effort to help individuals transform their beliefs about diversity. The program is currently in hiatus, but is mentioned here because those individuals who participated—who include Milwaukee's mayor and many private business leaders as well as grassroots activities—are a pool trained in diversity issues who could be mobilized as change agents.[157]

[154] Falk, B. (2009).
[155] BizTimes. (2011 October 07). *MMAC economic indicators are murky*. Retrieved from: http://www.biztimes.com/daily/2011/10/7/mmac-economic-indicators-are-murky
[156] Wisconsin DWD, 2006.
[157] Planning Council for Health and Human Services, Inc. (2010 August). *Milwaukee Mosaic Case Study*. Retrieved from: http://www.planningcouncil.org/PDF/mosaic%20pilot%20years%20report%20final.pdf

The YWCA is a significant asset to anyone in Milwaukee who is interested in increasing equity and inclusion. The mission of the YWCA is to eliminate racism, empower women and promote peace, justice, freedom and dignity for all. In pursuit of this mission, the local YWCA has developed several racial justice and anti-racism programs:

1. Camp Everytown [158] [159]

   People of different ethnic, religious, economic and cultural backgrounds, live and learn together as high school age delegates and adult staff create an inclusive community - a place to experience, appreciate, respect and understand people of diverse cultural traditions. Everytown prepares young leaders to challenge racism, sexism, heterosexism, ageism and ableism. The young people who come to Everytown are nominated by teachers, counselors, parents, and community leaders. Participation is based on the applicant's desire to participate and learn. Potential delegates are of high school age and must have completed the ninth grade.

2. Just Us (Justice Under Simple Terms: Understanding Stereotypes)[160]

   This racial justice program was designed by the Milwaukee YWCA specifically targeting youth enrolled in grades 9-12. Just "Us" is an antiracism curriculum divided into four programs meeting the needs of racial justice education in Milwaukee area high schools. Educators may choose to have four individual workshops that touch on each program, or turn one, two, or more programs into a series. Each program consists of eight weekly sessions for the length of the school's class period (i.e. 45 minutes). The Just "Us" series is conveniently offered to meet the needs of each participating school. The workshops are flexible as educators may regard certain materials more related and valuable to its student body. Whether choosing a one-time workshop or opting for a 32-week series, the curriculum is tailored to fit the preferences of the teacher and school.

3. Unlearning Racism Workshops [161]

   This workshop series provides an opportunity to discover the conscious and unconscious ways that racism has impacted our lives. Facilitated dialogue, activities, movies and listening pairs will move participants forward in addressing racism in our community. It is not expected that a participant will reverse a lifetime of experiences surrounding racism in six sessions. Rather, this series encourages individuals to incorporate knowledge and understanding into their own personal journeys as they begin or continue to eliminate racism in their sphere of influence. The expectation is that participants will attend all six sessions. Each session will last four hours.

During the planning phase Milwaukee LIHF engaged The People's Institute to do a short version of their **"**Undoing Racism Community Organizing Workshop" for members of the Collaborative. The Institute is headquartered in New Orleans but is a nationwide resource on anti-racism.

[158] YWCA of Greater Milwaukee. (2011). Everytown Wisconsin. Retrieved from: http://www.ywca.org/site/pp.asp?c=ekLPI7O1H&b=5105443
[159] Thomas-Lynn, Felicia. (2009 August 01). Summer camp with a difference. *Milwaukee Journal Sentinel*. Retrieved from: http://www.jsonline.com/news/wisconsin/52271972.html
[160] YWCA of Greater Milwaukee. (2011). Just Us. Retrieved from: http://www.ywca.org/site/pp.asp?c=ekLPI7O1H&b=3012681
[161] YWCA of Greater Milwaukee. (2011). Unlearning Racism. Retrieved from: http://www.ywca.org/site/pp.asp?c=ekLPI7O1H&b=1994075

3. Gaps

a. Health care and health care access

For insight into gaps in health care and health care access in Milwaukee, the City Health Department conducted in-person interviews with key leaders as well as focus groups with community residents to help identify the top community health needs in the city. Participants identified the following health issues as their top concerns:

- Access to healthcare /under/uninsured /healthcare-related issues
- Violence /crime /public safety
- Unemployment /job availability
- Poverty / financial stress
- Poor quality education
- Race relations /segregation
- Nutrition /obesity
- Teen pregnancy
- Equal opportunity for different races /immigration status
- Drugs and drug abuse
- STIs [162]

Another deficit that relates to health care is literacy. Literacy skills are the strongest predictor of health - more than age, income, employment status, education level, race or ethnicity, according to the Partnership for Clear Health Communication. Older patients, recent immigrants, people with chronic diseases and those living in poverty are especially vulnerable to low health literacy. [163]

Access to health care is closely tied to the presence of hospitals near the population in need. However, as noted earlier in this report, hospitals have been abandoning Milwaukee's central city for decades. To partially replace Doyne Hospital, the primary provider of health care to central city residents which was replaced in 1995 with Froedtert Hospital, Milwaukee County created the General Assistance Medical Program (GAMP). GAMP provided health coverage for low-income, childless adults – the portion of Milwaukee County's low-income population that didn't qualify for Medicaid at the time. When the State of Wisconsin expanded BadgerCare in 2009 to cover childless adults, the GAMP program was eliminated. Now there is concern that, with the state's proposed $500 million in Medicaid cuts over the next two years, private hospitals may be faced with further cuts in Medicaid reimbursement and/or an increase of uninsured patients, which could in turn lead them to further curtail operations in the central city. Consequently there could be no public safety net program to provide backup.[164]

[162] City of Milwaukee Health Department. (2008). *Community Health Assessment 2008*. Retrieved from http://city.milwaukee.gov/ImageLibrary/Groups/healthAuthors/MAPP/PDFs/2008_Comm_Hlth_Assessment809__2_.pdf
[163] Herzog. (2011 November 09).
[164] Peterangelo. (2011).

Mental Health

A recent report authored by the Human Services Research Institute found many gaps in Milwaukee's adult mental health care delivery system. Sections of the report are quoted below.[165]

- **Consumer Refusals -** Multiple data sources showed that consumers in Milwaukee County are refusing services at a very high rate. The analysis suggests that consumers are refusing services for a number of reasons, including a desire for more shared or independent decision-making and a need for more education regarding available services. The extremely high number of involuntary commitments to the system also may explain the high rate of refusals.

- **Opportunities to Increase and Expand Community-Based Services -** The analysis found that very few individuals are receiving an adequate amount of community-based services, including outpatient care. Accessibility issues included limited service capacity and issues with insurance. Taken together, the data suggests the need for a re-evaluation of the structure and amounts of community-based services, including outpatient and case management services.

- **Peer-Operated and Peer Support Services -** Analysis of the data demonstrated that it will be important to further develop peer-operated and peer support services in the mental health system in Milwaukee County. The data suggest a need for the expansion of peer-operated services as well as for consumer and provider education regarding the benefits of these services.

- **Use of Crisis Services -** Milwaukee County consumers are receiving crisis services more often than any other services, and the frequency of emergency detentions are a major challenge for all system stakeholders. Some key informants expressed a hope for greater availability of crisis prevention and crisis alternative services such as drop-in centers, crisis phone lines, and crisis respite.

- **Inpatient Service Capacity -** Stakeholders at all levels are similarly concerned about the efficiency and accessibility of inpatient care in the County. The analysis found that while there is sufficient inpatient capacity, there is a need to reorganize care so that the existing beds are used more efficiently.

[165] Human Services Research Institute. (2010).

b. African American families and communities

In doing the research for this report, it was noted that the majority of data available on African American males tends to focus on negative outcomes, with little information on the resiliency and success of some males. As an interviewee stated in one study, "We know one in three African American men has some experience with the criminal justice systems before age 30, but we don't know about the other two out of three."[166] The same study recommended that more needs to be known about the intersectionality of race and gender for black males.

Regarding the gaps in human services in Milwaukee, a recent study by the Social Development Commission[167] states that there is a consensus that not enough is being done on a wide variety of issues in Milwaukee, including:

- Employment
- Education
- Family and Relationships
- Health and Healthcare
- Use of Available Income
- Housing
- Food and Nutrition
- Transportation

[166] Trammel. (2008).

[167] Davis, GS. (2010 March). *CSBG Community Needs Assessment, Chapter II.3: Consumer Interviews*. University of Wisconsin-Milwaukee, Center for Urban Initiatives & Research, and the Social Development Commission. Retrieved from: http://www.cr-sdc.org/DefaultFilePile/PolicyandResearch/ConsumerInterviewReport.pdf

c. Economic and social determinants

Much has already been said about the job gap in the city of Milwaukee. There is one statistic, however, that sums up the state of employment today: it is estimated that the job gap in the inner-city is 25:1—that is, there is only one job available for every 25 inner city Milwaukee resident looking for work.[168]

Studies of job seekers generally show that they feel they lack the training or education needed to get a job. For instance, in a recent SDC study, seventy-one percent of respondents who indicated they were looking for work said they needed more training or education to get the job they wanted, or a better job.[169] The desired types of training are listed in the following table.

Table 15. Desired Types of Job Training

	Count	Percentage
Computer / Engineering/ Technical	29	21%
College Education	26	19%
More Education / Training (general)	25	18%
Medical	21	15%
Trades / Vocational	17	12%
GED / High School Diploma	14	10%
Business	13	9%
Other	7	5%
Childcare	5	4%
Food Service / Culinary	4	3%

Computer, engineering, or technical training was the type of training most frequently wanted by respondents (21%). Nineteen percent suggested that a college education would meet their needs. The third most common response was more education or training in general. Medical training was another common response, mentioned by 15% of respondents answering this question.

[168] University of Wisconsin-Milwaukee, Employment & Training Institute. (2009). *Socio-Economic Analysis of Neighborhood Issues Facing Milwaukee Public Schools Students and Their Families.* Retrieved from http://www4.uwm.edu/eti/2009/MilwaukeeSocioEconomicAnalysis.pdf

[169] Davis. (2010).

Transportation is another gap frequently cited by job seekers. In the SDC study, over half of respondents (59%) said they have a driver's license. Of those that did not, 27% said that it was because of legal problems, like tickets. Fifty-two percent of respondents indicated that they are car owners. Among these respondents, 52% indicated that the cost of car maintenance or repair has been a problem in the past year, and 44% said that the cost of car insurance has been a problem in the past year.[170] The

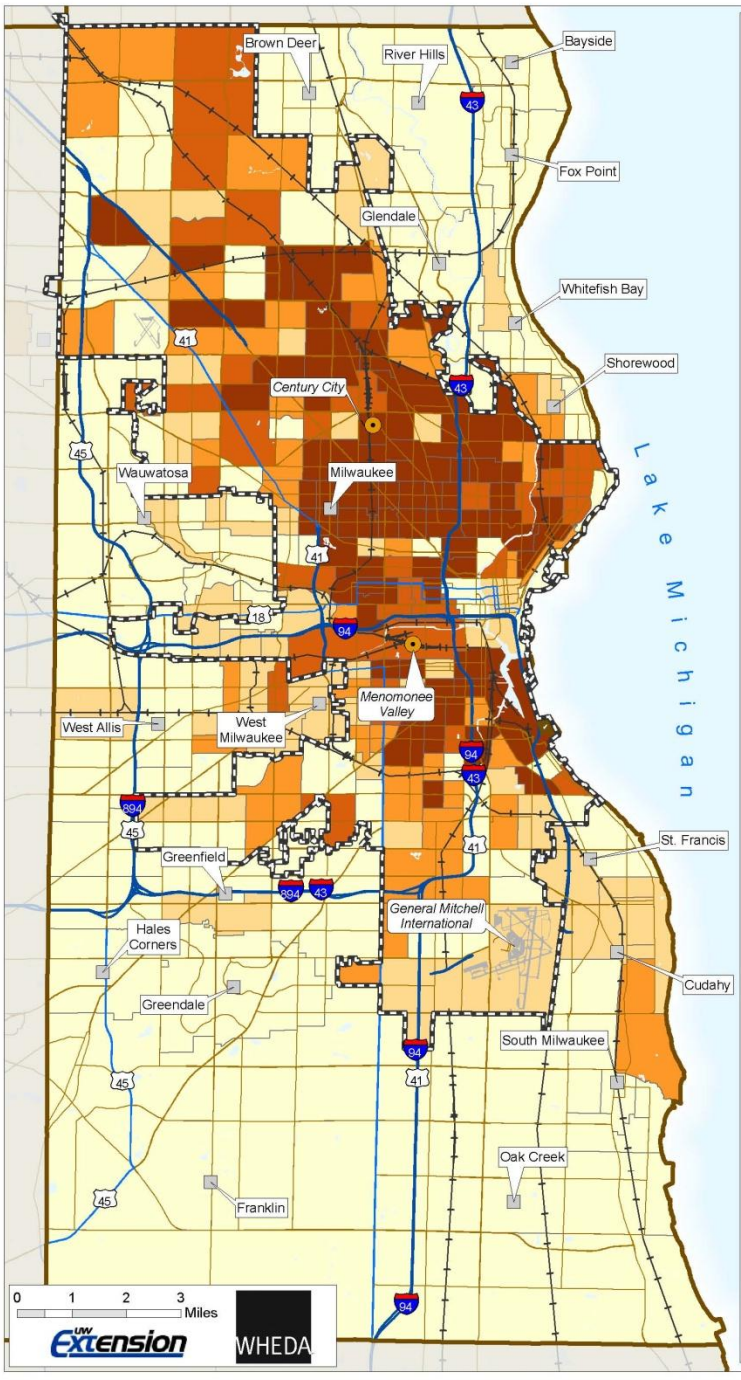
In the same study, respondents were asked if they have trouble getting where they need to go, like food stores, doctor's offices or hospitals. Nearly a quarter (23%) indicated that they had a problem getting where they need to go. Thirteen percent of all respondents reported that there are disabled persons in their household who have transportation problems, compared with 10% who have seniors in their household who have transportation problems.[171]

The map on the following page shows that workers in central city neighborhoods are more likely to rely on public transportation to get to work than are residents of other Milwaukee neighborhoods.

[170] Kovari. (2010).
[171] Kovari. (2010).

Percent of Workers Commuting to Work by Public Transportation

2006 to 2010 American Community Survey Estimates by Census Tract



Percent of Workers Age 16 and Over Commuting by Public Transportation

- Less than 2.5%
- 2.6% to 5.0%
- 5.1% to 7.5%
- 7.6% to 10.0%
- 10.1% or More

Other Features

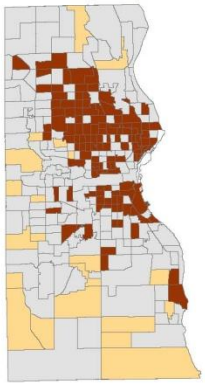
- Limited Access Highway
- Other Highway
- Major Road
- Railroad
- City of Milwaukee Boundary
- County Border
- City or Village Centroid

Area	Public Transportation (Margin of Error)
City of Milwaukee	8.5% (+/- 0.4%)
State of Wisconsin	1.8% (+/- 0.1%)
United States	4.9% (+/- 0.1%)

Data Sources: U.S. Census Bureau, 2006 to 2010 American Community Survey and University of Wisconsin-Extension Center for Community & Economic Development
Map Production: December 2011

Important Note: The values for tracts shown in different classes may not be statistically different. A statistical test is needed to make such a determination.

Census Tract Statistical Significance Compared to Wisconsin's Rate



- Not Statistically Different at 90% Level
- Higher than State at 90% Level
- Lower than State at 90% Level

UW Extension WHEDA

B. Social determinants of health

Beyond health care and individual health behaviors, we as a community must work harder to address the social factors - including racism, poverty and unemployment - that contribute to premature births. The benefits of addressing these "upstream" social and economic factors—which some experts believe are more powerful determinants of health than individual behaviors and access to health care—extend well beyond prematurity and would reduce health disparities in many areas, from infant mortality to cancer and other chronic diseases.

- Anna C. Benton, Milwaukee Journal Sentinel 6/5/10

The Milwaukee LIHF Collaborative, carefully considered all of the information in the preceding sections of this report, and performed an analysis to determine which ZIP codes of the City of Milwaukee were the most severely impacted by the social determinants of health. This analysis was performed as follows:

- The data for each of six indicators of interest to the Collaborative (African American population, African American infant mortality, household income, male unemployment and male incarceration) were divided into four groups (quartiles) to make the individual maps for each indicator.

- To make a final, combined map, each group was assigned a number from 1 to 4. The group with the highest value (darkest color) was given a 4, the next highest a 3, the next a 2, and the lowest value (lightest color) a 1.

- For example, the ZIP codes with the highest infant mortality rates were assigned a 4 for that indicator and the ZIP codes with the lowest infant mortality rates were assigned a 1 for that indicator.

- Scores for the 6 indicators were then added together to get a combined score for each ZIP code. Remember that not all ZIP codes had data available for Corrections System involvement.

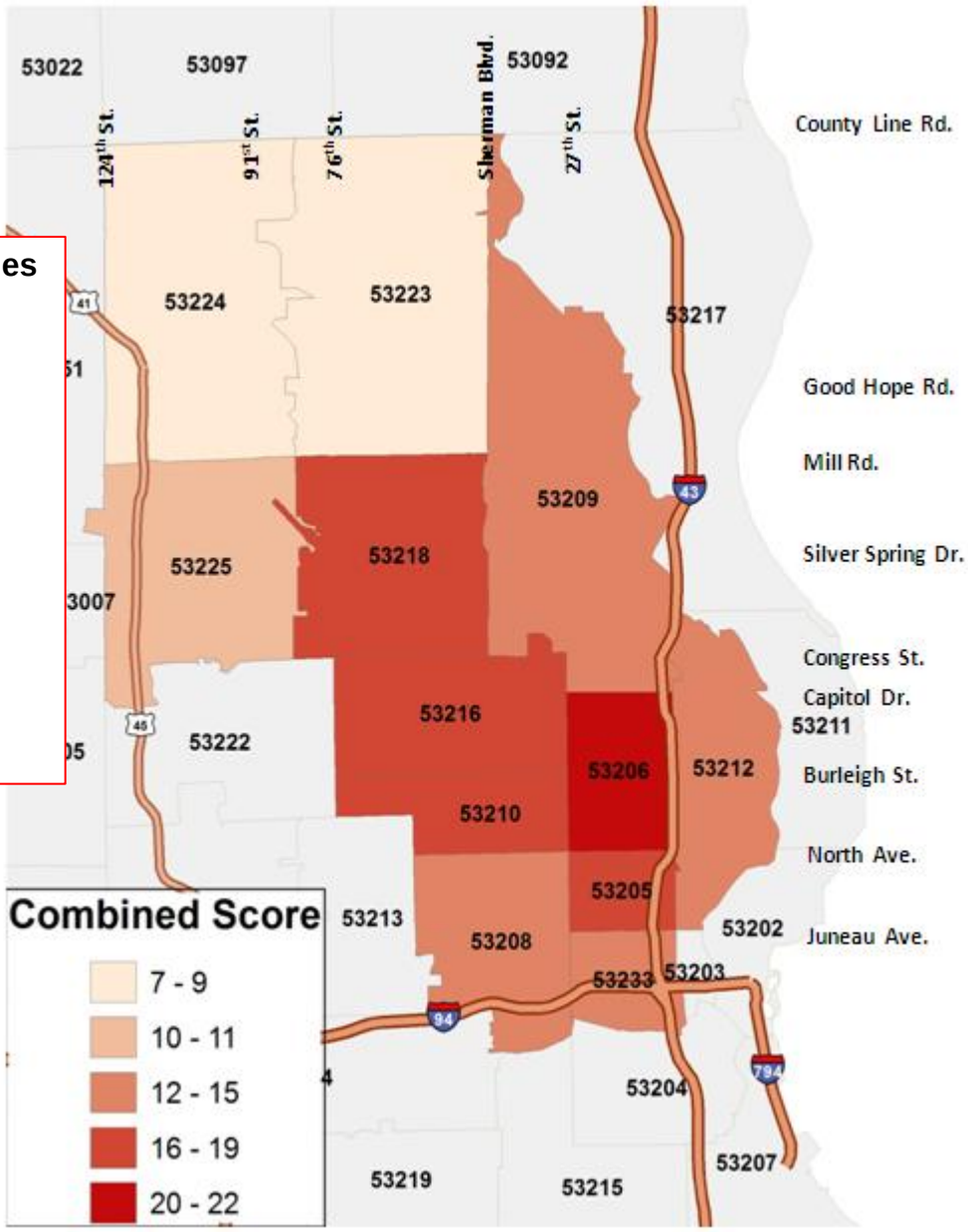
- The lowest possible combined score a ZIP code can have is 5; the highest possible combined score is 24.

The map on the following page therefore represents the ZIP codes of greatest need within the City of Milwaukee. These are the ZIP codes with higher combined scores which, in general, have higher rates of infant mortality, greater percentages of African American residents, lower average household incomes, higher male unemployment, larger numbers of total residents, and (where data is available) higher numbers of residents that are involved in the corrections system.

Milwaukee ZIP Codes of Greatest Need

Targeted Zip Codes

- **53206**
- **53210**
- **53205**
- **53216**
- **53218**
- **53233**
- **53208**
- **53209**
- **53212**
- **53225**
- **53224**
- **53223**

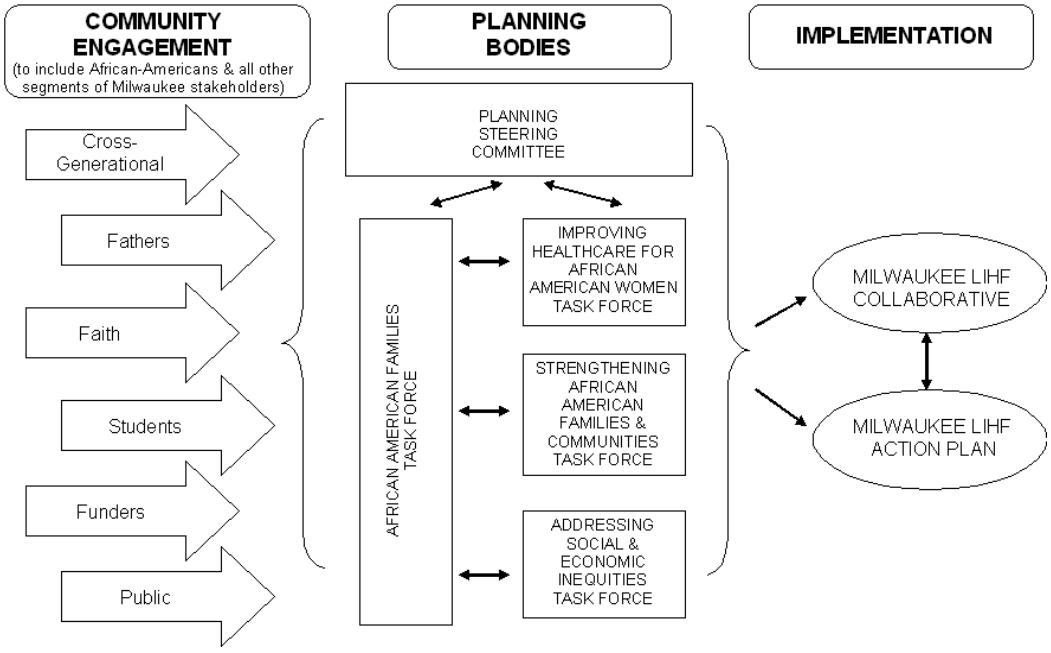


IV. The Milwaukee Lifecourse Collaborative

Collective Impact: The commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem. . . . The belief that large-scale social change comes from better cross-sector coordination rather than from the isolated intervention of individual organizations.
– Stanford Social Innovation Review, Winter 2011

A. Structure, Roles & Responsibilities – Planning Phase

The planning phase for Milwaukee LIHF officially lasted from June 2010 through July 2011, but in reality began about nine months prior to its official start date. In October and December of 2009, Milwaukee stakeholders (community members and representatives of a wide variety of organizations) participated in several community meetings to learn about the Milwaukee LIHF initiative and provide input on an application to the Wisconsin Partnership Project for planning dollars. Local people essential to the success of this endeavor, as well as possible volunteer leaders of the process, were identified and one-on-one meetings were held to get their feedback and solicit their support. Drafts of the proposal were sent out to all community members who expressed an interest, and their feedback incorporated into the submitted version. Support was expressed by 69 individuals and 41 agencies representing academic institutions, business, community based organizations, early education, Milwaukee Public Schools, the faith community, Federally Qualified Health Centers, state legislators, health care providers and health systems, local health coalitions, health departments, child welfare agencies, foundations and other funding partners, HMOs, State Department of Health Services, WIC program, and representatives of the target population. This group of "LIHF Supporters" continued to grow throughout the course of the planning process, resulting in more than 100 individuals actively involved in various committees and task forces related to the Milwaukee LIHF initiative (see Appendix C). The following graphic represents the structure of Milwaukee LIHF during the planning phase:



1. **Roles and Responsibilities of Milwaukee LIHF Volunteers – Planning Phase**

   a. ***Planning Steering Committee***. Individuals were selected to serve on the Milwaukee LIHF Planning Steering Committee to represent key sectors and organizations, while also ensuring community representation. Sectors represented included health care systems, major funding partners, institutions of higher education, local businesses, the City of Milwaukee Health Department, the faith community and local nonprofits focused on health, fatherhood, reproductive justice and other related issues. This group provided leadership, guided the planning process, and laid the ground work for the future development of the collaborative, including charter, governance, decision-making and funding. The steering committee met at least monthly, and engaged in frequent telephone conferences and email exchanges throughout the 13-month planning process to fulfill the following responsibilities:

   - Represent the community's stake and interest in the Milwaukee LIHF Collaborative project;
   - Be ambassadors and promoters of the project to the community;
   - Attend monthly meetings of the Planning Steering Committee;
   - Work with the conveners to organize and host informational and input sessions of the task forces organized around the three areas of focus;
   - Attend task force meetings whenever possible;
   - Assure engagement of key stakeholders;
   - Develop an overall project theory of change and logic model;
   - Help leverage additional resources for the project;
   - Review, vet and approve the Milwaukee LIHF action plan; and
   - Evaluate the process.
   - Review the evidence based strategies in the Lifecourse model;
   - Learn what's working now in Milwaukee;
   - Find out what is needed/missing in Milwaukee;
   - Examine related research;
   - Study evidence-based model programs;
   - Recommend the one (or at most two) best strategy(ies) in each domain for Milwaukee based on the 12-point plan;
   - Create the action plan based on the chosen Lifecourse strategy within the designated domain; and
   - Assist in creating the overall action plan for Milwaukee based on the selected strategy(ies).

   b. ***Planning task forces.*** Chairs for each of the task forces were identified from the core Steering Committee; one co-chair to be a professional and the other to be a representative of the community of concern. These co-chairs were responsible for convening community members, experts and practitioners around the Lifecourse strategies within their respective domains. For each of the identified strategies within the domain, the role of members of the Task Force was to:

   - Review the evidence based strategies in the Lifecourse model;
   - Learn what's working now in Milwaukee;
   - Find out what is needed/missing in Milwaukee;
   - Examine related research;
   - Study evidence-based model programs;
   - Recommend the one (or at most two) best strategy(ies) for Milwaukee based on the 12-point plan;

- Create the action plan based on the chosen Lifecourse strategy within the designated domain; and
- Assist in creating the overall action plan for Milwaukee based on the selected strategy(ies).

2. Community Engagement - Planning Phase

a. African American Task Force

The African American Taskforce provided the community leadership and perspective that is required for a successful community driven effort. It was composed of members of the impacted population who brought life experience, resources, wisdom, perspective and commitment to reducing African American infant mortality. They served as the lens through which the Collaborative's strategies and recommendations were vetted and approved.

b. African-American cross-generational engagement.

New Concept Self Development Center, Inc., a private non-profit comprehensive human series agency that has been serving the community for more than 30 years, was asked to partner with the Planning Council for Health and Human Services Inc. to assist in ***Engaging cross-generational input*** in the Life-course Initiative for Healthy Families planning process. Consistent with the Life-course model, the voices and perspectives of African Americans across the generations were sought out to be incorporated into the planning process. New Concept convened groups across the generations in an age-appropriate manner to and gathered their input and perspective. Groups included Adolescent Girls, Teen Mothers, Adult Women, Professional Women, Grandmothers, Group Home Women, Adolescent Boys, Adult Males, and Grandfathers. The groups were conducted between December, 20, 2010 and April 9, 2011. The discussions revealed personal stories, insights, and perspectives can be used to enhance the understanding of the problem, and add strength to the solutions that are proposed. Everyone that participated in the group experienced a loss, either themselves, within their family, or a close friend. Types of loss experienced include miscarriages, still births or the death of an infant before its first birthday. In the case of many individuals, they had experiences multiple losses.

Overall, participants were very interested in discussing the loss that they had experienced. The participants expressed some comfort and also some surprise in the fact that there were so many others who had experienced a loss similar to theirs (or their families). Participants had varying levels of knowledge of the situation, with the women and grandmothers being more informed and the adolescent boys knowing the least. More detailed results are included in Appendix D.

c. ***Youth Engagement*****.** To increase community engagement in the planning process, Milwaukee LIHF partnered with the Milwaukee Public Allies program. A team of six Allies committed to helping Milwaukee LIHF by facilitating infant mortality public awareness trainings for audiences of diverse youth and young adults at a variety of locations throughout Milwaukee County. The key methodology used by the Allies was to arrange showings of the video "When the Bough Breaks" from the acclaimed television series "Unnatural Causes." Allies were trained to facilitate pre- and post-discussions of the video to help audience members better understand the issue of infant mortality in general, and in Milwaukee in particular. The Allies were able to educate over 150 young people between the ages of 14 and 30 about the high rate of black infant mortality in Milwaukee. They made them aware of the different causes of black infant mortality and the role that racism plays in African-

American women in the United States having healthy babies. They were also able to get contact information for these 150 individuals to encourage them to stay connected and involved in Milwaukee LIHF. The information sessions helped to put the issue of black infant mortality on the activist agenda of audience members, many of whom were already socially aware but unfamiliar with the disparities in infant mortality in Milwaukee. The goal is for them to continue to work for change in the Milwaukee community and educate others about the issue of black infant mortality. In addition to Public Allies, the planning phase involved Alverno students, a Triumph intern from the Medical College of Wisconsin, and other Medical College interns.

d. ***Engaging public input*****.** A "virtual space" was created to facilitate input from the community at large into the planning process. It also served as a way to connect the various people directly involved in the task forces and committees. This space had a calendar where anyone involved in the project could post pertinent events. Meeting agendas and minutes were posted as well as links to media coverage of infant mortality in Milwaukee. In addition, monthly email newsletters, a blog, social media, and other methods were used to keep in contact with all interested parties and also encourage two-way communication with the public. http://milwaukee-lihf.wikispaces.com/

3. Roles and Responsibilities of Milwaukee LIHF Conveners (Staff) - Planning Phase

Milwaukee LIHF Planning Project Director (.25 FTE)

- Maintain overall responsibility for the project
- Provide overall staff leadership to the project
- Staff the Steering Committee
- Act as liaison to the WPP and to the other LIHF grantees;
- Build the collaborative by engaging diverse individuals as supporters
- Direct the planning process, including development of overall logic model and project theory of change
- Direct kickoff event
- Provide large group facilitation
- Direct engagement strategies
- Direct input and vetting of the plan by the steering committee
- Supervise the staff
- Be accountable for the overall planning phase of the Milwaukee LIHF project

Milwaukee LIHF Planning Project Manager (1 FTE)

- Build the collaborative by engaging diverse individuals as supporters
- Manage kickoff event
- Staff task forces (Health, Family and Socio-economic Task Forces)
- Manage development of task force logic models (Health, Family and Socio-economic Task Forces)
- Manage engagement of the faith community, fathers and students groups
- Help refine planning process and structure
- Identify existing examples of programs using strategies
- Summarize and present relevant data to the collaborative
- Manage sharing of information across task forces
- Assist co-chairs and members in completing tasks
- Provide expertise in outcome-focused planning
- Write reports

Milwaukee LIHF Community Engagement Manager (0.50 FTE)

- Build the collaborative by engaging diverse individuals as supporters
- Staff the African American Task Force
- Coordinate development of task force logic model (African American Task Force)
- Coordinate engagement of the cross-generational and funder groups
- Help refine planning process and structure
- Provide consultation on existing examples of programs using strategies
- Summarize and present relevant data to task force and groups
- Assist co-chairs and members in completing tasks
- Provide expertise in social change model

Milwaukee LIHF Planning Project Development Manager (.25 FTE)

- Manage literature review of strategies within the domains
- Compile existing data to support planning process
- Establish project web presence and communication plan to facilitate public input
- Assure information transfer across task forces through electronic access to information
- Manage local public education and awareness plan in collaboration with WPP
- Manage community needs assessment in collaboration with WPP
- Manage fund development strategies in preparation for implementation phase of project
- Work with WPP on cross-site evaluation of project

Milwaukee LIHF Planning Project Assistant (.50 FTE)

- Assist to schedule all project meetings and events
- Coordinate logistics for all project meetings and events, including food, meeting space, babysitting service, agenda and other meeting materials
- Take notes at all project meetings
- Provide written minutes of all project meetings

B. Structure, Roles & Responsibilities – Extended Planning & Implementation

1. Extended Planning Phase

Milwaukee LIHF engaged in an "extended planning phase" that occurred between the end of the planning phase and the beginning of the implementation phase (August 2011 through March 2012). This period allowed continued progress and helped bridge the effort from the original planning period to the implementation phase for the collaborative and the implementation and evaluation grants. This extended planning phase acknowledged the importance of maintaining the Milwaukee LIHF Collaborative's momentum, community engagement strategies and relationship building activities that will be needed for successful implementation.

The tasks the collaborative implemented during this period include the following:

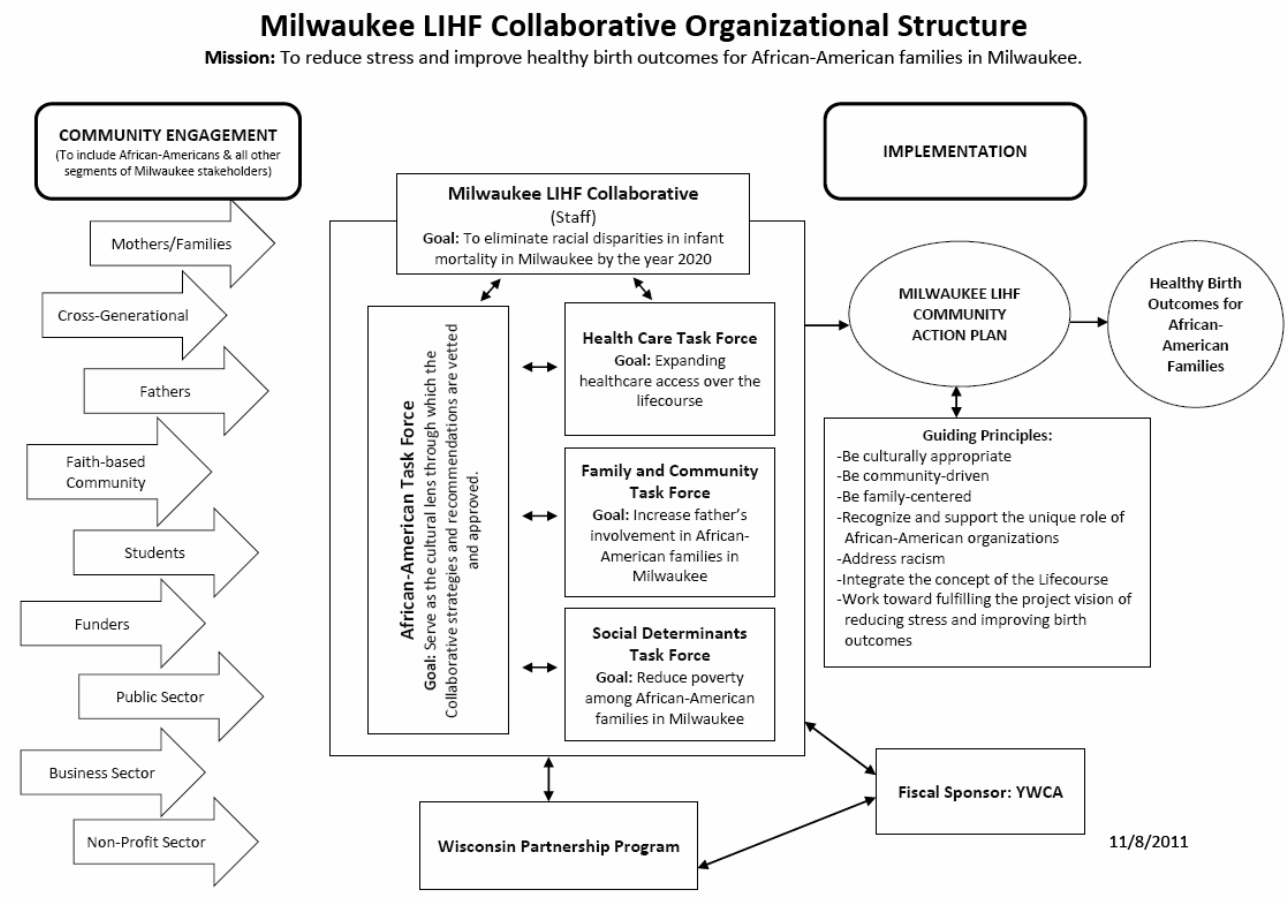
- Continuing to build public awareness and support of the Community Action Plan;
- Refining membership and roles of the Collaborative;
- Refining structure and policies of the Collaborative;
- Supporting monthly meetings of the Steering Committee and one additional meeting of each of the Task Forces;
- Building capacity of the Collaborative including further work on the essential components of the Community Action Plan, the effect of racism on maintaining a collaborative, and coaching and development for community consultants;
- Conducting outreach and orientation of potential grantees;
- Participating in WPP training and technical assistance efforts and helping to prepare community organizations for academic partnerships; and
- Working with WPP on the media campaigns, evaluation and communications.

2. Implementation Phase

At the completion of the extended planning phase in March 2012, Milwaukee LIHF will enter into the implementation phase. After this date, qualified entities will begin to receive grant funding to implement strategies that are in line with the priorities of the Community Action Plan, and WPP will continue to support the ongoing operations of the Milwaukee LIHF Collaborative. Because Milwaukee LIHF is not a 501(c)(3), in fall 2011, the Collaborative issued an RFQ for qualified agencies interested in serving as a fiscal sponsor. The YWCA of Greater Milwaukee was selected as the fiscal sponsor. The YWCA is in alignment with the LIHF mission in that the agency seeks, through racial justice work, to educate people on the disparities that exist in the community and how they can address these within their spheres of influence. The YWCA is deeply involved with and committed to the African American community: 40% of the board, 63% of the staff, and 80% of the population served by the agency is African American.

a. Organizational Structure – Extended Planning and Implementation Phases

The organizational structure for the Collaborative during the extended planning and implementation phases is represented on the next page, and includes details on the relationship between Milwaukee LIHF, the fiscal sponsor and WPP.



Milwaukee LIHF will hire a project consultant to direct and manage the implementation phase of its work. Specific responsibilities of the consultant will include:

- Assist the Collaborative in continuing to develop consensus and community buy-in for the Community Action Plan; coordinate public meetings and presentations, press relations and education sessions on the causes of racial disparities in birth outcomes and recommended strategies and policy changes.
- Strengthen and enhance the Collaborative and its task forces (Healthcare Access, Strengthening African American Families, Social Determinants and the African American Task Force) to assure shared governance. Staff regularly scheduled and special meetings, meet with Co-Chairs to establish agendas, assure timely notification of participants, arrange meeting time, place, materials, babysitting service and food within budget constraints. Record meetings, produce minutes, follow-up.
- Build awareness and participation among the impacted population, specifically African Americans of child-bearing age.
- Increase the involvement of the business sector in the initiative.
- Engage the faith community in building awareness and support.
- Act as liaison between Wisconsin Partnership Program (WPP) staff and the Milwaukee LIHF Collaborative. Engage academic partners from UW-Madison School of Medicine and Public Health; work with counterparts in Racine, Kenosha, and Beloit as well as other state and local efforts to address infant mortality.

- Support WPP efforts in evaluation, communication and development work groups and coordinate community participation in the work groups.
- Participate in the Division of Public Health's efforts to increase African American response rate to the PRAMS.
- Maintain public awareness of the work of the Collaborative by supporting the wiki and using other social media to engage and inform the impacted population and members of the broader public.
- Support additional WPP-sponsored community education and public awareness efforts.
- Work with Fiscal Sponsor to delineate various responsibilities and projected costs of implementing the Collaborative workplan.
- Prepare narrative reports and grant requests.
- Work with funded implementation grantees to coordinate efforts, share lessons learned, and measure and report progress toward the Community Action Plan.
- Coordinate and leverage resources by raising funds from State, local and national sources to support the Collaborative in Year 2 and beyond.

Required characteristics and abilities of the Milwaukee LIHF Collaborative project consultant include:

- Knowledge of African American culture and organizations;
- Familiarity with Milwaukee-based organizations and institutions;
- Experience with the life-course perspective, health and family issues;
- Specialized knowledge and experience in priority areas of the Community Action Plan including working with grass roots organizations and efforts to increase father involvement;
- Demonstrated ability to work well with a wide range of people;
- Experience in resource development, grant writing, and project management; and
- Ability to manage competing demands.

b. Operating Policies and Procedures - Extended Planning and Implementation Phases

I. IDENTITY

The Milwaukee Lifecourse Initiative for Healthy Families (LIHF) is a community driven collaboration with a goal of eliminating racial disparities in birth outcomes for African Americans through an active partnership of stakeholders. “Community-driven” will be reflected in the agreed upon leadership role for members of the impacted population and the African American Taskforce. It is more than focusing efforts on the impacted population and includes the genuine ownership, leadership and involvement of the impacted population in the effort. (See attached chart.) The collaboration is a collective impact initiative composed of members of the impacted population as well as representatives from different sectors who together make a long-term commitment to the common agenda of eliminating racial disparities in infant mortality in Milwaukee. The actions of the collaborative will be supported by a common agenda, a shared measurement system, mutually reinforcing activities, ongoing communication, and an independent support organization.[172]

The Collaborative is supported in part by the Wisconsin Partnership Program of the School of Medicine and Public Health at the University of Wisconsin. Recognizing the need for long-term investment, the support extends from April, 2012 through 2015.

II. VISION, MISSION, AND GUIDING PRINCIPLES

A. Vision

The overall vision for the Milwaukee LIHF Collaborative is that African American families have less stress and more healthy birth outcomes in a community where: residents love, trust, are nurturing and respect each other; healthy lifestyles across the lifecourse are promoted; and family supports, education and other resources are available.

B. Mission

The mission of the Milwaukee LIHF Collaborative is to reduce stress and improve healthy birth outcomes for African American families in Milwaukee.

C. Goals

The overall goal of Milwaukee LIHF is to eliminate racial disparities in infant mortality in Milwaukee by the year 2020. Subsets of this goal will include: increasing the number of African American babies who are full term; increasing the number of African American babies with healthy birth weights. Milwaukee LIHF will move beyond the clinical outcomes by addressing fatherhood and improving educational opportunities for African-American males; improving employment opportunities for African-American males; and reducing racism and poverty as it relates to African-American males. Specific outcomes measures and targets will be set for the year 2015.

[172] Kania, J. & Kramer, M. (2011 Winter). Collective Impact. *Stanford Social Innovation Review, 9(1).* 39.

Specific goals to reduce stress and promote healthy birth outcomes include:

1. Improving healthcare for African American families by **expanding healthcare access over the lifecourse.**
2. Strengthening African American families and communities by **strengthening father involvement in African American families** and
3. Addressing social determinants by **reducing poverty among African American families**.[173]

D. Guiding Principles

The Milwaukee LIHF Collaborative

1. Recognizes that infant mortality is a community issue.
2. Promotes culturally appropriate practices.
3. Acknowledges the role families play in promoting positive health behaviors.
4. Recognizes the unique and important role that African American organizations play by providing concrete, financial, and community support.
5. Supports the development and utilization of culturally appropriate research while recognizing that more research is needed.
6. Advances strategies that:
   a. Are community-driven
   b. Are culturally appropriate
   c. Are family-centered
   d. Address racism
   e. Incorporate the concept of the lifecourse

III. MILWAUKEE LIHF ACTIVITIES AND OUTCOME MEASURES

In accordance with the agreement with the Wisconsin Partnership Program, the Collaborative will focus its efforts and assess its progress in the following four key, inter-related areas. Additional activities and roles beyond those identified here will be developed.

1. **Provide strategic leadership** in the community on the issue of African American infant mortality and efforts to improve health for African American women, infants and families.
2. **Develop buy-in and sustain commitment** in the community for the Community Action Plan.
3. **Influence policy, community-level and other environmental changes** that support and amplify the impacts of other initiatives in the community focused on improving African American birth outcomes and health.
4. **Leverage local and other resources** to support efforts to improve birth outcomes and health among African Americans, as outlined in the Community Action Plan.

[173] Each taskforce will set measurable objectives.

Key Area 1: Provide strategic leadership in the community on the issue of African American infant mortality and efforts to improve health for African American women, infants and families.

Activities and Roles of the Collaborative	Main Outcome Measures
1. Raise and maintain public awareness of the issue of high rates of infant mortality and poor birth outcomes among African Americans in Milwaukee	• Increased awareness of infant mortality and poor birth outcomes
2. Serve as an information source in the community about infant mortality; local efforts to improve African American birth outcomes and health; and principles of the Lifecourse model.	• The Collaborative is seen as a key information source in the community and members are consulted about these topics.
3. Coordinate efforts in the community to improve African American infant survival and the health of African American women, infants and families, including efforts of the LIHF project grantees. Activities to focus on: • encouraging communication between service providers; agency leaders; and community members and advocates • on-going assessment of programs and services for gaps, duplication and barriers • developing strategies to maximize resources, improve service delivery, and meet community needs	• Improved service delivery and coordination • Increased interagency cooperation
4. Develop and maintain an organizational and governance structure for the Collaborative that: • encourages participation in the Collaborative by a broad range of stakeholders, and particularly African American community members • facilitates effective and inclusive decision-making • develops consensus and provides direction for future activities and efforts • focuses on building the capacity of the Collaborative to be successful in the four key areas • plans for and ensures sustainability of the Collaborative	• Active Involvement by African American community members in Collaborative meetings, events and decision-making • Ability of the collaborative to function effectively and efficiently • Increased capacity of the Collaborative in the four key areas • Ability of the Collaborative to sustain itself beyond the initial funding

Key Area 2: Develop buy-in and sustain commitment in the community for the Community Action Plan (CAP).

Activities and Roles of the Collaborative	Main Outcome Measures
1. Educate community members and leaders, the media and other stakeholders about the Community Action Plan, including its priorities and rationale	• Community is aware of the CAP priorities and rationale.
2. Advocate for the implementation of programs and policies included in the Community Action Plan	• Local activities, programs and funding decisions reflect the priorities outlined in the CAP
3. Organize and lead an annual review process for the Community Action Plan in which: • progress toward goals is reviewed and presented to the community • Collaborative members and other community members and leaders assess current priorities and efforts and provide input on future activities and priorities • Collaborative members publicly re-affirm their commitment to the Community Action Plan	• Number of new stakeholders who publicly commit to CAP • Proportion of existing Collaborative members who publicly re-affirm their commitment to the CAP

Key Area 3: Influence policy, community-level and other environmental changes that support and amplify the impacts of other initiatives in the community that are focused on improving African American birth outcomes and health

Activities and Roles of the Collaborative	Main Outcome Measures
1. Based on the priorities of the CAP and relevant information from the research literature, identify policy, community-level and other environmental changes most likely to support and amplify the impacts of other initiatives in the community.	• (Outcome measures to be developed based on the specific strategies undertaken and focusing on recommended priorities.)
2. Lead efforts to build support for and enact these changes.	
3. As part of the annual review process for the CAP, ensure that the strategies and changes continue to reflect the priorities of the relevant stakeholders.	

Key Area 4: Leverage local and other resources to support efforts to improve birth outcomes and health among African Americans, as outlined in the Community Action Plan

Activities and Roles of the Collaborative	Main Outcome Measures
1. Assess the Collaborative's current capacity to leverage needed resources.	• Financial resources leveraged • Non-financial resources (e.g., volunteer hours, in-kind donations, pro bono services provided) leveraged • Number of new funders supporting priorities outlined in the CAP
2. With input from all relevant stakeholders, develop a fundraising plan for the Collaborative.	
3. Implement the fundraising plan.	
4. Regularly assess the fundraising plan and revise as needed.	

Additional roles and activities will be determined by the Collaborative.

IV. MILWAUKEE LIHF STRUCTURE

A. Full Collaborative

The full Collaborative includes Steering Committee members, members of the taskforces, Convening Team members, fathers, members of the faith community and other LIHF supporters as well as members of the broader community who share the vision of eliminating racial disparities in infant mortality in Milwaukee and commit to working with the Milwaukee LIHF Collaborative to promote the Collaborative's policies and principles. Collaborative membership requires ascription to the mission, vision and goals as well as willingness to support the guiding principles and ground rules of the group. Collaborative members are expected to be aware of the status of the effort and advocate and promote the policy changes identified by the Collaborative. At least 60% of the members of the Collaborative shall be African American. Participation shall be documented.

All members of the full Collaborative are expected to adhere to the ground rules to: communicate openly with others in the group in a manner that is respectful and transparent; recognize expertise within members of the group including specific and specialized training and life experience; and assure that all members have the right to participate in the process and to be heard.

Meetings of the full Milwaukee LIHF Collaborative

Two plenary sessions will be held each year to inform members and the community of progress, assess results and recommend any directional changes.

B. Collaborative Steering Committee

The Steering Committee is made up of members of the African American Task Force and people from different sectors that make a long-term personal and/or institutional commitment to the agenda. They include members of the impacted population and others whose interest and/or expertise is necessary to reduce racial disparity in infant mortality. The Steering Committee provides direction and leadership to carry out the effort successfully. Anyone with an interest in eliminating racial disparities in birth outcomes is welcome to attend the Steering Committee meetings. At least 60% of the members of the Steering Committee shall be representatives of African American families who have been impacted by infant mortality. For the good of the effort and for the effort to continue moving forward, the following is *required* of Steering Committee members:

1. Attend 70% of meetings per year or participate by proxy. (In order to preserve continuity through a personnel change, attendance by the organization's prior representative will carry over for the organizations' new representative.):
2. Provide input on the progress of the effort.
3. Provide suggestions to improve the effort.
4. Attend a half-day retreat once per year to review the previous year's progress.
5. Participate in the vote on motions for the effort.
6. Serve on at least one taskforce or another aspect of the effort.
7. Participate in identifying additional resources.
8. Build and strengthen partnerships.
9. Serve as spokespersons for the effort.

Meetings of the Collaborative Steering Committee

The regular meetings of the Collaborative will be held at least ten times per calendar year, with meetings generally occurring every month. Meeting locations will rotate among partners, so that Steering Committee members become familiar with the partners and strategies. Agendas for the Collaborative Steering Committee meeting will be sent out prior to the meeting and made available to all members of the full collaborative.

C. Taskforces

The African American Taskforce provides the community leadership and perspective that is required for a successful community driven effort. It is composed of members of the impacted population who bring life experience, resources, wisdom, perspective and commitment to reducing African American infant mortality. They serve as the lens through which the Collaborative's strategies and recommendations are vetted and approved.

The domain Task Forces include:

Taskforce on Improving Healthcare for African American Families that will bring expertise and ownership to the goal of *expanding health access across the lifecourse* and the programmatic and policy issues recommended by the Collaborative.

Taskforce on Strengthening African American Families and Communities that will bring expertise, experience and ownership to the goal of *increasing father involvement* and the programmatic and policy issues recommended by the Collaborative.

Taskforce on Addressing Social Determinants that will bring expertise, experience and ownership to the goal of *reducing poverty* and the programmatic and policy issues recommended by the Collaborative.

Additional and ad hoc committees may be created at the direction of the Steering Committee. These may include, but are not limited to: communication, development, and measurement.

Taskforce Co-Chairs

Each taskforce will have co-chairs who serve as members of the Steering Committee and will lead the mission of the particular group. If a vacancy arises, nominations can be made by any member of the particular taskforce and these nominations can be for another group member, or for oneself. Whenever possible, it is recommended that the taskforce co-chair be informed of potential nominees and that the co-chair speaks with these nominees prior to the next taskforce meeting, in order to determine their willingness to accept the nomination. If no one is interested in the position from within the taskforce, nominations may be sought from and made by Steering Committee members. Once nominations have been presented to the taskforce, a vote will be taken and the co-chair will be elected by a simple majority of the taskforce.

The primary responsibility of the co-chair is to provide leadership, manage the efforts of the taskforce, and preside at all meetings of the taskforce. Co-chairs work closely with the Milwaukee LIHF Collaborative staff to stay abreast of the project timeline and tasks for which the group is responsible. Co-chairs are responsible for presenting timeline and task completion updates at each meeting.

Taskforce Meetings

Each taskforce meets as needed but no less than two times per year. The co-chairs will work with Milwaukee LIHF Collaborative staff to set the meeting agenda. A review of the timeline and task progress will occur at each meeting. The co-chairs should be present at all taskforce meetings. In the event that a co-chair is unable to attend, it is the responsibility of the co-chair to notify Milwaukee LIHF Collaborative staff as much in advance as possible. Milwaukee LIHF Collaborative staff will work with the co-chair to identify a taskforce member to facilitate the meeting.

Taskforce Actions and Recommendations

All recommendations by a taskforce, following proper vote by all present taskforce members, will be presented to the African American Taskforce by a co-chair of the group or designee in the case of their absence. The African American Taskforce will vet the recommendations and present them before the Collaborative Steering Committee. Actions which might require such presentation include policy/procedure changes, appointment of new co-chairs or members, or timeline-specific tasks which require collaboration from other groups. No recommendation will be made to the Collaborative Steering Committee without the full knowledge of the co-chairs and the taskforce members. Milwaukee LIHF Collaborative staff will assure that any such items are added to the next Collaborative meeting agenda for review and, if necessary, further vote.

V. MILWAUKEE LIHF PROJECT SUPPORT

A. Fiscal Sponsor

The YWCA of Greater Milwaukee will serve as Fiscal Sponsor. As Fiscal Sponsor, the YWCA is responsible for the receipt and disbursement of grant monies from the WPP, proper financial record keeping and reporting for the Collaborative, submission of a signed cooperative agreement with Milwaukee LIHF identifying the roles and responsibilities of each partner related to the financial compliance with the Collaborative, provision of a written budget and activity reports at least quarterly, attendance and participation at all required meetings and subcontracting with another organization and/or providing staff support to convene the Milwaukee LIHF Collaborative.

B. Staff Support

The Milwaukee LIHF project support is made up of a team of the Project Director and a Project Manager, project assistant as well as designated support from Collaborative members. The Project Director provides leadership on all aspects of the effort. The Director provides guidance to the Project Manager on the day-to-day operations of the effort. The Project Director will be involved in coalition-building, assisting the leadership of the Collaborative, and assuring the dissemination of results.

The Project Manager is responsible for the day-to-day operations of Milwaukee LIHF including communicating with all collaborative team members, meeting with community representatives, providing technical and other support for meetings, engaging in community outreach and planning, conducting focus groups and key informant interviews, completing data-related tasks, and otherwise organizing, communicating and implementing the various aspects of the collaborative. Together with the Co-chairs, the Project Director and Project Manager develop monthly meeting agendas, facilitate monthly meetings, and assure the progress of the Collaborative.

C. Meeting Support

LIHF staff will assist chairs with convening meetings and provide administrative support as needed. Support includes: working with taskforce chairs to create meeting agendas, compiling and sending out all applicable documents to taskforce members, reserving rooms and any necessary equipment (e.g. laptops, projectors, flip charts etc.), assisting presenters with their presentation tools, and creating and disseminating minutes. Staff is also available to provide special assistance and support, as needed.

VI. DECISION MAKING PROCESS

A. Group Decision by Consensus

Matters of policy and direction will be noticed on the agenda in advance of the meeting. After presenting formal information on the item, the presiding leader will open the floor for discussion. Members of the Collaborative can discuss the item, ask questions, or seek clarification. The preferred method of decision making is reaching consensus by which the entire group agrees on a particular course of action. If consensus cannot be reached and a decision which affects the direction of the effort is necessary, members may call for a vote which will be determined by a simple majority. (See attached formal voting procedures.)

B. Final Procedures

With proper notice, these processes may be amended, altered, and repealed and new procedures may be adopted at any regular meeting of the Steering Committee. In the absence of rules previously described, Robert's Rules of Order will be followed.

This document will be reviewed and reaffirmed or amended on an annual basis.

Milwaukee LIHF Operating Policies approved 11/5/2011

Milwaukee LIHF Collaborative Operating Policies & Procedures

Voting Procedures

1. No action that requires a vote shall be taken without a quorum (simple majority of Collaborative Steering Committee members) present.
2. Following a lack of decision-making by consensus and discussion of an item, the presiding individual will request a motion.
3. Such a motion will be written down by the presiding record-keeper, project coordinator or designee.
4. The presiding leader will seek a second on the motion. Following a second from a group member, the leader will open up the floor for discussion. If a second is not forthcoming, no action is taken on the item and there will not be a vote.
5. If there is a second to the motion, further discussion will begin and the presiding leader will recognize only one individual at a time. The recognized speaker may address only the motion on the floor.
6. At the conclusion of discussion, a voting member will call the question and a vote will occur. The record keeper will read the motion one final time.
7. Each eligible Collaborative Steering Committee member shall be entitled to one vote at any Collaborative Steering Committee meeting.
8. At a meeting at which a vote will take place, a list of eligible members will be presented by the Project Coordinator before the vote occurs.
9. In those instances when an individual has a pecuniary (financial) interest that individual may not vote.
10. The presiding leader is eligible to vote.
11. Prior to voting, the presiding leader will announce the number of eligible voters present.
12. The recorder will record the number of voting members present and will inform the group of the number of votes needed to pass the motion. For example, “With 20 members present, the motion will need 11 votes to pass.”
13. The presiding leader will announce whether the vote will be taken by a show of hands or written and then individuals will vote.
14. A motion will carry if a simple majority of those present and voting are in favor of the motion.
15. Following voting, the presiding leader will verbally announce the number of votes and whether the motion passed.
16. The vote will be recorded and reported in the notes of the meeting.

Milwaukee LIHF Collaborative Operating Policies & Procedures

Glossary

Common Agenda* - Requires all participants have a shared vision for change, including a common understanding of the problem and a joint approach to solving it through agreed upon actions.

Impacted Population - Refers specifically to African Americans in the designated geographic areas of the City of Milwaukee who have been or are at risk of being affected by infant mortality.

Independent support organization* - The backbone organization requires a dedicated staff separate from the participating organizations who can plan, manage, and support the initiative through ongoing facilitation, technology and communications support, data collection and reporting, and handling the myriad logistical and administrative details needed for the initiative to function smoothly.

Infant Mortality - Refers to the death of a baby before its first birthday.

Long Term Commitment - The goals for the collaborative extend to the year 2015. While personal circumstances may prohibit involvement of each individual to the full extent over this time period, members are asked to commit to the long term goal.

Mutually reinforcing activities* - Refers to a diverse group of stakeholders working together, not by requiring that all participants do the same thing, but by encouraging each participant to undertake the specific set of activities at which it excels in a way that supports and is coordinated with the actions of others.

Ongoing communication* - A strong Collaborative requires regular and ongoing face-to-face meeting time. Several years of regular meetings may be necessary to build up enough experience with each other to recognize and appreciate the common motivation behind different efforts. Participants must see their own interests will be treated fairly, and that decisions will be made on the basis of objective evidence and the best possible solution to the problem, not to favor the priorities of one organization over another.

Shared measurement system* - Refers to agreement on the common ways success will be measured and reported. Collecting data and measuring results consistently on a short list of indicators at the community level and across all participating organizations not only ensures that all efforts remain aligned, it also enables the participants to hold each other accountable and learn from each other's successes and failures.

** These items are defined by John Kamia and Mark Kramer in Collective Impact, Stanford Social Innovation Review, Winter, 2011, p.39. Their review of successful community initiatives found that each of these items was required in a Collaborative.*

C. Capacity to address system and community level changes

Following a review of the evidence-based practices associated with the life-course model, existing strategies and identified gaps, the task forces recommended policy-level changes. The policies below were vetted through a process of active and authentic engagement of members of the impacted population.

Increasing Health Care Access Policies

- Increase access to affordable care*
- Expand Badger Care coverage to youth, males, childless couples
- Provide incentives for providers to be in Badger Care HMO*
- Develop standards of care for pregnant women and families
- Include specialty care in Badger Care*
- Create networks of specialty service providers

Strengthening Father Involvement in African American Families Policies

- Provide information/education regarding rights of ex-felons
- Increase minimum wage
- Increase local job creation*
- Remove disincentives in child support and unemployment

Reducing Poverty among African American Families Policies

- Reduce structural barriers that promote racism and discrimination
- Increase deferred prosecution
- Reduce liability of juvenile records and nonviolent crimes
- Increase safety and security of workplace*
- Hold programs accountable for outcomes
- Expand relevant services offered by TANF/W2*

In addition to the above, a list of other potential areas of policy work was created and rated earlier in the planning process in response to a request from WPP. This list is included in Appendix G.

Milwaukee LIHF is interested in focusing its efforts on those policies from the list which best align with the programs that receive implementation dollars from WPP. Equally importantly, local grantees will be strongly encouraged to determine ways in which their programming can be supportive of the policy priorities of Milwaukee LIHF.

* *Several of the strategies discussed by the task forces under these broad headings are listed as having some evidence base in the document "What Works for Health: Policies and Programs to Improve Wisconsin's Health"*

D. Capacity to organize and coordinate maternal and child health services

Strong organizational leadership, community involvement and financial accountability are three important measures of organizational capacity. Milwaukee LIHF has spent two years developing a strong volunteer board leadership as well as community involvement, and will partner with the YWCA of Greater Milwaukee to draw on its expertise in financial management to ensure the Collaborative has the capacity necessary to organize and coordinate maternal and child health services in the target area.

1. Organizational Leadership. Milwaukee LIHF has had strong and diverse leadership from the outset. The core leadership group for the past two years has been stable, and includes representatives of key sectors such as the local health department and health care providers; foundations; the business community; the faith community; academics and community-based organizations. These leaders have developed a shared vision and consciousness of the urgency of the work. Members are committed and realize that the building of trust is a continual and ongoing process. Operating principles (see pages 89-98) have been established to help promote ongoing, honest and clear communication as well as clarity in responsibilities and representation. The Collaborative's leaders explicitly acknowledge the impact of racism and have taken steps to ensure that the Collaborative remains open and welcoming to all, for instance, experts in institutional racism were brought in to run a workshop for the entire collaborative in spring 2011. In addition, all chairman roles were shared by two individuals, with one chairperson in each duo being an individual from the impacted community.
2. Community Involvement. African Americans, as the community that is most impacted by the problem of infant mortality, have been central to all aspects of the Milwaukee LIHF planning process and will continue to be central to the future development of the initiative. The co-chairs of the Collaborative are African American women. Each of the three domain task forces has at least one co-chair who is African American. During the planning phase, 70% of active Collaborative participants on the Steering Committee and Task Forces were African American, and currently 70% of the combined Collaborative are African American. Additional commitment to African American involvement, including those who are not participating as part of their professional role, is demonstrated below.
    - The African American Taskforce, established at the onset of the planning phase and continuing during the implementation phase, consists exclusively of members of the impacted population who bring life experience, wisdom, and perspective to the discussion.
    - The African American Task Force serves as the lens through which the Collaborative's strategies and recommendations can be vetted and improved. The Operating Policies and Procedures and the organizational structure describe the African American Task Force's role (see page 94).
    - The voices of diverse youth and young adults, the majority of which were African American, were incorporated into the planning process by a Public Allies (AmeriCorps) team who provided awareness training on infant mortality and the life-course model.
    - The majority of participants in the WPP-sponsored media spokesperson training were African American as are all of the community members that Milwaukee has engaged in the communication, evaluation and PRAMS workgroups.
    - The continued primacy of the role of African Americans in Milwaukee LIHF is stipulated in the Operating Policies and Procedures, which state that "at least 60% of the members of the collaborative shall be African American," and that "at least 60% of the members of the Steering Committee shall be representatives of African American families who have been impacted by infant mortality."
3. Financial Accountability. The YWCA of Greater Milwaukee has been selected as the fiscal sponsor for Milwaukee LIHF. Selection of the Fiscal Sponsor was guided by a commitment to involve agencies where 60% of the Board and staff leadership, as well as clients served, are African American. This Wisconsin-based organization is duly registered as a 501(c)(3) with the IRS, and

holds Exchange Seal status with Guidestar. The organization's mission is eliminating racism, empowering women and promoting peace, justice, freedom, and dignity for all. The YWCA aligns with the LIHF mission in seeking, through racial justice work, to educate people on the disparities that exist in the community and how they can address these within their spheres of influence. The YWCA is deeply involved with and committed to the African American community: 40% of the board, 63% of the staff, and 80% of their served population is African American.

The YWCA Finance Department operates under the guidelines established under OMB Circulars 110, 122 and 133 and prepares all financial statements in accordance with FAS 117. The regular audit of YWCA has not found any deficiencies or highlighted any concerns with regard to internal policies, procedures or controls. They manage an annual budget of approximately $7 million. The YWCA has served as the fiscal agent for several organizations; three are mentioned here:

a) Annie E Casey Foundation – serving as the award agency and fiscal agent for Re-entry Workforce Development.
b) Milwaukee Area Healthcare Alliance (MAHA) – serving as fiscal agent for the collaboration between the YWCA and the Milwaukee Area Health Education Center.
c) Milwaukee Job Development Inc. (MJD) – served as the fiscal agent for a start-up workforce non-profit.

The YWCA is prepared to accept all financial and accounting responsibilities as designated by the LIHF Collaborative. The YWCA is also prepared to accept any and all legal liability associated with the responsibilities as the fiscal agent/sponsor. The YWCA is also willing to provide, when available, meeting space at no charge.

V. Improving Healthcare for African American Women and Families

High rates of infant death are a tragedy for our community, and they also point to a broad spectrum of social and economic issues that drive poor health at all ages. Turning the tide will take a massive effort from all sectors of this community, but if anything is worth fighting for, this is.

-- Milwaukee Mayor Tom Barrett, speaking at the city's 2nd Annual Infant Mortality Summit, 5/11/11.

The Milwaukee LIHF Healthcare Task Force, comprised of more than 30 community and organizational representatives, met monthly between September 2010 and July 2011 with the stated purposes of learning about the Lifecourse Model, infant mortality in general, and Milwaukee's black-white gap in infant mortality and its causes. The group examined evidence-based and promising practices related to improving health care for African American women and reviewed the following points of Dr. Lu's 12-point plan:

- Provide interconception care to women with prior adverse pregnancy outcomes
- Increase access to preconception care for African American women
- Improve the quality of prenatal care
- Expand healthcare access over the life-course.

After reviewing these approaches the task force decided to focus on the goal of **expanding healthcare access over the life-course for African American families.** They presented their recommendation and rationale at the Milwaukee LIHF Plenary Session on April 30, 2011 at the Dr. Martin Luther King, Jr. Community Center.

Subsequently, the Task Force examined a series of specific strategies related to this overall goal. The strategies, recommended by the Task Force and vetted and approved by the African American Task Force, are to:

1. Facilitate access to healthcare services (including preconception, prenatal and interconception care)
2. Reduce financial barriers to African American utilization of medical homes
3. Increase the capacity and quality of medical homes
4. Expand access to specialty care (including behavioral health and dental care)

A. Rationale for Health Care Recommendations

In selecting the focus on **expanding healthcare access over the life-course for African American families,** the Healthcare Task Force stated the following rationale for its recommendations:

- The desire to keep the focus on the life-course and families (not just women);
- The need to address multiple barriers;
- The importance of laying the groundwork for healthy behaviors and birth outcomes; and
- The need to focus on a small section of the community in order to enhance measurability and feasibility.

In reviewing the recommendations of each domain task force, the African American Task Force developed a set of guiding principles. These principles were shared and then used by domain task forces as they recommended strategies and in the vetting process. Recommended strategies must:

- Be culturally appropriate
- Be community driven
- Be family centered
- Recognize the unique role that African American organizations play
- Address racism
- Integrate the concept of the Lifecourse
- Work toward fulfilling the project vision of reducing stress and improving birth outcomes

B. Health Care Goal

To improve healthcare for African American women and families, the goal of Milwaukee LIHF is to expand healthcare access over the life-course for African American families in Milwaukee.

C. Health Care Objectives (SMART) for implementation phase

1. Access to healthcare services (including preconception, prenatal and interconception care) for African American women in Milwaukee will be improved.

2. Financial barriers to the utilization of medical homes by African American women in Milwaukee will be reduced.

3. The capacity and quality of medical homes available to Milwaukee's African American women will increase.

4. Access to specialty care (including behavioral health and dental care) for African American women in Milwaukee will increase.

D. Health Care Logic Model

<table>
<tr><th>Short Term Outcomes
(1 – 5 years)</th><th>Intermediate Outcome I
(3 – 8 years)</th><th>Intermediate Outcomes II
(5 – 10 years)</th><th>Long-Term Outcome
(10 – 20 years)</th></tr>
<tr><td>1. Improved access to healthcare services for African American families</td><td rowspan="4">Improved healthcare access over the life-course for African American families in Milwaukee</td><td rowspan="2">Improved African American infant survival and health will be in Milwaukee</td><td rowspan="4">Racial disparities in infant mortality in Milwaukee are eliminated</td></tr>
<tr><td>2. Reduced financial barriers to utilization of medical homes by African American families in Milwaukee</td></tr>
<tr><td>3. Increased capacity and quality of medical homes available to African American families in Milwaukee</td><td rowspan="2">Improved health status of African American families in Milwaukee</td></tr>
<tr><td>4. Expanded access to specialty care (including behavioral health and dental care) for African American families in Milwaukee</td></tr>
</table>

E. Culturally Relevant Strategies for Health Care

1. Facilitate access to healthcare services (including preconception, prenatal and interconception care)

Task Force members discussed the following ways to facilitate access to healthcare services:

- Provide or coordinate transportation to medical appointments. A confusing array of transportation services may be available and people may need assistance in determining how to access services. For example, transportation is a covered service for people enrolled in BadgerCarePlus for pregnant women, parents, and children covered by the Standard and Benchmark plans—but not the Core plan. HMOs can coordinate transportation services to Medicaid-covered services. People enrolled in SSI Medicaid and the Family Planning Waiver may also have access to transportation services for specific types of appointments. This complexity may be a barrier in itself.
- Improve and expand health literacy that is culturally appropriate.
- Utilize community health workers to connect people with a medical home and other medical and social services. The group defined a medical home as an identifiable source of medical service where there is a team approach to providing comprehensive primary care and a family-centered partnership between the family and the primary care provider. Services are comprehensive and individualized. A medical home provides all components of preventative care and makes referrals to subspecialty care; it starts at infancy and continues through a person's life. Care should be coordinated, affordable, geographically accessible, culturally competent, and holistic.
- Inform people about the services offered by Federally Qualified Health Centers. Engage in media campaigns, workshops, and other methods to get the word out.
- Assure cultural competence among all providers and staff in healthcare settings, from receptionists to doctors. This can be done through staff evaluations, monitoring staff, continuing education to focus on cultural competence, policy changes, etc.
- Change, develop and implement policies or legislation to reduce structural barriers that promote discrimination and racism.
- Recommend advocacy around policies and laws.
- Build trust between patient and provider so the provider can help address any additional non-health related issues a patient is experiencing.
- Provide care coordination and connect people with all needed services.
- Integrate and coordinate medical and social services.
- Create mechanism to transition patients from a pediatrician to a family practice provider.

2. Reduce financial barriers to African American utilization of medical homes

Task Force members discussed the following ways to reduce financial barriers to the utilization of medical homes:

- Provide access to adequate, affordable and comprehensive healthcare coverage.
- Provide education about insurance benefits.
- Expand/Maintain BadgerCare.
- Allow youth to be covered by their parents' BadgerCare until the age of 26 as commercial insurance provides.
- Provide incentives for health care providers to be in the BadgerCare HMO network.
- Change policies and laws to increase enrollment of young, single, childless African American adults (male and female) into BadgerCare.
- Recommend advocacy around policies and laws.

3. Increase the capacity and quality of medical homes

Task Force members discussed the following ways to increase the capacity and quality of medical homes:

- Increase weekend and evening hours of healthcare facilities.
- Expand the capacity of Federally Qualified Health Centers and community health centers.
- Increase the number of skilled African American healthcare workers.
- Remove barriers to becoming skilled healthcare workers. Assure affordable access to accredited colleges that lead to employment in a health system.
- Assure cultural competence among all providers and staff in healthcare settings, from receptionists to doctors. This can be done through staff evaluations, monitoring staff, continuing education to focus on cultural competence, policy changes, etc.
- Increase Medicaid reimbursement for providers.
- Develop standards of care for clinics that work with pregnant women and their families throughout the life-course.
- Directly fund and build capacity among organizations and agencies where the majority of board, staff, and the population served are African American (based on previously established Federal guidelines).
- Recommend advocacy around policies and laws.

4. Expand access to specialty care (including behavioral health and dental care)

Task Force members discussed the following ways to expand access to specialty care:

- Increase specialty services covered by BadgerCare and the number of providers who accept BadgerCare.
- Improve and expand health literacy that is culturally appropriate.
- Increase weekend and evening hours of healthcare facilities.
- Create networks of specialty providers.
- Assure cultural competence among all providers and staff in healthcare settings, from receptionists to doctors. This can be done through staff evaluations, monitoring staff, continuing education to focus on cultural competence, policy changes, etc.
- Integrate and coordinate medical and social services.
- Maintain Federal funding for WIC and other nutrition programs and connect people to these programs.
- Provide or coordinate transportation to medical appointments. A confusing array of transportation services may be available and people may need assistance in determining how to access services. For example, transportation is a covered service for people enrolled in BadgerCarePlus for pregnant women, parents, and children covered by the Standard and Benchmark plans- but not the Core plan. HMO's can coordinate transportation services to Medicaid-covered services. People enrolled in SSI Medicaid and the Family Planning Waiver may also have access to transportation services for specific types of appointments. This complexity may be a barrier in itself.
- Directly fund and build capacity among organizations and agencies where the majority of board, staff, and the population served are African American. Note: This recommendation is based on previously established Federal guidelines which required the Board to be comprised of a majority of the targeted population, the Executive Director or President to be from the targeted group and the services directed but not limited to the targeted population.
- Recommend advocacy around policies and laws.

F. Health Care Timeline and Activities

The activities listed in section E above will be implemented in the time period identified in section G below.

G. Health Care Expected Outcomes

The short-term outcomes (1-5 years) are:

- Improved access to healthcare services for African American families
- Reduced financial barriers to utilization of medical homes by African American families in Milwaukee
- Expanded access to specialty care (including behavioral health and dental care) for African American families in Milwaukee
- Increased capacity and quality of medical homes available to African American families in Milwaukee

The midrange intermediate outcomes (3-8 years) are:

- Improved healthcare access over the life-course for African American families in Milwaukee
- Increased capacity and quality of medical homes available to African American families in Milwaukee

The intermediate outcomes (5-10 years) are

- Improved African American infant survival and health in Milwaukee
- Improved health status of African American families in Milwaukee

The ultimate long term outcome (10-20 years) is:

- The elimination of racial disparities in infant mortality in Milwaukee.

H. Health Care Community Engagement and other Considerations

Engaging public input. A "virtual space" will facilitate input from the community at large and connect members of Milwaukee LIHF committees and task forces. This space has a calendar where anyone involved in the project can post pertinent events. Meeting agendas and minutes can be posted as well as links to media coverage of infant mortality in Milwaukee. In addition, monthly email newsletters, a blog, social media, and other methods will continue to be used to keep in contact with all interested parties and also encourage two-way communication with the public. http://milwaukee-lihf.wikispaces.com/

VI. Strengthening African American Families & Communities

More than 30 members of the Milwaukee LIHF Strengthening African American Families and Communities Task Force met monthly between September 2010 and July 2011 with the stated purposes of learning about the Lifecourse Model, infant mortality in general, and specifically Milwaukee's black-white gap in infant mortality and its causes. The group examined evidence-based and promising practices related to improving health care for African American women and reviewed the following points of Dr. Lu's 12-point plan:

- Strengthen father involvement in African American families
- Enhance service coordination and systems integration
- Create reproductive social capital in African American communities
- Invest in community building and urban renewal

After reviewing these approaches the task force decided to focus on strategies that **strengthen father involvement in African American families.** They presented their recommendation and rationale at the Plenary Session on April 30, 2011 at the Dr. Martin Luther King, Jr. Community Center.

Subsequently, the Task Force examined a series of specific strategies related to this overall goal. The strategies, recommended by the Task Force and vetted and approved by the African American Task Force, are to:

1. Engage, partner with and fund grassroots and informal efforts in the development of a comprehensive network of fatherhood resources and supports.
2. Increase relationship-building skills and self-worth for African American men and their families in ways that are culturally appropriate and community driven.
3. Increase the role that dads play in the community
4. Increase access to education and employment opportunities among African American males by providing mentoring, internships, and job opportunities
5. Strengthen formal and informal partnerships to address structural barriers, including racism and discrimination. Recognize that both informal and formal partners have equal value.

A. Rationale for recommendation(s) for Families & Communities

In selecting the focus on **strengthening father involvement in African American families,** the African American Families and Communities Task Force provided the following rationale for its recommendations:

- Fatherhood is frequently missing from the community conversation;
- Fathers play a needed and special role as leaders and supporters;
- Men can have a lasting positive impact on their families;
- Father involvement can make a big change in the community and on an individual level;
- If men are in disarray, the community will be too; and
- By addressing fatherhood, related issues including unemployment, healthy relationships, and systemic policies will also be addressed.

The focus on father involvement also addressed the guiding principles set forth by the African American Task Force which recommended that strategies must:

- Be culturally appropriate
- Be community driven
- Be family centered

- Recognize the unique role that African American organizations play
- Address racism
- Integrate the concept of the life-course and
- Work toward fulfilling the project vision of reducing stress and improving birth outcomes

B. Families & Communities Goal

Milwaukee LIHF will work to strengthen father involvement in African American Families in Milwaukee.

C. Families & Communities Objectives (SMART) for implementation phase

1. To create and sustain a comprehensive network of fatherhood resources and supports in Milwaukee through grassroots and informal efforts by 2016.

2. To increase relationship-building skills and self-worth among African American men in Milwaukee by 2016.

3. To increase the role that dads play in Milwaukee's African American community by 2016.

4. To increase access to education and employment opportunities among African American males in Milwaukee by 2016.

5. To engage formal and informal resources in an equal partnership to address structural barriers including racism and discrimination.

D. Families & Communities Logic Model

<table>
<tr><th>Short Term Outcomes
(1 – 5 years)</th><th>Intermediate Outcome I
(3 – 8 years)</th><th>Intermediate Outcomes II
(5 – 10 years)</th><th>Long-Term Outcome
(10 – 20 years)</th></tr>
<tr><td>1. Milwaukee has a comprehensive network of fatherhood resources and supports</td><td rowspan="5">Father involvement in African American Families in Milwaukee is strengthened</td><td>Improved African American infant survival and health in Milwaukee</td><td rowspan="5">Racial disparities in infant mortality in Milwaukee are eliminated</td></tr>
<tr><td>2. African American men in Milwaukee and their families have increased relationship-building skills and self- worth</td><td rowspan="4">Improved health status of African American families in Milwaukee</td></tr>
<tr><td>3. African American dads play an increased role in the Milwaukee community</td></tr>
<tr><td>4. African American males in Milwaukee have increased access to education and employment opportunities</td></tr>
<tr><td>5. Formal and informal resources are engaged in equal partnerships to address structural barriers including racism and discrimination.</td></tr>
</table>

E. Culturally Relevant Strategies for Families & Communities

1. **Engage, partner with and fund grassroots and informal efforts in the development of a comprehensive network of fatherhood resources and supports.**

   Taskforce members discussed the following ways to develop a comprehensive network of fatherhood resources and supports:

   - Go beyond just offering programs.
   - Reach out to black men through grassroots, non-traditional social networks. This will require the involvement of men who are known and trusted in the community.
   - Build social capital at the community level.
   - Look to African American history and culture to help develop this network.
   - Recognize the importance of churches in bridging gaps between formal and informal networks, and as an important resource for men.
   - Recognize and respect what informal networks bring to the table.
   - Provide services that are asset-based and wraparound the person, including mentoring and mediation services, as well as counseling and mental health services.
   - Create a website where all fatherhood resources and services are listed.
   - Directly fund and build capacity among organizations and agencies where the majority of board, staff, and the population served are African American (based on previously established Federal guidelines).

2. **Increase relationship-building skills and self-worth for African American men and their families through culturally appropriate and community driven approaches**

   Taskforce members discussed the following ways to increase relationship building- skills and self-worth:

   - Educate African American men and women about who they are and where they come from.
   - Provide healthy relationship information to children at a young age.
   - Talk to young women and men before they have kids to stress the importance of father involvement.
   - Change female and male perception that men are not needed to raise children.
   - Build partner support before, during, and after pregnancy.
   - Increase the number of responsible, healthy, and effective two-parent households.

3. **Increase the role that dads play in the community**

   Taskforce members discussed the following ways to increase the role fathers play in the community:

   - Encourage fathers to be involved in their children's and families' education.
   - Engage the faith-community to get the word out about community resources and events.
   - Make it easy and accessible for fathers to be involved (provide transportation, incentives, and make it clear that they are invited to attend community events).
   - Help ex-felons understand when they can and cannot vote.
   - Provide culturally appropriate mentoring.
   - Encourage conversations between men of all ages (young men, dads, and grandfathers).

4. **Increase access to education and employment opportunities among African American males by providing mentoring, internships, and job opportunities**

   Taskforce members discussed the following ways to increase access to education and employment:

   - Enhance skills.
   - Make continuing education accessible for men to allow them to stay in the workforce.
   - Emphasize entrepreneurship and self-sufficiency.
   - Create jobs.
   - Increase the minimum wage.

5. **Engage formal and informal resources in an equal partnership to address structural barriers including racism and discrimination.**

   Taskforce members discussed the following ways to strengthen informal and formal partnerships to address structural barriers to father involvement:

   - Change, develop and implement policies and legislation to reduce structural barriers that promote discrimination and racism.
   - Change policies that have to do with child support and unemployment.
   - Look to African American history and culture to address barriers.
   - Replicate successful strategies and mobilize the community around these.
   - Recognize and respect what informal networks bring to the table.
   - Create a fair and equal criminal justice system.
   - Make sure fathers have the same rights as mothers (eligibility for BadgerCare, etc.); protect fathers' rights.
   - Place children with biological fathers if the child is removed from his/her mother's care.
   - Establish paternity for fathers.
   - Increase co-parenting.

F. Families & Communities Timeline and Activities

The activities listed in section E above will be implemented in the time period identified in section G below.

G. Families & Communities Expected Outcomes

The short-term outcomes (1-5 years) are:

- Milwaukee has a comprehensive network of fatherhood resources and supports
- African American men in Milwaukee and their families have increased relationship- building skills and self- worth
- African American dads play an increased role in the Milwaukee community
- African American males in Milwaukee have increased access to education and employment opportunities
- Formal and informal resources are engaged in equal partnerships to address structural barriers including racism and discrimination

The midrange intermediate outcomes (3-8 years) are:

- Improved healthcare access over the life-course for African American families in Milwaukee
- Increased capacity and quality of medical homes available to African American families in Milwaukee

The intermediate outcomes (5-10 years) are

- Improved African American infant survival and health in Milwaukee
- Improved health status of African American families in Milwaukee

The ultimate long term outcome (10-20 years) is:

- the elimination of racial disparities in infant mortality in Milwaukee.

H. Families & Communities Community Engagement & Other Considerations

See “Community Engagement” under Section VII

VII. Addressing Socioeconomic Conditions & Stress

In 1970, the city's black poverty rate was 22% lower than the U.S. black average; today, Milwaukee's black poverty rate is 49% higher than the national rate. In 1970, the city's median family income for African-Americans was 19% higher than the U.S. median income for black families. Today, it's 30% lower.
- Milwaukee Journal Sentinel, 11/12/11, J Schmid

The Milwaukee LIHF Social Determinants Task Force, comprised of more than 30 members, met monthly between September 2010 and July 2011 with the stated purposes of learning about the Lifecourse Model, infant mortality in general, and specifically Milwaukee's black-white gap in infant mortality and its causes. The group examined evidence-based and promising practices related to improving health care for African American women and reviewed the following points of Dr. Lu's 12-point plan:

- Close the education gap
- Reduce poverty among African American families
- Support working mothers and families
- Undo racism

After reviewing these approaches the task force decided to focus on strategies that **reduce poverty among African American families.** They presented their recommendation and rationale at the Plenary Session on April 30, 2011 at the Dr. Martin Luther King, Jr. Community Center.

Subsequently, the Task Force examined a series of specific strategies related to this overall goal. The strategies, recommended by the Task Force and vetted and approved by the African American Task Force, are to:

- Remove structural barriers to obtaining and retaining jobs.
- Increase family-sustaining jobs for low income African American men and their families.

The focus on addressing poverty and the selected strategies also addressed the guiding principles set forth by the African American Task Force which recommended that strategies must:

- Be culturally appropriate
- Be community driven
- Be family centered
- Recognize the unique role that African American organizations play
- Address racism
- Integrate the concept of the life-course and
- Work toward fulfilling the project vision of reducing stress and improving birth outcomes

A. Rationale for recommendation(s)

The Social Determinants Task Force provided the following rationale for its recommendation to focus on reducing poverty among African American families:

- There are a large number of people in Milwaukee who live in poverty and poverty negatively impacts health outcomes;
- Basic needs must be met first;
- Reducing poverty can produce rapid improvements that will help people of all ages and the community; and
- Job related strategies will appeal to the public and to funders.

The focus on addressing poverty and the selected strategies also addressed the guiding principles set forth by the African American Task Force which recommended that strategies must:

- Be culturally appropriate
- Be community driven
- Be family centered
- Recognize the unique role that African American organizations play
- Address racism
- Integrate the concept of the life-course and
- Work toward fulfilling the project vision of reducing stress and improving birth outcomes

B. Social Determinants of Health Goal

To address socioeconomic conditions and reduce stress, Milwaukee LIHF will focus on reducing poverty among African American families in Milwaukee.

C. Social Determinants of Health Objectives (SMART) for implementation phase

1. To reduce structural barriers to obtaining and retaining jobs for African Americans in Milwaukee by 2016.

2. To increase family-sustaining jobs for low income African American men and their families in Milwaukee by 2016.

D. Social Determinants of Health Logic Model

<table>
<tr><th>Short Term Outcomes
(1 – 5 years)</th><th>Intermediate Outcome I
(3 – 8 years)</th><th colspan="2">Long-Term Outcome
(10 – 20 years)</th></tr>
<tr><td>1. Reduced structural barriers to obtaining and retaining jobs for African Americans in Milwaukee</td><td rowspan="2">Reduced poverty among African American families in Milwaukee</td><td>Improved African American infant survival and health in Milwaukee</td><td rowspan="2">Racial disparities in infant mortality in Milwaukee are eliminated</td></tr>
<tr><td>2. Increased family-sustaining jobs for low-income African American men and their families in Milwaukee</td><td>Improved health status of African American women in Milwaukee</td></tr>
</table>

E. Culturally Relevant Strategies for Social Determinants

1. Remove structural barriers to obtaining/retaining jobs.

Taskforce members discussed the following strategies for reducing structural barriers to obtaining/retaining jobs:

- Make sure that employers are not holding a person's criminal background against them. Enforce current laws that say you cannot discriminate against people based on prior convictions.
- Increase deferred prosecution cases, especially for African American youth.
- Decrease liability of juvenile records and adult non-violent crimes. These issues should not impact education or employment.
- Educate corporations that it's illegal to have blanket policies that discriminate against hiring felons.
- Increase the number of businesses that hire people re-entering from the criminal justice system.
- Change, develop and implement policies and legislation to reduce structural barriers that promote discrimination and racism.
- Directly fund and build capacity among organizations and agencies where the majority of board, staff, and the population served are African American (based on previously established Federal guidelines).
- Ensure that all agencies that receive funding are actually helping people and are being held accountable for their outcomes.
- Limit the types of information that can be shared about a person's criminal background.
- Help people keep jobs once they get them.
- Remove barriers to child care and transportation so that people can get to work.
- Provide sick leave to workers.
- Revise child support and drug testing policies.
- Integrate and coordinate services.
- Expand transitional jobs programs so that they last for 12-18 months (instead of 6-8 months) and pay a family-sustaining wage.

2. Increase family-sustaining jobs for low income African American men and their families.

Taskforce members discussed the following ways to increase family-sustaining jobs for low-income African-Americans:

- Increase family income and wealth through policies that support local job creation.
- Connect people who do not have barriers to employment with a job; for people who do have barriers to employment (like mental health issues, child support debt, prior records, etc.), first address their barriers and then connect them with a job.
- Assure that all programs working to reduce a person's barriers to employment are effective and use culturally appropriate methods, are family-centered, and are community driven.
- Increase education, skills, and training for jobs that are available and will provide family-sustaining wages. Training should translate into a job that can sustain a family).
- Find out from employers what kinds of skills they need in employees.
- Forecast what kinds of jobs will be needed in the future; then provide training for those positions.
- Integrate and coordinate services.

- Provide on-the-job mentoring. Use models that do not make mentors feel as though their job is being threatened.
- Expand relevant services offered by TANF/W2.
- Ensure that families and businesses located in the city of Milwaukee feel safe and secure.
- Increase the minimum wage.
- Directly fund and build capacity among organizations and agencies where the majority of board, staff, and the population served are African American (based on previously established Federal guidelines).
- Ensure that all agencies that receive funding are actually helping people and are being held accountable for their outcomes.
- Emphasize the value of entrepreneurship.

F. Social Determinants of Health Timeline and Activities

The activities listed in section E above will be implemented in the time period identified in section G below.

G. Social Determinants of Health Expected Outcomes

The short-term outcomes (1-5 years) are:

- Reduced structural barriers to obtaining and retaining jobs for African Americans in Milwaukee
- Increased family-sustaining jobs for low-income African American men and their families in Milwaukee

The midrange intermediate outcomes (3-8 years) are:

- Improved healthcare access over the life-course for African American families in Milwaukee
- Increased capacity and quality of medical homes available to African American families in Milwaukee

The intermediate outcomes (5-10 years) are

- Improved African American infant survival and health in Milwaukee
- Improved health status of African American families in Milwaukee

The ultimate long term outcome (10-20 years) is:

- The elimination of racial disparities in infant mortality in Milwaukee.

H. Social Determinants of Health Community Engagement & other Considerations

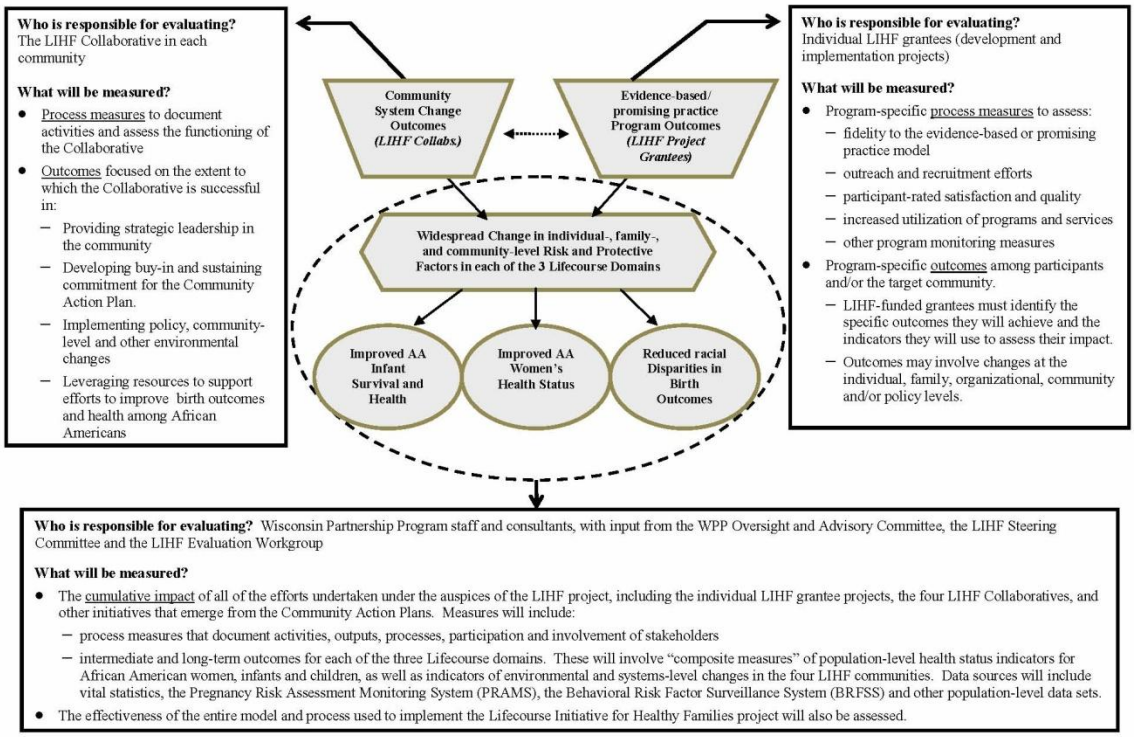
See “Community Engagement” under Section VII. Also, the social determinants task force developed the following additional community engagement strategy:

- Businesses, including large corporations and hospital systems, need to share the responsibility and get engaged.

VIII. Milestones and Evaluation Plan related to SMART objectives

The Milwaukee LIHF Collaborative is scheduled to discuss milestones and the evaluation plan at its meeting on 3/27/12. Specific milestones will depend in part on what is ultimately selected for funding in the implementation phase. The Collaborative intends to work with WPP and the evaluation consultants as well as the implementing agencies to establish agreed-upon outcomes, measures and reporting periods, in accordance with the evaluation scope and responsibilities as set out below.

LIHF Implementation Phase: Summary of Evaluation Scope and Responsibilities 6.27.11



IX. Budget and Resources to Address the Plan

The Milwaukee LIHF Collaborative has chosen the YWCA of Greater Milwaukee to be the fiscal agent for WPP funds designated to Milwaukee for implementation of the Community Action Plan. While the precise number of Wisconsin Partnership Program dollars to fund the plan are unknown at this time, the Collaborative is recommending that WPP direct approximately $750,000 per year for the five year period to the Milwaukee initiative. This recommendation is based on the assumption of the original $10,000,000 commitment for four sites over the five year period. It also assumes that the planning phase has adequately demonstrated that the complexity and depth of the problem in Milwaukee necessitates additional resources going to this community. The Collaborative further recommends that 60% of the WPP dollars allocated to Milwaukee be dedicated to programs that promote the following identified priorities aimed at increasing father involvement in African American Families:

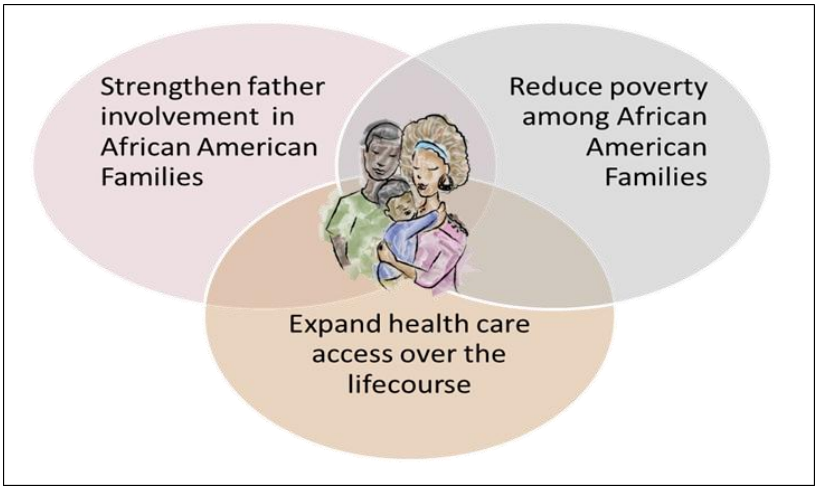
a. Engage, partner with and fund grassroots and informal efforts in the development of a comprehensive network of fatherhood resources and supports. Recommended strategies include reaching out to black men through grassroots, non-traditional social networks, building social capital at the community level, recognizing the importance of churches and directly fund and build capacity for organizations where a majority of board, staff and population served is African American.

b. Increase relationship building skills and self-worth for African American men and their families in ways that are culturally appropriate and community driven. Recommended strategies include changing female and male perceptions that men are not needed to raise children.

c. Increase the role that dads play in the community, including helping ex-felons understand when they can and cannot vote.

This recommendation was made by the African American Task Force and confirmed by the Collaborative as a way to best leverage existing resources and target existing gaps. Thus if Milwaukee's implementation dollars are set at $750,000 per year, it is recommended that $450,000 of that amount focus on strategies that promote strengthening father involvement in African American families and that the balance ($300,000) support the recommendations for improving healthcare for African American women and reducing poverty among African American families.

The Collaborative further recommends that all strategies and organizations funded for implementation through WPP resources should integrate the three domains as depicted below.



Based on factors known to be associated with infant mortality, the Collaborative has recommended a specific geographic focus which incorporates the ZIP codes of highest need. The planning took into consideration three-year rolling averages of infant mortality rates, cumulative live births, total population, African American population, average household income, median female age, percent male, as well as unemployment and involvement in the corrections system in examining data by ZIP codes. While additional work is ongoing, the Collaborative identified twelve ZIP codes to be those of highest need and therefore the target of the implementation effort. Due to Milwaukee's hyper-segregation, the included ZIP codes reflect the majority of the African American population's location in the city. It would be necessary to significantly reduce the rate of infant mortality in these ZIP codes to meet the 2020 goal of eliminating racial disparities in birth outcomes in Milwaukee. The ZIP codes are: 53205, 53206, 53208, 53209, 53210, 53216, 53218, 53223, 53224, 53225 and 53233. The map on page 80 identifies the ZIP codes of highest need based on a composite index but recognizes that within ZIP codes there can be significant variation and pockets of both needs and assets. It is therefore recommended that the applicants for implementation grants fully describe within their proposals the geographic focus of their approach within the area the Collaborative has identified for this plan. The description should build on the work of the Collaborative but include natural neighborhoods, assets and informal support networks.

To help assure a good mix of approaches in the implementation phase, the Collaborative further recommends that interested applicants consult with the Collaborative to benefit from the expertise of the group that has been working together for more than 18 months. Just as the Collaborative will work with implementing agencies in its annual review of progress, interaction before applications are submitted will help strengthen the proposals and assure focus and improved outcomes.

Finally, to respect and adhere to the community-driven approach that has shaped this plan, it is recommended that all strategies funded for implementation through WPP resources conform to the guiding principles established by the African American Task Force and used in strategy selection. That is, programs selected for implementation support should show evidence of being: culturally appropriate, community driven, family centered, recognize the unique role of African American organizations, address racism, integrate the concept of the lifecourse and work toward the project vision of reducing stress and improving birth outcomes among African American families.

Until such time as the WPP implementation funds are received, the Collaborative will continue to work on a variety of tasks including: continuing to build public awareness and support of the Community Action Plan; refining membership and structure of the Collaborative; holding monthly meetings; building capacity of the Collaborative; conducting outreach to potential grantees; participating in WPP training; and working with WPP on media and evaluation activities.

X. Sustainability Plan

After the official end of the planning process in July 2011, volunteers involved were given the option of ending their service to the project, or continuing. The great majority of individuals opted to continue their involvement, including all members of the steering committee and the African American Task Force. As the group looked to the future, there was recognition that local funding and support would be needed. In August and September of 2011, seven Milwaukee LIHF supporters donated a total of $15,500 to the project (Black Health Coalition of Wisconsin $7,000; United Way of Greater Milwaukee $2,500; Milwaukee Fatherhood Initiative $1,000; Aurora Health Care $2,000; Greater Milwaukee Committee $1,000; the YWCA of Greater Milwaukee $1,500; and Zilber Family Foundation $2,500.) Additionally, the Women's Fund and the Planning Council provided in-kind staff leadership. The Medical College of Wisconsin is contributing the time of Clarene Mitchell (Program Manager, Institute for Health and Society - Health Equity and Urban Clinical Care Partnerships) to the project on an ongoing basis. The Planning Council has also contributed more than $24,000 of in-kind resources to the two-year planning process.

Beginning in October 2011, funding was secured from WPP to extend the planning phase of Milwaukee LIHF through March 2012. During this time, the Collaborative undertook a variety of tasks including:

- Building public awareness and support of the Community Action Plan;
- Refining membership and roles of the Collaborative;
- Refining structure and policies of the Collaborative;
- Supporting monthly meetings of the Steering Committee and one additional meeting of each of the Task Forces;
- Building capacity of the Collaborative including further work on the essential components of the Community Action Plan, the effect of racism on maintaining a collaborative, and coaching and development for community consultants;
- Conducting outreach and orientation of potential grantees;
- Participating in WPP training and technical assistance efforts and helping to prepare community organizations for academic partnerships; and
- Working with WPP on the media campaigns, communications and evaluation.

To support this work, the Collaborative has identified a need to secure an additional $250,000 for agencies/organizations to partner with grass roots and non-traditional organizations in providing technical assistance and capacity building. Mechanisms to help assure sustainability include:

1. Using a community-driven approach: Community-driven efforts give control of decisions and resources to the members of the impacted population. Community-driven collaboratives often work in partnership with support organizations and service providers including local government, the private sector and nonprofits. The impacted population is not viewed as the target of the effort but rather the impacted population and their institutions are viewed as assets and partners in the process. The advantages of a community-driven approach are that it improves efficiency and effectiveness, allows efforts to be taken to scale, makes solutions more inclusive of the interests of the impacted population and enhances sustainability.[174] This approach has been a cornerstone of the Milwaukee effort beginning with the establishment of the African American Task Force, their delineation of the effort's Guiding Principles, the vetting of the domain task force recommendations, and the established priority of increasing father involvement in African American families. The role of the African American Task Force is clearly defined in the Operational policies of the Collaborative. The recommendation that implementation funds focus on grass roots or nontraditional organizations where African Americans compose the majority of board and staff leadership as well as constituency reinforces this approach.

[174] Dongier, P., et.al. (2002). Chapter 9: Community-Driven Development. In Klugman, J. (Ed.), *A Sourcebook for Poverty Reduction Strategies.* 301-331. Washington DC: World Bank.

2. Addressing the need for policy change: Throughout the process the Collaborative identified both program- and policy-related solutions. While programmatic approaches may provide more immediate relief and individual level behavioral change, policy level changes are more systemic and therefore more sustainable. Examples of policy level changes contained in the recommendations include: expanding health care coverage to youth, males, and childless couples; providing incentives for providers to be in HMO's; developing standards of care for pregnant women and families; including specialty care (mental and dental health) in low income insurance programs; creating networks of specialty providers; providing information and education regarding rights of ex-felons; increasing minimum wage and local job creation; removing disincentives in child support and unemployment; reducing structural barriers that promote racism and discrimination; increasing the use of deferred prosecution; reducing liability of juveniles with records of nonviolent crimes; increasing safety and security of the workplace; expanding relevant services offered by TANF/W2; and holding programs accountable for their outcomes. See also Appendix G for related policy level recommendations. The Collaborative will prioritize policy level changes that reinforce and sustain programmatic changes.

3. Focusing resources on a place-based-strategy: By defining the targeted area and asking implementing organizations to further specify and elaborate on the geographic area of focus, Milwaukee LIHF is following a place-based strategy common in the Obama administration's efforts with Promise Neighborhoods (Department of Housing and Urban Development and Choice Neighborhoods (Department of Education). Place-based strategies leverage investments by focusing resources in targeted places and drawing on the compounding effect of well-coordinated action. The core principles of place-based strategies are that change comes from the community level and often through partnership and that complex problems require flexible, integrated solutions. The Harlem Children's Zone and the Best Baby Zone work now being done by Dr. Michael Lu are also examples. This approach helps assure the sustainability of the effort as well.

4. Leveraging resources: By recommending that 60% of the WPP implementation resources be focused on strengthening father involvement in African American families, the Collaborative is leveraging available resources from the health domain and current efforts aimed at reducing poverty. Members of the Collaborative (e.g. Fatherhood Initiative, United Way, City of Milwaukee Health Department, Black Health Coalition etc.) are already undertaking a number of efforts that support the recommendations in the plan. They will be asked to formally identify and report on their contributions in these areas. Additionally, these and other larger organizations have a responsibility to partner with smaller agencies that might not have the capacity to apply for WPP funding on their own. Focusing on an identified gap helps to assure that resources are targeted and more impactful. From the onset, Milwaukee LIHF has recognized that resources from WPP, while substantial, will not be sufficient to support the entire effort that is needed to turn the tide on racial disparities in birth outcomes in Milwaukee. Continued participation and fundraising by Collaborative members will also help to assure the sustainability and success of Milwaukee LIHF.

XI. Conclusions and Recommendations

A. Lessons Learned to date

1. The impact of racism must be acknowledged

By definition, the Milwaukee LIHF planning process involved a dimension not always present or acknowledged in collaborations: racism. From the very beginning, participants and staff recognized that the project would need to address the topic of racism head on. Just a few months into the process, the steering committee co-chairs ran a series of workshops on racism for Milwaukee LIHF participants. And as a result of input from steering committee members, dollars from the planning budget were allocated to bring experts from the New Orleans-based People's Institute on Racism and Beyond to Milwaukee in spring 2011. They led a special session on institutional racism for a diverse group of about 80 people, including the steering committee, task force members, and the general public. The session was extremely well received, but participants felt more time was needed to educate the members of the steering committee and develop a trusting team across experiences of oppression and privilege. As a result, the steering committee recommended that WPP consider facilitating access to experts from the Institute for all four Wisconsin LIHF communities during the bridge period.

2. Ensuring a community-driven process is the key to sustainability

Ensuring that the project was "community-driven" was another dimension of the project that required sustained effort and creative solutions. Even the term "community driven" needed to be defined as "more than focusing efforts on the impacted population and includes the genuine ownership, leadership and involvement of the impacted population in the effort." Meeting times (early evenings) and locations (in the central city, close to bus lines) were carefully chosen to make it as easy as possible for the impacted population to attend. Stipends for meeting attendance and transportation were built into the budget, as was money to pay for babysitting services during meetings. Sandwiches, fruit and other nourishing snacks were served at each steering committee or task force meeting. Each task force was led by co-chairs, one of whom was a "professional" member of Milwaukee LIHF and one of whom was someone who was not being paid by his/her employer to participate. At least one co-chair for each task force was a member of the impacted community. Informal leadership development was continuous, but more formalized training would have been a wonderful addition to the process. Unfortunately, neither time nor money allowed for this added dimension of community engagement and development, but there is no denying that many individuals gained valuable leadership skills as a result of their participation.

3. Creating a common agenda requires leveraging resources

For a community-wide project such as LIHF to succeed, it is important to leverage resources and piggyback on the efforts of similar initiatives. Some of the ways Milwaukee LIHF found to be the most effective included:

- Over the course of the planning process, there were several major events in Milwaukee that centered on infant mortality (Aurora Family Service's Annual Summit, the Women's Fund Social Change Exchange, the Milwaukee Fatherhood Initiative, and the City of Milwaukee's Infant Mortality Summit, to name only a few). While not initiated by Milwaukee LIHF, these events boasted large attendance due in part to the Collaborative's efforts in getting the word out.

- In January of 2011 the Milwaukee Journal Sentinel began running a yearlong series of articles on the city's black-white infant mortality gap. These articles have been featured on the front page of many Sunday editions, and have included tie-in articles and opinion pieces during the week. Volunteer leaders of Milwaukee LIHF, along with Planning Council and Women's Fund staff associated with the project, were often interviewed for these stories.

- A meeting was held with the Donor's Forum of Wisconsin, a regional association of grantmakers, to inform them of the Milwaukee LIHF initiative's goals and objectives.

- To get the word out among emerging leaders, medical students and other young people, Milwaukee LIHF worked in partnership with Public Allies, the Medical College of Wisconsin's Urban and Community Health service learning program, Alverno College's Nursing Program, and the University of Wisconsin Madison - School of Medicine and Public Health's TRIUMPH program. Public Allies, in particular, did an outstanding job, presenting the video "Unnatural Causes" to 140 individuals at seven community sites in diverse neighborhoods.

- Through a partnership with the Women's fund, eight bus shelters around Milwaukee featured a message from Milwaukee LIHF during the month of October 2011.

- Milwaukee LIHF relied extensively on data collected by the city's Fetal Infant Mortality Review (FIMR) to learn what can be done to prevent fetal and infant deaths occurring in the City of Milwaukee. The FIMR team is concerned with both infant deaths (babies who are born alive but die within the first year of life) and fetal deaths (babies who die before they are born, but after the 20th week of pregnancy). This resource is vital to the work being done by the Collaborative and therefore Milwaukee LIHF will continue to partner with FIMR to reduce infant mortality in the city.

- Milwaukee LIHF is also committed to coordinating with the work of the other LIHF sites in Racine, Kenosha and Beloit. Sharing our lessons learned and continuing to work together will be key to continual progression toward implementing the 12-point Lifecourse plan in our communities.

4. It takes time to establish trust and shared vision

The Milwaukee LIHF planning process learned to weather the changes that are inevitable in a lengthy project. Issues around personal/family health, child welfare, domestic violence, interpersonal disagreements, employment changes, educational pressures and even death had an impact on the evolution of the collaboration. Several Milwaukee LIHF leaders were forced by life circumstances to take temporary leaves of absences from the project; others had to leave permanently. Such changes created continuity challenges but new leaders were quick to step up and most transitions were smooth and orderly.

5. Ongoing, honest and clear communication is a necessity

Avoiding jargon, making documents available well in advance of meeting dates, and distributing documents in a format that works best for all involved are important ways of keeping all participants in a planning process "in the loop." For instance, Milwaukee LIHF kept careful records of which participants did not have easy access to email and used the U.S. Postal Service to mail hard copies of documents to those individuals well ahead of meeting dates.

To further enhance communication, Milwaukee LIHF created a virtual space (http://milwaukee-lihf.wikispaces.com/) to make the Collaborative's message accessible to the wider community, conducted radio and television interviews, and regularly provided project updates via the distribution of monthly e-newsletters.

Keeping a complex initiative such as Milwaukee LIHF open, straightforward and transparent was not always easy. When disagreements arose that could not be resolved quickly during meetings, additional phone conferences and in-person meetings were called to continue to discuss the issues and hear the voices of all involved. The lesson was to always keep the channels of communication open and listen, listen, listen.

6. Clarity in responsibilities and representation is necessary for continuity

For a planning process such as Milwaukee LIHF to be successful, there needs to be a common understanding by all main interest groups of the approach that will be used. In particular, clarity around the issue of representation is crucial when dealing with difficult issues (such as racism) or fear. Having clear rules and responsibilities in place before any dispute arises—and revisiting them often—can help avoid needless conflict.

7. A trusted convener is critical

A community-driven planning process involving a large number of interested individuals and groups benefits immensely from the services of a trusted, local convener. Such a convener can:

- Design a process that makes sense for the local community;
- Provide outreach to all sectors in an impartial way;
- Regularly monitor progress and ensure that the process stays on course;
- Ensure continuity if volunteer leadership experiences a transition;
- Prepare materials, meetings and events in support of the volunteer leadership;
- Facilitate group activities to ensure that all sectors are heard and involved;
- Assist in training volunteer leaders in their roles and responsibilities;
- Provide follow-up, documentation and publicity for the initiative; and
- Bring an understanding of the local situation that cannot be achieved by someone from another community.

B. Call to Action

A plan is not an end in itself, but rather the means to an end. The Milwaukee LIHF Collaborative will ensure that its Community Action Plan is disseminated to the public at large, that it is integrated with other city initiatives working toward similar goals, and that it is used as a guide for decision making and action by all sectors of the community. Below are a few recommended actions specific sectors of the Milwaukee community can take that will help end the disparities between black and white birth outcomes by 2020.

1. Academics & Infant Mortality Experts: Study the causes of health disparities in Milwaukee, particularly as they relate to infant mortality. Research practices that have been effective in eliminating disparities elsewhere but consider always the applicability of such practices in Milwaukee. Evaluate home-grown solutions to determine their effectiveness and possible replicability.

2. Business Sector: Support living-wage jobs and healthy local retail like grocery stores, banks and restaurants in the neighborhoods most impacted by infant mortality. Provide opportunities to men who are re-entering the community from jail or prison.

3. Education Sector: Expand training programs, particularly for African American males, that help prepare them for family-sustaining jobs. Build partnerships with the business sector to match education with the needs of local industry and jobs that have promising career pathways.

4. Faith Sector: Help identify and groom leaders. Host Milwaukee LIHF meetings. Spread messages created by the Collaborative. Contribute funding to the effort to end the black-white gap in infant mortality in the city by 2020.

5. Community-based Organizations: Align programming to help achieve the outcomes advocated by Milwaukee LIHF. Consider moving beyond dimply providing services that alleviate harm to looking at ways to change the structures that cause disparities.

6. Government & Policy Sector: Recognize that policy decisions in many sectors—including housing, education and employment—impact infant mortality. Include local leaders who are engaged in Milwaukee LIHF in key policy decisions affecting the impacted community and its health. Assist Milwaukee LIHF to leverage state and federal resources that can help advance the agenda set forth in the action plan.

7. Funders: Develop an understanding of the complexity of the problem of health disparities in general and of infant mortality in particular. Become involved in the leadership of Milwaukee LIHF. Commit to align efforts with those of other actors involved in the Collaborative. Provide funding to support not only specific programming related to reducing infant mortality in Milwaukee, but also for the coordination role of the Collaborative itself.

8. Health Care Providers and Health Care Systems: Reach beyond the comfort zone of the institution to understand how the community's social needs affect health. Look internally to consider how structures and policies reinforce health disparities and find ways to rethink how health care is delivered to community members most in need. Provide volunteers and leadership to Milwaukee LIHF and also to the projects implemented around the city that are a part of the effort to eliminate the black-white gap in infant mortality in the city. Contribute financially to support the goals of the Collaborative.

9. Milwaukee Health Department: Partner with Milwaukee LIHF to seek state and national funding that is synergistic with the goals of the Collaborative. Ensure continued funding for Milwaukee Fetal Infant

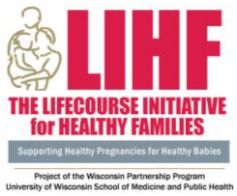
Mortality Review so that data is available to monitor progress toward the goal of eliminating the black-white disparity in infant mortality in the city by 2020. Help Milwaukee LIHF determine what interventions are effective. Ensure that Health Department policies and programs are in sync with the goals set forth by Milwaukee LIHF.

10. Media: Take the time to understand the issues that underlie the infant mortality statistics. Resist the impulse to present negative images of Milwaukee's African American population. Instead, seek to produce coverage that reflects the strengths of the community and the work that is being done to combat challenges like infant mortality.

11. Community Members (including members of the impacted community): Realize the power that you have to make a difference. Embrace new technologies to tell the stories you feel need to be told and to distribute them to a broad audience. Collaborate with neighbors and other local leaders to advocate for the changes you want to see happen in your community.

No initiative of the scope of Milwaukee LIHF can be successful without the ongoing involvement of the entire community. Milwaukee LIHF invites YOU to:

- Read - Stay informed of the issue of infant mortality through local newspapers, reading the Milwaukee LIHF e-newsletters, checking the Milwaukee LIHF wiki, subscribing to the Medical College of Wisconsin's Health Equity Alert, etc.;
- Speak – Tell your own story of how infant mortality has impacted your life and the life of your family;
- Write – Send letters to the local media in response to articles and stories that are related to infant mortality;
- Meet – Attend meetings of the Milwaukee LIHF Collaborative and/or its task forces;
- Recruit – Invite your friends, coworkers and others to become involved in the Milwaukee LIHF Collaborative; and
- Give – Contribute your time and treasure to sustain the Milwaukee LIHF Collaborative in its quest to eliminate the black-white gap in infant mortality in Milwaukee by 2020.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The Milwaukee COMMUNITY JOURNAL
www.communityjournal.net
WISCONSIN'S LARGEST AFRICAN AMERICAN NEWSPAPER

February 22, 2012

GUEST COMMENTARY

Community-driven Infant Mortality Initiative offers hope

Submitted by Milwaukee Lifecourse Initiative for Healthy Families (LIHF) Collaborative
Co-Authored by Milwaukee LIHF Collaborative Co-Chairs; Earnestine Willis, MD, MPH of the Medical College of Wisconsin and Shawn Green of Faith Partnership Network

We'd like to thank the Milwaukee Journal Sentinel and the Milwaukee Community Journal, Wisconsin's largest circulated African American newspaper, for highlighting the need for community-wide support to address the black-white infant mortality gap through the Empty Cradles series.

The coverage has helped to raise awareness broadly through the city of Milwaukee about our disgraceful distinction of having one of the worst racial disparities in infant mortality in the nation.

We would also like to thank the Wisconsin Partnership Program (WPP) of the University of Wisconsin School of Medicine and Public Health for their leadership on this issue and their financial support of the Lifecourse Initiative for Healthy Families (LIHF).

Although there have been efforts over the course of many years, working in this regard locally, it is extremely invigorating to have increased financial and human resources on a local level, active engagement of the most impacted people and new stakeholders involved in ridding our city of this epidemic. Milwaukee is one of four communities in southeastern Wisconsin to receive a planning grant from WPP to combat this issue.

The Milwaukee Lifecourse Initiative for Healthy Families (Milwaukee LIHF) Collaborative' s mission is to reduce stress and improve healthy birth outcomes for African-American families in Milwaukee.

This community-driven effort has aggressively tackled this issue over the past 18 months and has been coordinated by the Planning Council. This process is offering hope that the lives of more African American infants will be averted from untimely death.

More than 140 diverse stakeholders have committed efforts to build buy-in across all sectors.

Their frequent meetings have focused on documenting the problem, learning about potential solutions, contributing knowledge from different life experiences and disciplines, and recommending a community action plan.

This plan sets priorities that are backed by promising practices with local relevancies to have a positive impact on birth outcomes. The priorities are:

1) increasing access to medical care over the lifespan for African American families,

2) increasing the role of fathers in African American families and

3) reducing poverty among African American families. These priorities were vetted by our African American Task Force and supported by specific strategies that were recommended by community and academic experts. The Milwaukee LIHF Collaborative has been able to mobilize constituents from different backgrounds and perspectives, and gained their commitment, active engagement and indication of intentions to address infant mortality disparities in a coordinated manner. Solid relationships have been built and serve as the foundation for our efforts to work in partnership to accomplish a common goal.

Our efforts have not focused on gaining media headlines as we have focused on the tough work of developing solutions to save lives of the most vulnerable amongst us, our infants. For respectful community engagement, we understand the necessity of building the trust within the impacted community, which takes time.

Milwaukee LIHF Collaborative partners have been at the table working through the differences that have historically kept our communities apart. We must understand that real community engagement, based on proven theories, demands outreach to the impacted community, consulting with the community, involving the community in the process, truly collaborating and sharing power.

It is essential that the impacted community believes they are involved in, and crucial to the success of, the process and can influence the solutions. Building capacity to improve health involves the development of sustainable skills, resources, and organizational structures.

The Milwaukee LIHF Collaborative encourages the Milwaukee Journal Sentinel to continue to shine a light on the injustices of the City's black-white infant mortality gap and asks that everyone take a honest look at the role that racism and economics play in this disparity as well as putting consistent and strong commitments toward this work.

The implementation phase for the WPP grants will begin in the spring of 2012 and we will continue working to influence and support any interventions funded by this Program. After all, to see real improvement in the African American infant mortality disparity, the cornerstone of any effort must involve the community and collaborate with its members.

Milwaukee LIHF Collaborative has established an ambitious goal – eliminating the black-white infant mortality gap in Milwaukee by 2020- because we believe the lives lost and those yet to come deserve our utmost efforts to make Milwaukee a community that is welcoming to all infants. Social, cultural, physical, and economic foundations are important factors in the overall health of the community.

Thus, we cannot afford to look at infant mortality with narrow lenses and expect improvements. Our conversations are deep and broad; but large-scale social change requires broad cross-sector coordination, not isolated interventions of individual organizations. The work of real community engagement may be hard and time consuming, but it is ESSENTIAL!

Dr. Earnestine Willis *Shawn Green*

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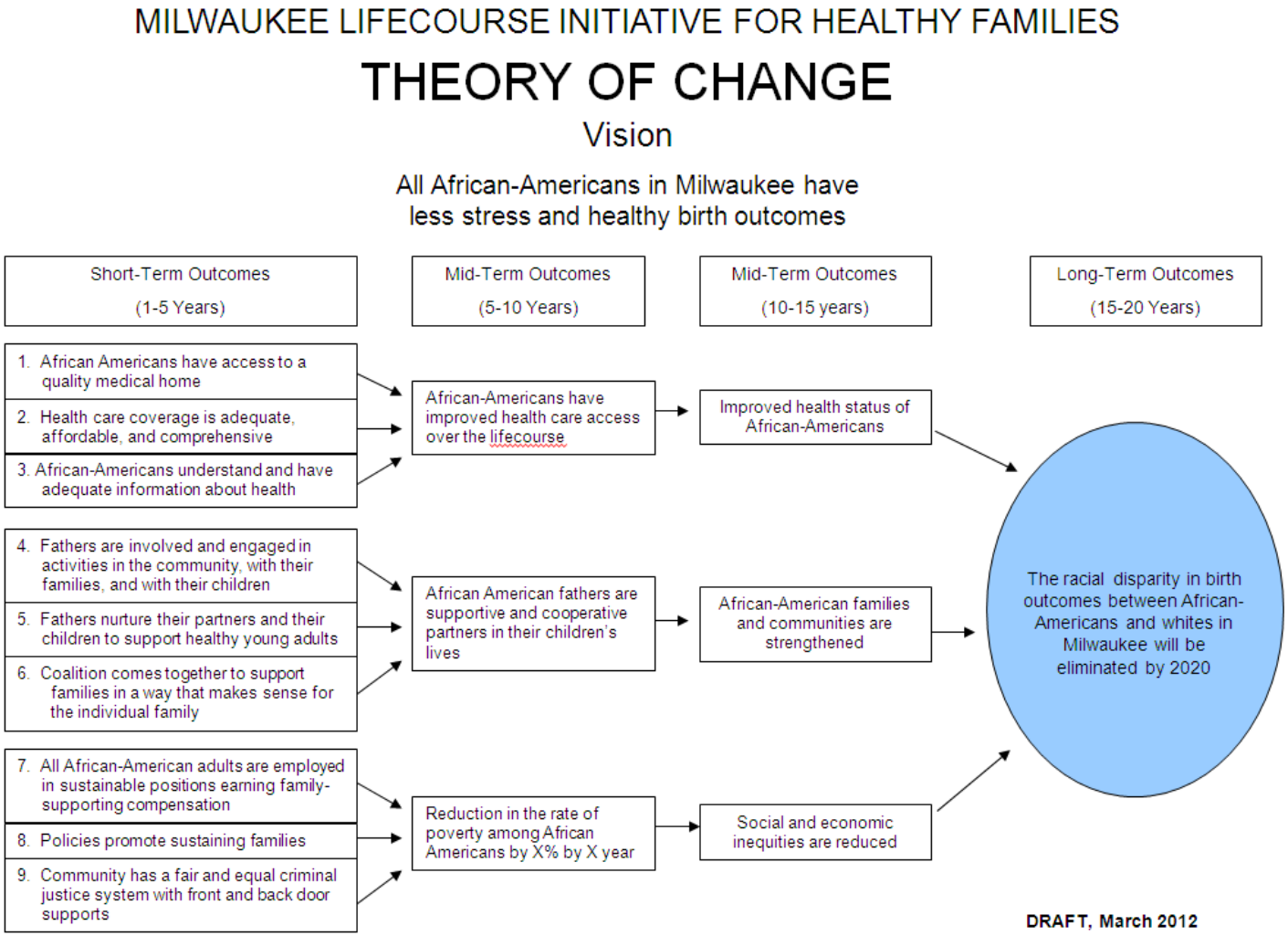
Project of the Wisconsin Partnership Program
University of Wisconsin School of Medicine and Public Health

Appendices

A. Theory of change (optional)

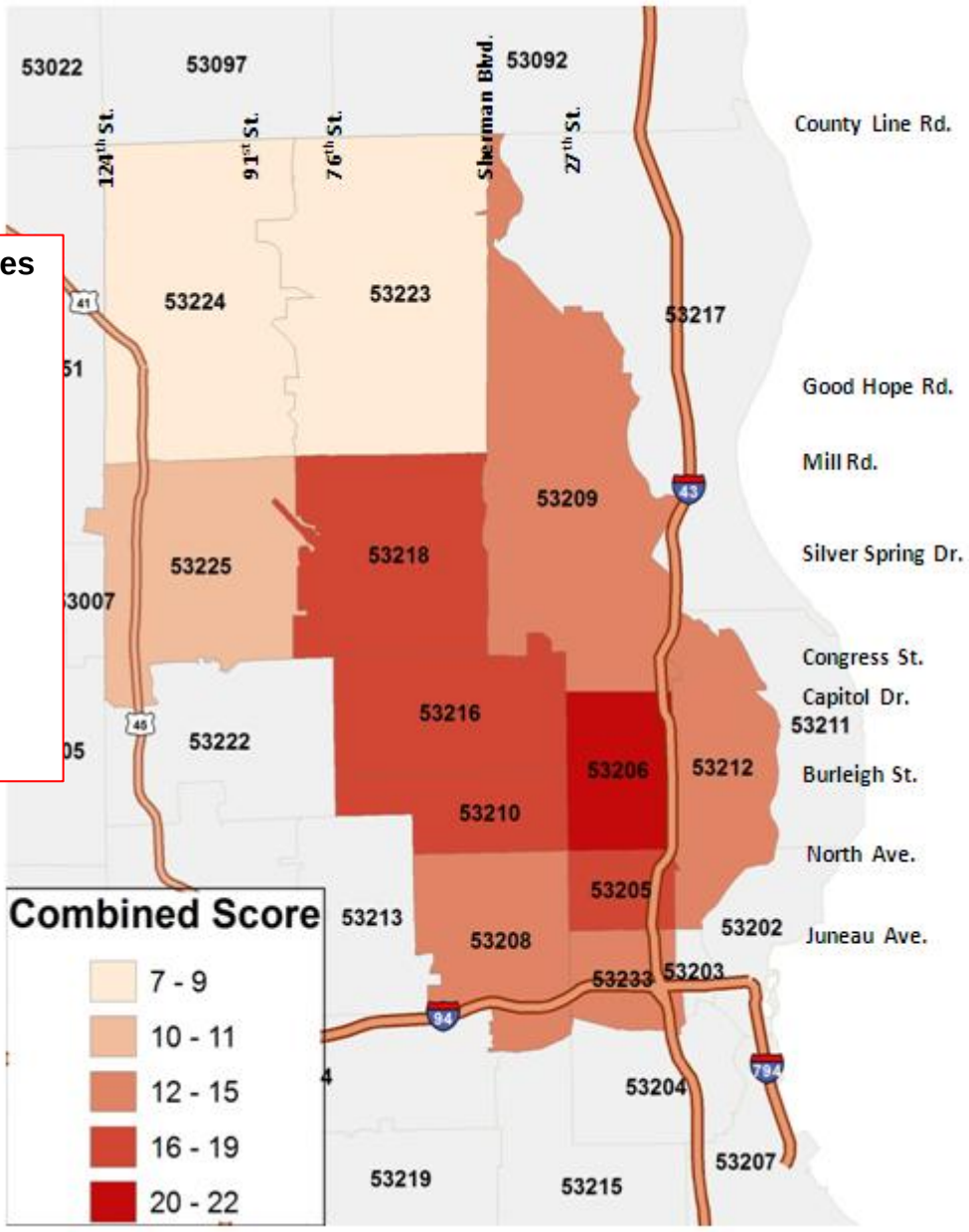


B. Map of area where project will be implemented

MILWAUKEE ZIP CODES OF GREATEST NEED

Targeted Zip Codes

- 53206
- 53210
- 53205
- 53216
- 53218
- 53233
- 53208
- 53209
- 53212
- 53225
- 53224
- 53223



C. Milwaukee LIHF Collaborative – Planning Phase Supporters & Staff

Steering Committee

Nicole Angresano, United Way of Greater Milwaukee
Anna Benton, Milwaukee Health Department
Erin Frederick, Joseph and Vera Zilber Family Foundation
Jessica Gatharimu, Milwaukee Health Department
*Shawn Green, Faith Partnership Network
Richard Greene, Greater Milwaukee Committee
Nancy Hahn, New Concept Self Development Center
Mark Huber, Aurora Health Care
Donna Johnson, New Concept Self Devlopment Center
Edward McDonald, UW Extension
*Patricia McManus, Black Health Coalition
Clarene Mitchell, Medical College of Wisconsin
George Morris, Milwaukee County Medical Society
Sarah Noble, Reproductive Justice Collective
Lakisha Outlaw, Community Consultant
David Pate, UW-Extension
Paula Penebaker, YWCA of Greater Milwaukee
Terence Ray, Milwaukee Fatherhood Initiative
Danna Rhinehart, Milwaukee Area Workforce Investment Board, Inc.
Bettie Rodgers, Law Office of Bettie Rodgers
Nicole Thomas, Public Allies and Reproductive Justice Collective
Chandala Williams, Community Consultant
*Earnestine Willis, Medical College of Wisconsin

** denotes co-chair*

In November, 2011 the original Steering Committee for the Planning Phase merged with the African American Task (see page 137) to form the Milwaukee LIHF Collaborative. Several members of domain task forces (page 134- 136) as well as LIHF supporters continued active participation at that point.

Improving Healthcare for African American Women Task Force

Kathlyn Albert, Community Consultant
Bernadette Allen, Froedert & The Medical College of Wisconsin
Janice Ancona, Wheaton Franciscan-St. Joseph
Patricia Aniakudo, Meta House
Vanessa Barnabei, Medical College of Wisconsin
Judy Bartels, Milwaukee Health Services, Inc.
Jenna Bowen, Community Consultant
Christy Brooks, Von Briesen & Roper, s.c.
Jean Davis-Mallett, Froedtert Hospital
Sarah Fraley, Department of Health Services
Jessica Gathirimu, Milwaukee Health Department
Julie Gosseck, Community Consultant
Dorise Hardin, Black Health Coalition of Wisconsin
Janice Harrell, CHIMC
Gina Hinton, Milwaukee Health Services, Inc.
*Mark Huber, Aurora Health Care
Joyce King, CHIMC
Dana Lauer, United Healthcare Community Plan
Edna Mathews, Omnipotence, Inc.
Wanda Montgomery, Children's Hospital and Health System
Priscilla Neal, Aurora Family Service
Cacy Odom-Williams, Aurora Health Care
*Bettie Rodgers, Law Office of Bettie Rodgers
Mary Shaw, Milwaukee County Breast Feeding Coalition
Bill Solberg, Columbia St. Mary's
Joy Tapper, Milwaukee Health Care Partnership
Ann White, Department of Public Health
Azure'De Williams, American Heart Association, Midwest Affiliate
Earnestine Willis, Medical College of Wisconsin

** denotes co-chair*

Strengthening African American Families and Communities Task Force

Dekisha Bell, Community Consultant
Dalvery Blackwell, African American Breast Feeding Network
Jan Buchler, The Parenting Network
Ptosha Davis, The Lauren Group
Ella Dunbar, Social Development Commission
Rodney Evans, ABCs 4 Healthy Families
Walter Fields Jr., Enduring Truth Fellowship
*Shawn Green, Faith Partnership Network
Demetrius Hamilton, CHIMC
Yolanda Hamilton, CHIMC
Claudette Hamm, Aurora Health Care
Elizabeth Hill-Karbowski, Wheaton Franciscan St. Joseph
Vivian Jackson, Children's Health Alliance of Wisconsin
Andre Jones, Department of Children and Families
Curtis Marshall, State of Wisconsin Division of Public Health
Dwayne McDonald II, Department of Children and Families
* Terrence ray, Milwaukee Brotherhood Initiative
Cherrie Richardson, Black Health Coalition
Carole Stewart, Milwaukee Health Services, Inc.
Dennis Walton, Milwaukee Brotherhood Initiative
Benjamin Watson, Coalition for Promoting Positive Black Fatherhood
Barbara E. White, WI NW Jurisdiction COGIC Family Initiative
*Chandala Williams, Community Consultant
Greg Williams, Milwaukee Area Workforce Investment Board

** denotes co-chair*

Addressing Social Determinants Task Force

*Nicole Angresano, United Way of Greater Milwaukee
Aretha Brown, Kids Matter, Inc.
Jill Denson, Milwaukee Health Services, Inc.
Michelle Doneis, Community Consultant
Bernard Glover, B&B Home Improvement
Nancy Hahn, New Concept Self Development Center
Kennita Hickmann, Community Consultant
Janel Hines, Greater Milwaukee Foundation
Kenneth James, Community Consultant
Maureen Kartheiser, March of Dimes Wisconsin Chapter
Stacy Racine Lynch, Community Consultant
Kate Masley, Alverno College
Benetria McGowan, Alverno College
Teresa Ortiz, Community Connect Health Plan
*David Pate, UW-Milwaukee
Donald Payton, Black Health Coalition of Wisconsin
Paula Penebaker, YWCA of Greater Milwaukee
Geimain Powell, Community Consultant
Danna Rhinehart, Milwaukee Area Workforce Investment Board, Inc.
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Megan Rutkowski, Community Advocates
Trina Salm Ward, Center for Urban Population Health
Rachel Shoates, YWCA of Greater Milwaukee
Geof Swain, Milwaukee Health Department and UW School of Medicine and Public Health
Laura Tate, Community Consultant
Madeline Wake, Marquette University
Christal West, Jump at the Sun and Medical College
Jarvis West, Jump at the Sun and Medical College
Robert Williams, St. Vincent De Paul Society

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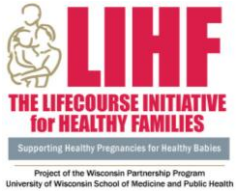

African American Task Force

Ingrid Carter, Black Health Coalition of Wisconsin
Ethel Crittendon, New Concept Self Development Center
Annie Crockett, Black Health Coalition
Tonda Davis, SDC Head Start
Waanita DeCatur, Black Health Coalition of Wisconsin
Rodney Evans, ABCs 4 Healthy Families
Toni Griggs, Community Consultant
Dorise Hardin, Black Health Coalition
Janice Harrell, CHIMC
Kim Hauman, Penfield Children's Center
Janette Herrera, Black Health Coalition of Wisconsin
Kenneth James, Community Consultant
Chivarlo Johnson, Black Health Coalition of Wisconsin
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Tosheba Johnson, New Concept Self Development Center
*Joyce King, CHIMC
Patricia McManus, Black Health Coalition of Wisconsin
Rachel Morgan, Black Health Coalition of Wisconsin
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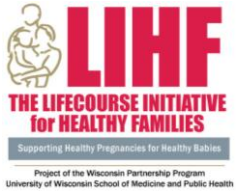
*Lakisha Outlaw, Community Consultant
Donald Payton, Black Health Coalition of Wisconsin
Cherrie Richardson, Black Health Coalition of Wisconsin
Dorothy Smith, Black Health Coalition of Wisconsin
*Nicole Thomas, Public Allies and Reproductive Justice Collective
Reginald Walton, Milwaukee Health Services, Inc.
Christal West, Black Health Coalition of Wisconsin
Jarvis West, Black Health Coalition of Wisconsin
Portia Williams, Black Health Coalition of Wisconsin

** denotes co-chair*



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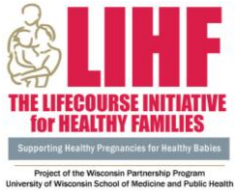
Lorinda Black, Central Racine County Health Department



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Sandra Butts, Community Volunteer
Chyra C., Community Volunteer
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Linda Campbell, Marquette University
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Rosie Caradine-Lewis, Community Volunteer
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Rebekah Carey, Wisconsin Lutheran College
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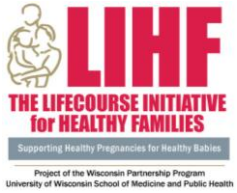
Kathy Carter, Center for Quality Community Life, Inc.
Jewell Carter, Social Support Network
Han-Yang Chen, University Wisconsin
Ron Cisler, Center for Urban Population Health
Brandy Clarke, Job Corps
Shaveela Clayton, Community Volunteer
Arleta Cobb, Community Volunteer



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Pat DeLessio, Legal Action
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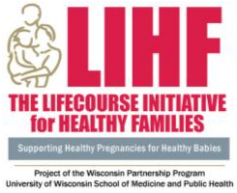

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Laura Gembolis, Herzfeld Foundation
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Margaret Gesner, Central Racine County Health Department
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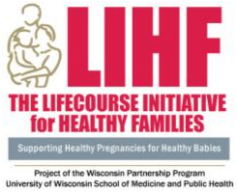
Nancy Gillian, BHC
Ricky Gillon, Free at Last Ministries
Carla R. Givens, Community Volunteer



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Karen Gralton, Community Volunteer
Kalyani Grasso, Women's Fund of Greater Milwaukee
Kristen Gravatt, Wisconsin Apprentice Organizers Project
Alesia Gray, CHIMC
Shawn Green, Faith Partnership Network
Richard Greene, Greater Milwaukee Committee
Angie Grice, Community Volunteer
Tamara Grigsby, Wisconsin State Legislature
Jacqueline Grimes, Aurora Medical Group
Nancy Grode, New Concept Self-Development Center, Inc.
Dawn Groshek, Rosalie Manor Community & Family Services
Tristan Gross, Neu Life Community Center
Dr. Veronica Gunn, Children's Hospital and Health System
Nancy Hahn, New Concept Self Development
Lucina Halbur, Set Ministry, Inc.
Mario Hall, Community Volunteer
Yolanda Hamilton, CHIMC
Demetrius Hamilton, CHIMC
Claudette Hamm, Aurora Health Care
Pamela Hansen, Milwaukee Public Schools
Melissa Hanson, Planning Council for Health and Human Services, Inc.
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Robert Harris, Division of Public Health
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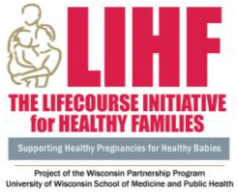
Jeanne Hewitt, UWM School of Public Health
Kennita Hickman, Community Volunteer
Elizabeth Hill-Karbowski, Wheaton Franciscan St. Joseph



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Tina Hope, Jump at the Sun
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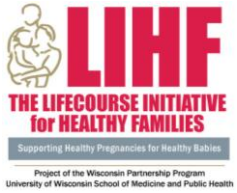
Vivian Jackson, Children's Health Alliance of Wisconsin
Darryl Jackson, Community Volunteer
Bobby Jackson, Community Volunteer
Linda Jackson Cocroft, Black Women 50+Health & Lifestyles Magazine; Woman II Woman, Education & Empowerment
Angelia Jamerson, Community Volunteer
Kenneth James, Community Volunteer
Eric Jaskolski, Rosalie Manor
Cathei Jaus, Community Volunteer
Terry Jaus, Community Volunteer
Sue Jehl, Froedtert Hospital
Andrea Jehly, Community Volunteer
Theresa Jemison, St. Matthew AME Church
Dianne Jenkins, Wisconsin Department of Children and Families
Shaneé Jenkins, Community Volunteer
Steve Jerbi, All People's Church
Araceli Jimenez, MATC
Tosheba Johnson, New Concept Self Development Center
Chivarlo Johnson, Black Health Coalition of Wisconsin
Christine Johnson, Community Volunteer
Christye Johnson, Community Volunteer
Donna Johnson, New Concept Self Development Center
Quantia Johnson, Community Volunteer



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Tamara Johnson, MPS
Sharicus Johnson, Milwaukee Health Services
Rachel Johnson, Community Volunteer
Ramona Johnson, Black Health Coalition of Wisconsin
Andre Jones, Statewide Fatherhood Initiative
Jennifer A. Jones, Children's Trust Fund
Monica Jones, Milwaukee Health Services
Weneaka Jones, Rosalie Manor
Cynthia Jordan, Community Representative
Tamiko Jordan-Obregon, Milwaukee Center for Leadership Development
Raejean Kanter, American Diabetes Association
Bernadette Karanja, Social Development Commission
Maureen Kartheiser, MSED, March of Dimes Wisconsin Chapter
Murray Katcher, Wisconsin Division of Public Health
Carol Keintz, Next Door Foundation
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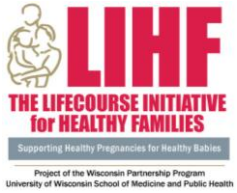
Dana Lauer, United Healthcare Community Plan
Carolyn Lee, Bureau of Milwaukee Child Welfare



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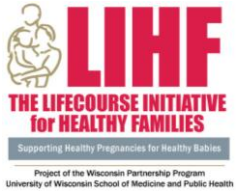

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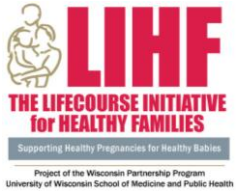

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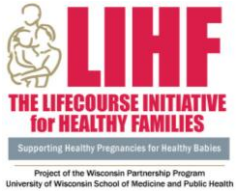

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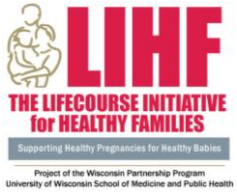
Dionne Shaw, Women's Fund of Greater Milwaukee
Mary Shaw, Milwaukee County Breast Feeding Coalition



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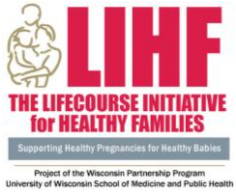

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Kerri Tyler, Black Health Coalition of Wisconsin
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Dorothy Valentine, Set Ministry, Inc.
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Madeline Wake, Marquette University
Kadeitra Wallace, Student
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Schonta Ward, Milwaukee Health Services
Charlie Ward, Community Volunteer
Kanika Ward, Kosmic Kare Day Spa
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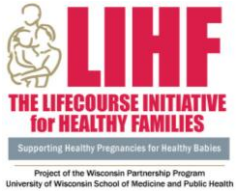

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Ann White, Department of Public Health (WIC)
Marcus White , Greater Milwaukee Foundation
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Deshawn Wilkerson, Community Volunteer
Angie Wilks-Tate , Milwaukee Health Services
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Robert Williams, St. Vincent De Paul Society
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Ramona Williams, Milwaukee County
Lisa Williams, Community Volunteer
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Greg Williams, MAWIB
Conor Williams, Community Advocates
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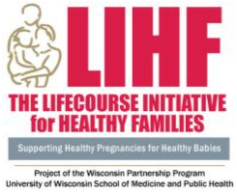
Shalonda Yankaway, Black Health Coalition of Wisconsin
Jasmine Zapata, Community Volunteer
Jessica Zigman, Medical College of Wisconsin &Planning Council for Health and Human Services, Inc.
Suzanne Zipperer, Community Volunteer
Danielle Zirkel, Penfield Children's Center



Convening Staff

- Tommie Colón-Longoria, Planning Council
- Quinton Cotton, Planning Council
- Artency Davis, Planning Council
- Ann Fisher, Women's Fund of Greater Milwaukee
- Margaret Henningsen, Women's Fund of Greater Milwaukee
- Lonna Kruse, Planning Council
- Elaine Maly, Women's Fund of Greater Milwaukee
- Sue McKenzie, Planning Council
- Valerie Nash, Planning Council
- Kathleen Pritchard, Planning Council
- LG Shanklin-Flowers, Women's Fund of Greater Milwaukee
- Dionne Shaw, Women's Fund of Greater Milwaukee
- Curtis Smith, Planning Council
- Julie Whelan Capell, Planning Council
- Jane Wilke, Planning Council
- Dana Wilson, Planning Council

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- Jim Dressner
- Angelica Dudenhoefer
- Jason Farina
- Melissa Hanson
- Holly Hyland
- Tom Kaleekal
- Lusia Shan Lu
- Keania Nwambo
- Erin Shawgo
- Stephanie Swinney
- Ashley Tikkanen
- Theresa Umhoefer
- Robert Williams
- Jessica Zigman

D. Engaging Cross-Generational Input Report

New Concept Self Development Center, Inc., a private non-profit comprehensive human series agency that has been serving the community for more than 30 years, was asked to partner with the Planning Council for Health and Human Services Inc. to assist in ***Engaging cross-generational input*** in the Life-course Initiative for Healthy Families planning process. Consistent with the Life-course model, the voices and perspectives of African Americans across the generations were sought out to be incorporated into the planning process. New Concept convened groups across the generations in an age-appropriate manner to and gathered their input and perspective. Groups included Adolescent Girls, Teen Mothers, Adult Women, Professional Women, Grandmothers, Group Home Women, Adolescent Boys, Adult Males, and Grandfathers. The groups were conducted between December, 20, 2010 and April 9, 2011. The discussions revealed personal stories, insights, and perspectives can be used to enhance the understanding of the problem, and add strength to the solutions that are proposed. Everyone that participated in the group experienced a loss, either themselves, within their family, or a close friend. Types of loss experienced include miscarriages, still births or the death of an infant before its first birthday. In the case of many individuals, they had experiences multiple losses.

New Concept implemented a process that included recruitment, pre-screening of participants, facilitation of the group discussions, and the videoing of select, agreeable participants to share with the stakeholders. Staff gathered demographic information about participants, including age, gender, race/ethnicity, income, and ZIP code. Participants were offered a $25.00 VISA card as incentive for their participation and to offset transportation and/or childcare costs. Participants signed sign-in sheets at each focus group and provided their signature upon receipt of the gift cards. Participants under 18 were provided with consent forms to be signed by their parent in order to take part. Participants agreeable to the videoing session signed media releases agreeing for their images and audio to be used as needed for the LIHF Project. Anita Spencer was the New Concept staff responsible for recruitment, follow up and facilitation of the groups. Nancy Hahn provided oversight, took notes at the group session and maintained relations/provided updates to the funding source and the LIHF Steering Committee.

Recruitment for participant took place at the LIHF Kick Off event, through various community CBO newsletters, through word of mouth, through flyers distributed in the community and at various community based organization, and from New Concept's current and past participants. Follow up prior to group sessions included a confirmation letter that was mailed, and follow up reminder calls a day or two before the scheduled group. Participation for each group was over recruited with the understanding and past experience telling that not all who say they will attend actually show up on the day that the group takes place. This was the case for the LIHF groups as the actual group sizes ranged from 4 – 10 participants, with the least participation from the adolescent boys. Two groups had to be rescheduled due to inclement winter weather, which did not seem to have any effect on the participation in those groups. Two groups developed as a result of contacts from outside interested parties; one expressing that the views of professional African American women be included and one asking that the group take into consideration the specific experiences of women in recovery.

Sue McKenzie from In Health WI, was contracted to provide the equipment, video the sessions, and edit the final product. The video taping took place on April 9, 2011, with 13 participants from the various groups divided into two taping sessions. During the videoing session, the participants were filmed discussing the same questions that were asked at the original group discussion.

Overall, participants were very interested in discussing the loss that they had experienced. The participants expressed some comfort and also some surprise in the fact that there were so many others who had experienced a loss similar to theirs (or their families). Participants had varying levels of knowledge of the situation, with the women and grandmothers being more informed and the adolescent boys knowing the least.

Information from the report was shared in the following manner: Demographic information was shared at the May 24, 2011 Steering Team Meeting; Initial Draft of the report was discussed at the Planning Council LIHF Staff Meeting on June 6, 2011 for suggestions on presentation to the African American Task Force and about other means for dissemination; a PowerPoint presentation summarizing the report was shared with the African American Task Force at their meeting on June 15, 2011 at the Black Health Coalition.

GROUPS HELD

Total of nine groups held with a total of 75 participants; one video group with a total of 13

Teen mothers – 12/20/10 = 8 participants
Adult males – 12/29/10 = 10 participants
Adult females – 1/13/11 = 7 participants
Teen boys - 2/16/11 = 4 participants
Professional women - 3/3/11 = 7 participants
- 3/9/11 = 9 participants (Edna)
Grandmothers - 3/16/11 = 7 participants
AODA (Meta House) - 3/29/11 = 8 participants
Grandfathers - 4/6/11 = 7 participants
Teen Girls - 4/7/11 = 8 participants
Videoing Group - 4/9 /11 = 13 participants

AGE

12-17 yrs =16 participants
18-21 yrs = 3 participants
22-34 yrs = 9 participants
35-44 yrs = 14 participants
45-54 yrs =15 participants
55-64 yrs = 13 participants
65-74 yrs = 5 participants

Gender

Males = 21 participants
Females = 54 participants

Income

$0 -$9,999 = 13 participants
$10,000 – $14,999 = 16 participants
$15,000 – $22,999 = 16 participants
$23,000 – $33,999 = 17 participants
$34,000 – $49,999= 4 participants
$50,000 -- $74,999 = 9 participants

Race/Ethnicity

72 African American
3 White (AODA)

ZIP

53202 = 1
53205 = 11
53208 = 15
53209 = 6
53210 = 10
53212 = 14
53216 = 8
53218 = 7
Unknown = 3

FOCUS GROUP QUESTIONS

1. Who do you know that lost a baby before its first birthday? What happened?
2. How did this loss impact that person/you and their family?
3. Why does the person/you think this happened?
4. Why did the doctors say this happened?
5. What could they have done have done to prevent this?
6. Are you aware of ways a person can prevent losing a baby?

Copies of the full report are available upon request.

E. Description of process for selecting evidence-based programs

Starting in December of 2010 and ending in March of 2011, all domain taskforces (healthcare, social determinants, and families and communities) focused on one point in their area of focus at each of their monthly meetings. For instance, in December the Improving Healthcare for African American Women taskforce focused on expanding healthcare access over the lifecourse. In January, this Taskforce focused on increasing access to preconception care for African American women, in February they discussed improving quality of prenatal care, and in March the group talked about providing inter-conception care for women with prior adverse pregnancy outcomes.

At each of these domain taskforce meetings over this four-month period, the group was assigned to discuss current efforts, effective strategies, evidence-based and promising practices, and what is needed locally to improve healthy birth outcomes. Presenters were at most meetings to talk to participants about current programs or efforts. At some meetings, evidence-based and promising practices were discussed at length.

In April, each of the domain taskforces narrowed their focus (from four points to one). For example:

- The Strengthening African American Families and Communities Taskforce decided to focus on strengthening father involvement in African American families.
- The Improving Healthcare for African American Women decided to focus on expanding healthcare access over the lifecourse.
- The Addressing Social Determinants Taskforce decided to focus on reducing poverty among African American families.

Once each taskforce had a focus area, the groups began to discuss goals, objectives, and strategies at their May, June, and July meetings. Workgroups, which were smaller working groups made up of Taskforce members that met outside of Taskforce meetings, were formed in May to look at evidence-based models and promising practices related to the focus area.* The Workgroups discussed many of the model programs identified by Dr. Lu in the “12-Point Plan.” Other programs were identified by workgroup members.

A document of all evidence-based and promising practices across the three domain taskforces was compiled (“Draft Summaries of Selected Evidence-Based and Promising Practices”). These programs and practices were then linked to the strategies identified by the domain taskforces. After this process was complete, it was clear that there was a lack of programs or practices related to medical homes. Therefore, conveners did Internet research to find effective models. Ten programs were added to the summary document based on this research.

The African American Taskforce vetted the domain taskforce strategies; however, they did not vet the individual programs. They did note that any programs should fit with the guiding principles (they should be culturally appropriate, community driven, family-centered, recognize the unique role of African American organizations, address racism, integrate concepts of the lifecourse, and work toward fulfilling the project vision of reducing stress and improving birth outcomes). The African American Taskforce also noted that in addition to programs, there will need to be a focus on policy change. Both programs and policies will be needed to eliminate disparities in infant mortality in Milwaukee.

* The Families and Communities Workgroup met on May 23rd and June 8th. The Healthcare Workgroup met on May 4th, June 7th, and June 21st. The Social Determinants Workgroup met on May 18th, June 14th, and July 6th.

F. Inventory of selected programs & strategies

A. Arizona Department of Health Services Medical Home Project

http://www.azdhs.gov/phs/owch/projects.htm

The Arizona Department of Health Services Medical Home Project is a system of linkages between school nurses and health care providers. The Bureau of Women's and Children's Health contracts with the American Academy of Pediatrics, to develop and implement a system for linkage between individual pediatricians, family practice physicians, specialists and school nurses to provide a medical home for uninsured children of low income families who have no other source of health care. Qualified children are referred by school nurses to the Medical Home Project who then connects the child to participating health service providers who these providers have agreed to accept a Medical Home Project assigned fee of $5.00 or $10.00 as payment in full for the office visit. In 2007, 77 primary care providers and 54 specialty providers participated in the Medical Home Project. 811 services were provided to children as a result of referrals through the Medical Home Project.

- medical care
- diagnostic procedures
- prescribed medications.
- primary care
- prescriptions
- specialty services(i.e.-eye glasses)

B. Birthing Project USA

http://www.birthingprojectusa.org/intro.html

This is a volunteer effort to encourage better birth outcomes by providing one-on-one practical support and education to women during pregnancy (The Birthing Project USA also works with children who are born to mothers in the project and fathers). Services are primarily targeted to African American women; however, services can also be provided to pregnant women of all ethnicities who need medical care and social support to optimize their birth outcomes.

This Birthing Project USA: The Underground Railroad for New Life provides local efforts with technical and practical support through its national resource center. Local projects can operate from homes, churches, service groups, places of employment, clinics, health departments and hospitals - any place where a group of ten women can commit to being conductors on The Underground Railroad for 18 months.

The Birthing Project USA's mission is to assist local communities in improving their health status by addressing the systemic causes of their lack of well-being. Birthing Projects actively engage community residents in
1) Identifying their needs.
2) Planning, implementing and evaluating services.
3) Working collaboratively with other agencies, organizations and individuals.

Specifically, the Birthing Project USA:

- Provides information, training and support to women and organizations who are interested in starting a Project in their communities.
- Assists local projects to identify and obtain necessary community services and resources.
- Assists local projects in establishing collaborative efforts.
- Assists local projects in developing long term strategic and action plans.

- Sponsors an annual training and networking conference for local projects, professional colleagues and other stakeholders.
- Provides Leadership Development and support for grassroots girls and women.
- Provides technical assistance and consultation to organizations, agencies and institutions that provide health and human services to African American and other underserved youth and women and their families.
- Shares the history, experience and outcomes of this innovative model at meetings, conferences and trainings.

The workgroup likes the overall approach of having a support person or "big sister," but wants more information on outcomes. There is some concern about the lack of medical supports for women during the prenatal period.

C. Building Bridges: Medical Home and Library

www.aap.org/catch/implementgrants.htm

The Building Bridges project, addresses both the need for a medical home and the need for improved literacy by linking vital community resources: the community health center (which serves as a medical home for families), the neighborhood library, and other community partners.

The program targeted immigrant and low-income families who already use the library, and provided them with information on health insurance and medical homes.

Building Bridges Goals & Objectives include:

- Provide information about as well as connect families to medical homes.
- Increase utilization of and dispel myths about the library.
- Improve parents' readiness to change as it relates to health care access and literacy promotion.

D. Catalyst Center: Financing Care for Children and Youth with Special Health Care Needs (CYSHCN) and Medical Homes

http://www.medicalhomeinfo.org/how/payment_and_finance/

The Catalyst Center seeks to promote adequate financing for comprehensive, family-centered care of CYSHCN. The Center works with a broad range of stakeholders in financing and coverage issues including government agencies, parent groups, health and social service agencies, employers, payers and other stakeholders to determine family and community needs, identify gaps in current funding to meet those needs, and develop creative funding strategies. As researched by the Catalyst Center, states are developing innovative ways to finance initiatives that strengthen the existing health care system. For example, states have developed strategies to procure services in ways that improve quality or delivery of care, whether it is through medical home supports, youth transition services, or primary care case management. States are developing strategies to fund new services for CYSHCN that are not typically covered by health insurance, including care coordination (by blending state Title V and Medicaid funding, or by blending Title V and private insurance funding) and integrated care for children with specific diagnoses (by blending funding from multiple state agencies).

E. Center for Driver's License Recovery and Employability

http://licenserecovery.org/

The Center for Driver's License Recovery and Employability is a broad public-private partnership that includes Wisconsin Community Services, Legal Action of Wisconsin, Milwaukee Area Technical College, and the City of Milwaukee Municipal Court. The Center was founded to increase the number of licensed low-income drivers in Milwaukee County, improving their ability to secure family-supporting jobs. The Center model integrates case management services with legal services, increasing the effectiveness and efficiency of the license recovery process. Its objectives are to:

- Provide direct service case management and legal services to low-income Milwaukee County drivers to recover and retain their driver's licenses;
- Restore free driver's education for low-income students statewide;
- Improve public policy to limit the use of license suspension and revocation to sanction unsafe drivers and increase the use of alternatives to suspension and revocation; and
- Increase community awareness that driver's license suspensions and revocations hinder employment and perpetuate poverty among low-income individuals.

F. Center for Fathers, Families and Workforce Development (CFWD)

http://www.childwelfare.gov/pubs/usermanuals/fatherhood/chaptereight_e.cfm

The Center for Fathers, Families, and Workforce Development (CFWD), empowers low-income families by enhancing the ability of men to fulfill their roles as fathers and helping men and women to contribute to their families as wage earners.

CFWD organized a team parenting program called 50/50 Parenting, which recognizes that never-married parents, together or not, may need support in working together for the health and well-being of their children. Their support team might include the children's grandparents, the parents' new spouses or partners, and influential "others" in the family's life. The overarching goal of the 50/50 Parenting program is to promote the well-being of low-income children by encouraging healthy relationships between their biological parents.

This program has two goals. First, it aims to help couples that want to marry to gain the knowledge, attitudes, and skills they need to develop and sustain a healthy marriage. Second, it assists low-income mothers and fathers for whom marriage is not an option to form healthy co-parenting relationships. The curriculum includes sessions for a variety of audiences. The program is guided by the following principles:

- Participation is voluntary at all times. The curriculum acknowledges that marriage is not appropriate for, legally accessible to, or desired by everyone. -The program is offered in a style that is open and respectful to participants from a wide variety of backgrounds, cultures, and religions.
- The curriculum promotes a model of "healthy" and "safe" marriages based on respect between equals.
- Efforts to promote marriages or co-parenting relationships should never supersede nor compromise the safety of the children or the mother.
- Race, culture, and socioeconomic status have a profound impact on the gender roles and identities of individuals coming for services. Efforts should be taken to address gender-role stereotypes that lessen the ability of mothers and fathers in fragile families to form healthy marriages or to work cooperatively in the best interest of their children
- Anger is a normal feeling, and conflict is a natural and normal occurrence in relationships. -- -Violence is not the natural. Violence is a choice and is an unacceptable way to resolve conflicts in relationships or to discipline children.
- The curriculum addresses unemployment, incarceration, substance abuse, depression, or physical illness which can make it difficult to have a healthy relationship.

G. Center for Health Equity and Social Justice

http://www.bphc.org/chesj/Pages/default.aspx

The Center aims to serve as a mentor for public health organizations working toward health equity by promoting community mobilization, community-based participatory research, program development, and program evaluation.

Specific activities of the Center include:

- Coordination of a Health Equity Training Center that provides education, training, and technical assistance in three areas: improving access to healthy and affordable foods; expanding youth to health careers programming; and developing neighborhood strategies to eliminate disparities;
- Development of training curricula and materials to educate community health workers, health care providers, and public health professionals about the social determinants of health and racial and ethnic disparities;
- Establishment of the New England Partnership for Health Equity, which is a learning collaborative among New England communities engaged in health equity work;
- Development and implementation of blueprints for action and community coalition building;
- Facilitation of a variety of regional and national activities to support a broad-based health equity movement; and
- Advocacy to eliminate racial and ethnic health disparities through data collection, policy, and strategy development at the local, state, and federal level.

H. Centering Pregnancy

http://www.centeringhealthcare.org/pages/centering-model/pregnancy-overview.php

Centering Pregnancy is a model for complete prenatal care to women within a group setting with the following goals:

- Strengthen the family bonds essential to nurture and raise a healthy child.
- Create an integrated team of health care providers to serve women and their families throughout pregnancy and into the postpartum period.
- Promote new ways of nonhierarchical interaction between health care providers.
- Strengthen women, their families, and health care professionals and the communities in which they live and work.

All prenatal care occurs within the group setting except for the initial assessment and medical or psychosocial concerns involving the need for privacy. Women begin prenatal care with history and physical examination in the office/clinic space. Then, they are invited to join 8-12 other women of similar gestational age to meet together to obtain all future prenatal care, share support from other women, and obtain knowledge and skills related to pregnancy, childbirth and parenting. Women are encouraged to bring the baby's father/support person to their group sessions. Women are enrolled in groups between 12 and 16 weeks gestation and continue through their pregnancies, following the recommended schedule of prenatal visits from the American College of Obstetrics and Gynecology.

The program has 10 defined 2-hour sessions, each with the same format. A health care provider completes individual prenatal assessments during the first 30 minutes of each session. These are conducted in one corner of the room - providing some privacy but not totally shielded from others. Participants are encouraged to bring general questions to the group and can discuss private questions with the provider at the beginning of the session.

Results from the randomized control trial found that women assigned to group care were significantly less likely to have preterm births compared with those in standard care. Women in group sessions were less likely

to have suboptimal prenatal care, had significantly better prenatal knowledge, felt more ready for labor and delivery, and had greater satisfaction with care. Breastfeeding initiation was higher in group care. There were no differences in birth weight or in costs associated with prenatal care or delivery.

The model is being implemented at four sites in Milwaukee and has some support from the workgroup. This model does not address issues before a woman becomes pregnant.

I. CIGNA and Holston Medical Group (HMG) Patient-Centered Medical Home Pilot Program in Tri-Cities and Southwest Virginia

http://newsroom.cigna.com/article_display.cfm?article_id=1261

CIGNA (NYSE:CI) and Holston Medical Group (HMG) started a pilot of the patient-centered medical home model, in which a primary care physician is responsible for monitoring and coordinating nearly all aspects of a patient's medical care.

The pilot represents a collaborative approach between CIGNA and the 150 health care professionals of Holston Medical Group to improve patient access to care, to improve continuity, coordination and quality of care, and to lower medical costs. It encompasses:

- use of electronic medical records to track medical history
- case management/disease management within the practice
- onsite urgent care
- extended hours
- education to help people navigate their health care system
- better availability of appointments
- pay for performance – doctors will be rewarded for improving quality and lowering costs

The pilot program, which began August 1, focuses on individuals, especially those with chronic illness or ongoing medical needs, who receive care from Holston Medical Group's primary care physicians who practice family medicine, internal medicine and pediatrics.

J. Community Health Workers (based on New York State's Community Health Worker Program, which is used by the Northern Manhattan Perinatal Project)

http://www.health.state.ny.us/community/pregnancy/health_care/prenatal/community_health_worker/

Community health workers provide outreach, education, referral and follow-up, case management, advocacy and home visiting services to women who are at highest risk for poor birth outcomes, particularly low-birth weight and infant mortality. The CHWP is targeted to specific communities with high rates of infant mortality, out-of-wedlock births, late or no prenatal care, teen pregnancies and births, and births to low-income women. The program's focus is on getting pregnant women into early and consistent prenatal care and ensuring their families receive primary and preventive health care services.

Services are provided by paraprofessionals who live in or are familiar with the community. They create a bridge between providers of health, social and community services and the underserved and hard-to-reach populations within the community. Community health workers (CHW) are trained to provide basic health education and referrals for a wide range of services, and to provide support and assistance in navigating the health and social services system. The CHWs:

- Conduct intensive outreach efforts to pregnant women, including pregnant women who are uninsured, underinsured, are not involved in prenatal, health or other community services, and other high risk populations living in the target area to help get these women into prenatal and other health care services.

- Develop and maintain a relationship with the family during home visits, which are made at least monthly throughout the woman's pregnancy and throughout the infant's first year of life.
- Provide basic health education to families on a range of topics including lead poisoning prevention, HIV risk factors and measures to prevent transmission, risk factors associated with prenatal substance abuse (including tobacco), domestic violence, family planning, breastfeeding and other important health topics.
- Ensure parents understand the need for children to receive immunizations and regular health care.
- Help families address such issues as completing high school education, selecting appropriate childcare and handling the multiple demands of work/school and child rearing.
- Work with parents in their homes to improve parent-child interaction and to promote their understanding of normal child development.
- Assist families with application procedures for such services as Medicaid, Child Health Plus and WIC.
- Assist families to develop the necessary skills and resources to improve their health status, family functioning and self-sufficiency.

http://www.ahrq.gov/downloads/pub/evidence/pdf/comhealthwork/comhwork.pdf

Community Health Worker (CHW) interventions were associated with a greater likelihood of initiating breastfeeding among African Americans, more frequent use of nonviolent discipline methods by parents, and higher parenting efficacy scores when compared with video-intervention or no-intervention controls. CHWs were also associated with significant attenuation in the decline of cognitive and motor development among infants with failure to thrive and with a lesser degree of increase in depressive symptoms among postpartum women when compared with no intervention. No significant advantage to CHW intervention was seen for improvements in incidence of low birth weight, presence of neonatal or infant health problems, language development, maternal stress or self-esteem, continuation of breastfeeding beyond 1 week, tobacco exposure for children of smokers, continued drug use among mothers with known prior drug use, growth of children with failure to thrive, or incidence of child maltreatment when compared with nurse interventions, multidisciplinary specialty clinical care, video or print intervention, routine health care, or no intervention.

Most studies involving CHWs for maternal and child health have been concerned with high-risk populations. For maternal and child health, CHWs appear to be most beneficial when addressing existing health conditions instead of potential conditions (i.e., primary prevention). Of the 15 studies that were evaluated, 8 studies reported statistically significant benefit to CHWs, compared with nurse interventions, multidisciplinary specialty clinical care, video or print intervention, routine health care, or no intervention. CHWs have not yet been shown to improve key health outcomes relating to maternal and child health such as prematurity, low birth weight, sustained breastfeeding, or child maltreatment relative to other alternatives such as video or print intervention, routine health care, or no intervention. The lack of such findings suggests that either further research is needed to demonstrate benefits or that there is a true lack of benefit for CHWs in this domain.

K. Disparity Reduction at the Practice Site

http://www.medicalhomeinfo.org/state_pages/north_carolina.aspx

Robert Wood Johnson Foundation helped to fund and develop an initiative by CHCS to support quality improvement in small practices racially and ethnically diverse populations, since small provider practices play a critical role in caring for Medicaid beneficiaries. The three-year project is helping Medicaid agencies and health plans partner with small practices to reduce racial and ethnic disparities and improve overall outcomes. State-led teams in Michigan, North Carolina, Oklahoma and Pennsylvania are helping practice sites implement interventions focused on tracking patients and outcomes using an electronic data management tool; adopting evidence-based guidelines for targeted chronic conditions; and incorporating team-based care into ongoing practice operations.

L. Earned Income Tax Credit (EITC)

http://www.irs.gov/individuals/article/0,,id=96406,00.html

The Earned Income Tax Credit (EITC) is a refundable federal income tax credit for low to moderate income working individuals and families. Congress originally approved the tax credit legislation in 1975 in part to offset the burden of social security taxes and to provide an incentive to work. When EITC exceeds the amount of taxes owed, it results in a tax refund to those who claim and qualify for the credit.

To qualify, taxpayers must meet certain requirements and file a tax return, even if they do not have a filing requirement. To qualify for EITC, you must have earned income from employment, self-employment or another source and meet certain rules. In addition, you must either meet the additional rules for Workers without a Qualifying Child or have a child that meets all the Qualifying Child Rules for you.

The workgroup noted that this strategy has some overlap with the other domains. There would need to be a literacy component added.

M. Ellis Medical Home Project

http://www.ellismedicine.org/AboutEllis/GrowthAndExpansion/GrowthMedicalHome.aspx

Ellis Hospital formed the medical home in collaboration with a number of community partners promotes patient-centered, physician-guided, better coordinated and cost-effective care. The Ellis Medical Home is an innovative approach to improving access to health care, social and community services. The overall goal is to improve quality of care and access to primary care and preventive/wellness medicine. The total cost of the project was an estimated $6 million. The Ellis Medical Home is within Ellis Hospital which is located in Schenectady, NY.
The services provided include family medicine, pediatrics, dental, imaging & x-rays, laboratory, diabetes education, day surgery, wound care, insurance enrollment, and nutrition counseling etc.

The Ellis Medical Home Project highlights include:

- Community Shuttle
- Electronic Health Records
- Health Services Navigation
- Family Health Center: primary care for men, women and children, including annual physical exams, immunizations, sick visits, follow-up care, OB/GYN care and specialty referrals.
- Pediatric Health Center: from check-ups, immunizations and sick visits to wellness medicine and hospital care, our team provides the primary care a child needs through every stage of growth and development (age birth to 18 years).

N. Empowering Families of Milwaukee

http://city.milwaukee.gov/EmpoweringFamiliesof23827.htm

The City of Milwaukee Health Department partners with several community-based organizations to provide home visitation and supporting services (including access to health, social, and child development support for families) to expectant and young families. Community partners include: Children's Services Society of Wisconsin, La Causa, Inc., and St. Vincent de Paul Society of Milwaukee Family Resource Center.

EFM is a home visiting service that provides personal visits to pregnant women and their families, and mothers and families with children from birth to 5 years old. Teenage and adult women of any age who are pregnant or have an infant up to two months old can enroll in EFM if they live in one of the eligible Milwaukee ZIP Codes. The long-term goals of EFM are to improve birth outcomes in Milwaukee, enhance family functioning, support child health, safety and development, and prevent child abuse and neglect.

EFM's services to families include:

- Health assessments and information
- Goal setting and care planning
- Development screenings, information, and activities
- Home safety assessments
- Referrals to community resources and invitations to community events

O. Financial Literacy Program

http://www.federalreserve.gov/pubs/bulletin/2002/1102lead.pdf

http://www.financialeducatorscouncil.org/financial-literacy-programs.html

The National Financial Educators Council certifies and features financial literacy programs that represent the best practices in the industry. The NFECs' mission is to help organizations and individuals reduce the time and cost associated with locating a financial education program. The following are products and services that the NFEC offers:

Financial Literacy Software - Virtual learning centers, games and simulation.

Workshops and Events - Nationally recognized events, classes and workshops.

Financial Education Products - Top rated financial literacy products for individuals.

Teaching Financial Literacy - Certified Financial Education Instructor (CFEI) training.

Financial Education Services – Consulting and program development.

Employee Financial Education – Programs that educate and deliver a ROI.

The following are a few of the major kinds of financial literacy programs

- Homebuyer Counseling Programs: Home ownership, a primary mechanism for household asset accumulation, is the cornerstone of government housing policy objectives and community development strategies. Prepurchase counseling has long been a way of preparing and qualifying prospective homeowners—particularly those who have low income, inadequate savings, or impaired credit histories—for the financial responsibility of a mortgage. Many affordable-housing programs include a financial literacy component, with such training generally addressing debt management, budgeting, and saving. Borrowers receiving counseling had, on average, a 19 percent lower ninety-day delinquency rate than borrowers with ''equivalent observable characteristics'' not receiving counseling. Those who received individual counseling had a 34 percent lower delinquency rate than those who received no counseling, and those who received classroom and home study training had 26 percent and 21 percent lower delinquency rates respectively. Telephone counseling did not lower delinquency rates. The reduction in delinquency rates was found to be attributable to the type of counseling format, regardless of the organization providing the counseling.
- Savings Initiatives: America Saves is a program in which communities conduct local savings campaigns. The program includes efforts to enroll residents as savers and the provision of no-fee savings accounts, motivational workshops, and one-on-one consultation. The pilot program in Cleveland, Ohio, has more than 100 organizational participants, has enrolled 1,500 ''Cleveland Savers,'' and has involved more than 2,000 individuals in motivational workshops. An area-wide survey suggests that through these efforts, some 10,000 Cleveland-area residents have been persuaded to save more effectively. Money 2000 was initiated to provide information and tools to consumers seeking to improve their savings and spending patterns. Program participants reporting

progress toward their financial goals increased their savings, on average, approximately $1,600 within a twelve-month period and decreased their credit balances an average of more than $1,200.

- Monetary incentives: Matched-savings programs known as individual development accounts (IDAs) were designed to address the concern that many lower-income earners do not have access to employer-sponsored savings programs, such as 401(k) plans. Participants open savings accounts and specify a savings objective. Their contributions are matched by sponsoring organizations such as nonprofit organizations, corporations, government agencies, and foundations. Matching funds are forfeited if the funds are withdrawn for any reason other than to purchase a home, start a small business, or fund higher education. Generally favorable outcomes have been reported. Financial training appears to have played an important role in the success of IDAs: Average monthly net deposits increased with each additional hour of training up to twelve hours (training beyond that amount had little effect).
- Workplace Programs: Many employers have instituted training seminars to help employees assess their needs and evaluate their options for the future, most often these seminars are focused on financial education about 401(k) programs. The Weyerhaeuser program and the UPS program are both strongly supported by management and are offered at regular intervals. The programs consist of one- or two-day workshops tailored to particular age groups. Employees receive extensive resource materials, including workbooks that incorporate explanations of the companies' benefits in the context of broader financial planning strategies. The Weyerhaeuser program takes a holistic approach, covering nonfinancial topics such as health and quality of life in the workshops. The UPS program augments written resource materials with a web-based service to help employees develop a personal financial action plan and computer software to provide information on such topics as budgeting, managing debt, saving, insurance, and wills. One study found that employees who attended training workshops subsequently increased their participation in 401(k) plans. Another study drew a similar conclusion, with more than half of those participating in counseling sessions and workshops changing at least one financial behavior. Retirement accumulation, by nearly all measures, was found to be significantly higher for respondents whose employers offered financial education. In addition, rates of participation in 401(k) plans for both respondents and spouses were higher in the presence of employer-sponsored financial education. The study found a significant relationship between financial education and the rate of total saving; however, there was essentially no relationship between financial education and total wealth accumulation. One study found that financial wellness was positively correlated with worker productivity (as measured by supervisors' performance ratings) and worker health (as a function of absentee records).

  Notes: One study found that consumers appear to benefit from practical and applied learning: The major source of learning for all groups was a difficult financial experience. The researchers concluded that teaching financial literacy in the abstract appears to be ineffective and that providing consumers with ready access to information on an ongoing basis may better help households having minor financial difficulties avoid exacerbating their situation through unproductive behaviors.

P. Genesee County REACH (Racial and Ethnic Approaches to Community Health)

http://www.gchd.us/Services/PersonalHealth/REACH/default.asp

The REACH US Coalition is working to reduce African American health disparity in infant mortality. A community action plan was implemented in 2010 that is designed to:

- Foster community mobilization
- Enhance the "babycare" system
- Reduce racism

The following activities make up the community action plan:

- *Maternal and Infant Health Advocates (MIHAs)* – work directly with pregnant women, new mothers and families in high risk ZIP codes, providing support and helping them navigate appropriately and successfully through the medical/social services system.
- *PRIDE Medical Services Committee* – comprised of maternal/infant health hospital administrators, obstetricians and gynecologists, perinatologists, neonatologists, pediatricians, social workers, nurses, and insurers. The committee concentrates its work on the clinical environment in Genesee County with the goal of shaping the future direction of maternal and infant health to increase healthy birth outcomes by influencing health policies and supporting training and research.
- *Community Windshield Tour* – provides a visual perspective to groups of physicians, hospital administrators, medical residents, and others working within Genesee County to assist them in gaining an understanding of the neighborhood environmental conditions and experiences of women and families at risk for poor birth outcomes.
- *Undoing Racism Workshop* - helps participants develop their own analysis of history, culture, and power relationships. They move beyond a focus on the symptoms of racism to an understanding of what it is, where it comes from, how it functions, why it persists and how it can be undone.
- *Community Dialogue Sessions* – guides participants through a structured dialogue to develop supportive relationships and learn from each other about infant mortality, African American culture, racism, and systemic community health care and economic problems, and then leads them to develop a plan of action to combat these issues. This process has yielded two particularly active action groups: Black Men for Social Change and Women Taking Charge of Their Health Destiny
- *The African Culture Education Development Center* - provides an environmental milieu and curriculum that supports a positive view and understanding of pride and respect of African Americans and their culture. It also challenges and changes the thinking of the health care provider and business/economic sectors.

During the period of the REACH 2010 initiative, the African American infant mortality rate in Genesee County dropped from a high of 23.5 deaths per 1,000 live births to an all time low of 15.2. The white rate dropped from a high of 13.1 to 8.9, with the over-all Genesee County rate dropping from 13.1 to 8.9. The disparity ratio dropped from a high of 3.6 African American infant deaths for every white infant death to 2.4.

Q. Georgia Fatherhood Program

http://www.dtae.org/teched/CTS/fatherhood.html

http://www.acf.hhs.gov/programs/cse/pubs/2002/best/georgia.html#N100B9

Child Support Enforcement in the Georgia Department of Human Resources developed the program Fatherhood Works! to provide employment and life skills training to unemployed and underemployed noncustodial parents. The services it provides consequently increase child support payments. The program addresses child support enforcement, responsible fatherhood, job counseling and placement and peer support. It is available to all parents who want to support their children, but lack the financial means necessary to do so. Case managers are assigned to participants and track participants monthly to determine employment retention and completion of the program. During the time participants are in the program, they are required to contribute at least 50 percent of their child support obligation. Noncustodial parents are typically in the program from three months up to two years.

The program serves approximately 3,000 noncustodial parents a year. Over 10,000 noncustodial parents received at least on service from the program. In 2001, 3,115 participants received services. About 47 percent became employed and paid their child support obligation. A university-based evaluation team, which conducted a survey of 250 noncustodial parents in Georgia, founds the program had a significant gain in employment, from 30 percent to 66 percents and had a 14-percentage point gain in health benefits for children, from 7 percent to 21 percent.

R. HHS Awards to Support Patient-Centered Medical Home Research

http://whatworksforhealth.wisc.edu/searchResults.asp

The Department of Health and Human Services (HHS) has announced more than $14.2 million to develop, implement, and test strategies to increase the adoption and dissemination of interventions based on patient-centered outcomes research among racial and ethnic minority populations. The funds will be used to help ensure those Americans have the needed tools to make informed decisions about their health care options. Those tools should fit individual patient needs and preferences with the long-term goal of improving health outcomes. The National Institutes of Health (NIH), National Institute for Minority Health and Health Disparities (NIMHD) awarded grants to centers of excellence at universities and medical schools in Florida, Hawaii, Illinois, New Mexico, and New York, and the HHS Office of Minority Health awarded a contract to Westat, Inc. of Rockville, MD.

S. Job Corps

http://www.jobcorps.gov/home.aspx

http://www.milwaukeejobcorps.org/

Job Corps' mission is to attract eligible young people, teach them the skills they need to become employable and independent, and place them in meaningful jobs or further education.

Job Corps employs a holistic career development training approach which integrates the teaching of academic, vocational, employability skills and social competencies through a combination of classroom, practical and based learning experiences to prepare youth for stable, long-term, high-paying jobs. It targets low-income youth between the ages of 16-24.

From a study in 2001:

- Job Corps centers deliver comprehensive and consistent services.
- Job Corps makes a meaningful difference in participants' educational attainment and earnings.
- The gains from Job Corps are found across most groups of students and types of settings.
- Job Corps is cost-effective: the value of benefits from the program exceed its costs.
- 74% of Job Corps students are high school drop-outs.
- 90% of Job Corps graduates go on to jobs, apprenticeships and higher education.

The Milwaukee Job Corps Center is currently seeking 300 young people between the ages of 16 and 24 to fill its training slots. Job Corps is offering a free 2-year training program in three fields:

- Health Care: Certified Nursing Assistant, Medical Office Assistant
- Manufacturing: Manufacturing technician, materials handling, welding
- Construction: HVAC, Cement Masonry

The workgroup noted that there could be some overlap with the health strategy, if health insurance is offered. Would want to know that the jobs people are being trained for would offer a family sustaining wage.

T. Magnolia Project

http://www.magnoliaproject.org/

The Magnolia Project's mission is to improve the health and well-being of women during their childbearing years (15-44) by empowering communities to address medical, behavioral, cultural & social service needs. The goals are to work with women to address those risk factors (pregnancy intervals, nutrition issues, substance/alcohol abuse, psychosocial problems, family planning and other issues) that impact their health & may affect a future pregnancy. The Magnolia Project offers highly personalized, community-based services to women living in Jacksonville ZIP codes 32202, 04, 06, 08 and 09.

Specific services include:

- Health Education: The information women need to stay healthy is integrated into all services.
- Clinical Services: Include well-woman and prenatal care, family planning, STD treatment, primary care and free pregnancy tests.
- Case Management: Women with special problems receive intensive case management to coordinate services across providers to meet their needs.
- Community Outreach: Activities are targeted to at-risk African American pregnant and inter-conceptional women of childbearing age who reside in the Project target area.
- Birthing Project: mentoring program for black women by black women

Infant mortality dropped in Jacksonville and the area served by the Magnolia Project in 2006. The city's infant death rate was 9.5 deaths per 1,000 live births, compared to 11.6 deaths per 1,000 in 2005. Infant mortality rates dropped by 27% in the five ZIP code areas served by the Magnolia Project. Black infant deaths citywide were 12.9 deaths per 1,000 in 2006, compared to 16.9 deaths per 1,000 in the previous year. The gap between black and white outcomes also narrowed during 2006.

Of the programs listed in the 12-Point Plan, the workgroup noted that the Magnolia Project has the potential of focusing on the overall health of women and addresses the period of inter-conception.

U. Maine Patient-Centered Medical Home Pilot

http://www.mainequalitycounts.org/major-programs/patient-centered-medical-home/35/168-pcmh-summary.html

The Maine Quality Forum (MQF), Quality Counts, and the Maine Health Management Coalition collaborated to lead the Maine Patient Centered Medical Home (PCMH) Pilot, which highlights primary care. Twenty six practices were selected to participate in 2009 in the 3-year period of the pilot which started January 2010, have used the PCMH model as a first step in ultimately achieving the goal of state-wide implementation of a PCMH.

The Pilot has engaged all major private and public payers in the state to provide an alternative reimbursement model to participating practices that recognizes the infrastructure and system investments needed to deliver care in accordance with the PCMH model, and rewards practices for demonstrating high quality and efficient care. The Pilot will be evaluated using a comprehensive approach that assesses changes in clinical quality, patient experience, cost and resource use, and practice change. The evaluation will use nationally recognized measures of quality, efficiency, and patient-centered measures of care that reflect the six aims of quality care identified by the Institute of Medicine (i.e. safe, effective, timely, efficient, equitable, and patient-centered care).

The 26 participating practices include a diverse mix of 22 adult and 4 pediatric practices from around the state that were selected for their leadership and commitment to the principles of the PCMH model; diversity of practice size, location, ownership; and ability to link with and leverage existing improvement opportunities going on across the state.

V. Male Initiative Program

http://www.healthystartpittsburgh.org/index.php?cID=106

The Male Initiative Program (MIP) is designed to educate fathers – and other men involved in the life of a child – about how important they are to the outcome of a pregnancy and the ongoing health and well-being of the baby. MIP is available to any man who is either a father, biological or non-biological, or primary male caregiver and where the mother or female caregiver is enrolled with Healthy Start and resides in the project area. The primary goal of MIP is to assist fathers and other positive male role models to maintain involvement with their children and families through the promotion of parenting skills and the benefits derived from peer and program support.

Free, in-home MIP services include:

- Case management
- Help in identifying and connecting families with other health and social services via referrals
- Counseling, depression screening and referral
- General health and prevention education on prenatal/postpartum care, childbirth education, diet, exercise and nutrition, HIV/AIDS and other sexually transmitted diseases (STDs), smoking cessation, and substance abuse
- Spouse/Significant other support
- Job placement
- Breastfeeding support
- Relationship Strengthening/Father to Father Support

In an effort to expand the successful MIP to include a greater volume of community participants, the Responsible Fatherhood Coalition was created. Promoting Responsible Fatherhood (PRF) encourages and supports fathers in building and maintaining relationships with their children and their children's mother. Fathers, mothers and caregivers who are residents of Allegheny County and have children ages 0-5 years old are eligible to participate in this program. The origin of the name, Promoting Responsible Fatherhood, is used not to take the focus off the importance of family, but rather to place focus on the need to re-energize and reengage the participation of fathers in the lives of their children.

PRF offers the following in-home, free services:

- Case management services by an outreach workers.
- Help in identifying and connecting families with other health and social services.
- General health and prevention education on prenatal/postpartum care, childbirth education, diet, exercise and nutrition, HIV/AIDS and other sexually transmitted diseases (STDs), smoking cessation, and substance abuse.
- Career Assistance.
- Prevention Relationship Enhancement Program (PREP).
- Helping fathers/male caregivers overcome barriers that often prevent them being an effective and nurturing parent.
- Domestic Violence education.
- Depression screening.

W. Milwaukee Fatherhood Initiative

http://www.milwaukeefatherhood.com/

The MFI's mission is to inspire, educate, equip and engage all sectors of society in supporting and promoting benefits associated with responsible fatherhood. The MFI's vision is to attain a greater number of Milwaukee area children growing up with involved, responsible and committed fathers – or male caregivers – in their lives.

The MFI focuses on the following:

- Driver's License Recovery- Helps to eliminate a cyclical obstacle that some minorities and low income people may get caught in which can cause legal, financial and social consequences.
- Child Support Debt Reduction – With this component, men who attended the MFI summit workshops were eligible for a credit toward back child support owed to the State of Wisconsin. At that time almost one million dollars of back debt has been forgiven.

- Media/Public Relations - A consistent, strong communications plan is needed regarding the issue of fatherhood and its impact on all segments of Milwaukee. The MFI works on media campaign development to highlight the benefits of fathers' involvement with their children.
- Education - The MFI identifies resources for men to help them academically, teach them good parenting skills and works with them to become good financial stewards. Together these strategies enable men to seek and secure better employment opportunities, become better parents to their children and work with them to help provide more financial security to their children.
- Men's Health - This component encourages men and fathers to make a life-long commitment to healthier living. By encouraging men to focus on their own health and wellbeing, this will promote healthy lifestyles in their families and communities as a whole.
- Summit - The purpose of this annual, two-day event is to bring men together to discuss the issue of fatherlessness, identify solutions and resources, promote positive images of the father role and gather data to help address the many obstacles that prevent men from being involved, responsible and committed fathers.

X. Milwaukee Transitional Jobs Collaborative

http://www.transitional-jobs.com/

As a local leader on transitional jobs, the Public Policy Institute helped to found the Milwaukee Transitional Jobs Collaborative, which seeks to obtain state and federal programs and funding to make transitional jobs available to Wisconsin's unemployed. Other organizations in the collaborative include the Archdiocese of Milwaukee, Good Jobs and Livable Neighborhoods, the Greater Milwaukee Foundation, the Interfaith Conference of Greater Milwaukee, the Milwaukee Area Workforce Investment Board, Milwaukee Community Service Corps, MICAH, Milwaukee Homicide Review Commission, the New Hope Project, Northwest Side Community Development Corporation, Policy Studies Inc., Social Development Commission, Thomas & Associates, UMOS, Milwaukee Urban League, WISDOM and the YWCA.

Y. National Fatherhood Initiative

http://www.fatherhood.org/

The NFI's mission is to improve the well-being of children by increasing the proportion of children growing up with involved, responsible, and committed fathers.

National Fatherhood Initiative is used in many programs in the US. Their fatherhood resources include audiovisual curricula, brochures, discussion boards, posters, interactive resources, as well as training, capacity-building workshops, CD-ROMS and premium content for leaders and funding**.**
The NFI uses a "3-E" strategy to accomplish its mission.

1. EDUCATE: The organization works to educate all Americans, especially fathers, about the important role dads play through:
   - Media Appearances
   - Research
   - NFI Website

2. EQUIPPING ORGANIZATIONS AND FATHERS: By working with local, state and national organizations across the country, this program has a unique strategy to "go where the dads are," reaching fathers at their point of need with skill building resources to help them be the best dads that they can be.

3. ENGAGING: To effectively change the culture, NFI partners with a variety of companies and organizations to raise awareness, create unique and groundbreaking programs and reach as many fathers and families as possible.

Some programs that the Workgroup was interested in exploring included:

- *NFI - Dr. Dad* http://www.fatherhood.org/Page.aspx?pid=487
  The Doctor Dad™ Workshops is a collection of four workshops for expectant and new fathers that increase fathers' ability to care for the health and safety of infants and toddlers. It provides fathers with the knowledge and skills they need to successfully take care of sick and injured children, and to keep their children well, reduce the risk of injury, and create a safe home environment. The workshops are entitled Well Child, Sick Child, Injured Child, and Safe Child and they cover topics such as: infant nutrition, immunization, temperament, safety in the car and kitchen, parental anger, fevers, the common cold, dehydration, burns, scrapes, and choking.

  From a 2011survey of 263 fathers, a total of 29.10% gain in knowledge of child health and safety was recorded as well as a 31.4% gain in confidence in the ability to perform basic parenting skills amongst the participants surveyed. Personal testimonies from mothers and fathers corroborate the survey's finding.

- *NFI - 24/7 Dad* http://www.fatherhood.org/Page.aspx?pid=1032
  The 24/7 Dad™ program provides fathers of all races, religions, cultures and backgrounds with innovative tools, strategies and exercises to develop characteristics men need to be good fathers 24 hour a day, 7 days a week. The curriculum can be implemented in a group setting, or in a one-on-one home-based session. The program is available in two sets of curricula, which include a manual, handbooks and a CD-ROM evaluation tool.

  The more basic format, 24/7 Dad™ A.M., covers topics such as: family history, what it means to be a man, discipline, working with mom and co-parenting, and showing and handling feelings.

  The more in-depth version, 24/7 Dad™ P.M., covers topics such as: boyhood to manhood; knowing myself; dealing with anger; improving my communication skills; and stress, alcohol, and work.

  Dads Matter, a program designed to enable fathers to improve relationships with their children, improve their parenting skills and overcome barriers that prevent them from being effective parents, collected data regarding knowledge and confidence before and after utilizing the 24/7 Dad curriculum. The program saw a mean increase in knowledge of 10.82 points and a mean increase in confidence of 70.58 points.

- *NFI - Inside Out Dad*
  InsideOut Dad™ is a reentry program designed to connect inmate fathers to their families and prepare them for release. Hundreds of state and federal facilities, pre-release programs, community organizations and more are using this reentry program.

  The curriculum includes 12 core session and 26 optional sessions that coordinate with the core topics to make it flexible for a wide variety of people and programs. Topics covered include:

  -About Me: Remembering My Past—What Kind of Father Am I?
  -Being A Man: What is a Man?—Physical and Mental Health, Masculinity and the Media
  -Relationships: Love and Relationships—Improving my Communication Skills
  -Handling and Expressing Emotions: Expressing Anger—Stress and Anger, Carrying Emotions
  -Discipline: Styles and Discipline—Culture, Morals and Discipline, Being a Fair, Loving Father
  -Fathering from the Inside: Creating a Fathering Plan—Paper Hugs, Reading to Your Kids

  The program has been proven to significantly improve inmates' knowledge of and attitudes toward parenting and increase their contact with their children and families.

Z. New Hope Project

http://www.ywca.org/site/pp.asp?c=ekLPI7O1H&b=5724125

http://www.mdrc.org/project_8_30.html

The New Hope Project both directly helps individuals find jobs and advance in the workforce, and shapes policies that provide greater work opportunities for low-income individuals.

The mission of the New Hope project is to ensure individuals can continue to work and earn an income through jobs that offer hope, security, and continued prosperity. The New Hope Project model uses innovative strategies to make work pay.

- Transitional jobs (transitional jobs can provide a short-term income source, valuable current work history, and on the job training to participants who face barriers to employment)
- Job retention incentives
- Work supports

Intensive case management, skill building workshops, real paychecks and retention bonuses, and access to resources and work supports make the New Hope Project model stand out as an effective bridge between job seekers and successful employment.

New Hope also offers a Fatherhood Support Program in partnership with the Next Door Foundation (this is an official program of the Milwaukee Fatherhood Collaborative and is a partner of the Milwaukee Fatherhood Initiative). This program offers peer and mentoring support, a positive environment and other related resources for fathers to improve parenting skills, relationships and financial support for their children. The Fatherhood Support Program meets weekly for a two hour support group session focused on topics selected by our fathers, such as discipline, child support, role models in the community, relationships, and laws affecting fathers.

The following is information from a long-term evaluation of the New Hope demonstration project:

- Adults in the New Hope program were more likely to work than their control group counterparts, and the combination of earnings supplements and the Earned Income Tax Credit also resulted in higher incomes. Less consistently, New Hope also had some effects on parents' well-being. Most of these effects did not last beyond the three years that the program operated — except for a subgroup of individuals facing moderate barriers to work, for whom New Hope increased employment, earnings, and income through Year 8.
- New Hope affected children's environments by increasing parents' use of center-based child care — an effect that persisted through Year 5, or two years after New Hope child care subsidies had ended. By Year 5 and lasting into Year 8, New Hope led children and youth to spend more time in structured, supervised out-of-school activities.
- Positive effects on children's academic performance and test scores were evident at the two- and five-year marks. By Year 8, effects on performance had faded, and new effects had emerged. New Hope children reported being more engaged in school than control group children, and their parents were less likely than control group parents to report that their children had repeated a grade, received poor grades, or been placed in special education. New Hope also improved children's positive social behavior, effects that lasted through Year 8. At the eight-year point, New Hope adolescents were less likely than their control group counterparts to have cynical attitudes about work and were more likely to have taken part in employment and career preparation activities.

AA. Northern Manhattan Perinatal Project

http://www.sisterlink.com/

Northern Manhattan Perinatal Partnership (NMPP) is a non-for-profit organization comprised of a network of public and private agencies whose mission is to save babies and help women take charge of their reproductive, social, and economic lives. These entities are not only concerned with the needs of women during the pregnancy period but develops programmatic, clinical and policy interventions to improve women's health during the birthing process, the early childhood stage, the adolescent period and meeting the needs of women over thirty-five years of age. NMPP offers over 22 services and programs.

NMPP programs and services include:

- Comprehensive Prenatal-Perinatal Services Network: 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.
- Teenage Services Act Program (TASA): "Sisters of Strength" is a program dedicated to providing case management and linkages to programs/support groups for pregnant, parenting teens and teens at risk for pregnancy (only for those receiving public assistance and Medicaid or Medicaid).
- Central Harlem Healthy Start: Healthy Start is a program that offers case management, health education and other services for pregnant and parenting women, infants and their families. Assists with advocacy, interconceptual care, prenatal care access, housing, public assistance, and WIC referrals; counseling, domestic violence, HIV/AIDS and other health education, home visits and escorts to health and social services appointments.
- The Fatherhood /Mankind Program: Provides services to men 24 years and over and their children. Program helps fathers who have been incarcerated, need counseling, unskilled and unemployed, and/or seeking to navigate the social service system so that they may provide the kind of nurture and support so desperately needed by children. The Program promotes the positive involvement of fathers in the lives of their children as well as helps facilitate the provision of economic support for these children. This is achieved by fostering responsible fathering and stability through such activities as effective parenting skills development, individual or family/group counseling, mediation and conflict resolution training, visitation arrangement assistance, father-to-father mentoring as well as employment assistance. In collaboration with other organizations, the continuum of services include workshops and trainings around issues related to father's legal rights, job preparedness and successfully completing GED classes as well as preparing men with remedial help so that they may be prepared for college.
- The Infant Mortality Reduction Initiative (IMRI): A program that addresses the needs of women, infants and children. NMPP is one of 5 Regional Perinatal Coordinating Bodies that provides direct services to women, infants and children and technical support to other community based organizations. Provides case management, health education workshops in the community and referrals for services. The target population is women of reproductive age (14 years to 45 years of age) and interconceptional and preconceptional women with children under the age of two. Provides Health Education Workshops in the community and on site. Case management services are provided, linkage and referrals and specialty training in preconceptional and interconceptional health are provided.
- St. Nicholas Family Support Network Program: Preventive program that provides individual, group and family counseling, workshops and art therapy groups to at-risk-families with children who have a high probability of entering the NYC foster care system. The staff of social workers and support staff work with families to prevent child abuse and neglect, and placement of their children in foster care system. Services are provided in the homes, schools, and at the agency's location. In addition, the Network provides linkages to community resources through referrals and advocacy to assist with the following: daycare, Housing Assistance, parenting education, Health Support Service, Tutorial, and Psychological Evaluation. The goals are to increase awareness and to assist families that are affected by child abuse & neglect, domestic violence, etc.

- The Center for Preschool and Family Learning Head Start (CPFLHS): A federally funded Early Childhood program that offers comprehensive services to low income children and families. The services provided are categorized into three major content areas: Education and Early Childhood Development, Child Health and Safety and Family and Community Partnerships. CPFLHS staff advocates for families both to improve social conditions and in helping with immediate needs. This service area serves to ensure that every family gets all the information, access to community services and benefits in the community. The staff works with families individually and helps to link them to the services provided in the community.
- The Managed Care Consumer Assistance Program (MCCAP): Assists anyone living in the 5 boroughs of NYC with information, advice, technical assistance, and advocacy as it relates to health insurance or accessing the health care they need. Assist individuals with a range of issues such as applying for public health insurance or choosing a doctor, to billing questions, appeals, and fair hearings. MCCAP also provides workshops for the general community and staff at various organizations on various topics including Eligibility and Recertification for Medicaid & Family Health Plus and Consumer Rights. MCCAP is funded through Community Service Society (CSS) by the City Council.
- BABY STEPS: A voluntary, primary prevention home visiting program that provides intensive home visiting services to new and expectant parents and their families who reside in Central Harlem. The goal of this program is to prevent child abuse and neglect through the promotion of child health and development, positive parent-child interaction and family self-sufficiency. Intensive home visiting services are provided to families who are pregnant or have a baby under three months old and live in one of the target ZIP Codes. Services are provided until the child enters Head Start or reaches 5 years of age.
- The SisterLink Community Action for Prenatal Care Program: An HIV prevention program focused on reducing the incidence of periantal transmission of HIV. The program targets high-risk women affording them access to specialized prenatal care and comprehensive case management services. Compromised of seven core components including a highly visible social marketing campaign and a 24-hour hotline, the coalition works to engage and link high-risk women to a network of over 75 provider organizations.
- Community Health Worker Program (CHWP): A case management program that provides health and family support services to pregnant and parenting families. CHWP services include advocacy, referrals, home visits, and outreach and child health insurance enrollment services. Community Health Workers are recruited from the East Harlem community, trained and sent back into the community to locate, enroll and service the needs of mothers and babies.
- The Building Bridges, Building Knowledge, Building Health (BBKH) coalition: Since 2006, the coalition has been working on a comprehensive diabetes prevention and management project, recognizing that diabetes is one of the most prevalent health issues among our target populations. Working at six levels of prevention, the goal is to reduce health disparities in diabetes by building a public health social movement in the target communities of East and Central Harlem, Washington Heights, and the South Bronx. As with all of the work of this program, culture and faith are incorporated as community assets in prevention.

These services increase the self-sufficiency of poor and working class women and meet their social and health needs from the womb to the tomb. NMPP was responsible for developing and executing a community plan that reduced Central Harlem's infant mortality rate from 27.7 deaths per one thousand live births in 1990 to 6.1 deaths in 2008.

The Workgroup is interested, but wants more information in the following areas:

- Sources of funding
- Demographic profile of the community (prior, during, and after)
- Understanding about the overlap in programs – Do programs serve the same ZIP Codes? Were the same people being served by all the programs? What were the linkages between the programs?
- Information on the development of a formal organization to oversee the project

BB. Northern New Jersey MCH Consortium

http://www.maternalchildhealth.org/welcome

The Northern Consortium's mission is to improve the health of women, children, and families. It does this by offering a variety of programs, aimed at healthcare professionals, pregnant women and new mothers, and consumers.

Healthcare Professionals

- Total Quality Improvement (collects and evaluates data for maternal health indicators)
- Breastfeeding Task Force (provides information and training to hospitals and other community agencies on topics related to breastfeeding)
- Family Outreach Program (works with pre-school staff to provide group trainings and technical support)
- Black Infant Mortality Reduction Resource Center (BIMRRC) (produces materials that train both consumers and physicians on how to avoid the loss of life).
- Postpartum Depression (information and resource center on postpartum depression and perinatal mood disorders) Services also for pregnant women and new mothers.
- Lead Poisoning Prevention (educations on lead prevention and importance of screening) Services also for pregnant women and new mothers, and consumers.
- NJ Immunization Information System Registry (NJIIS) (ensures accurate and complete data on immunizations)
- Perinatal Addictions Prevention Project (encourages healthcare providers that provide services to pregnant women to screen every pregnant woman for alcohol, tobacco, or other drug use and partner violence). Services also for pregnant women and new mothers.
- Fetal Infant Mortality Review (FIMR) (explores what happened when a baby dies during pregnancy or infancy) Services also for pregnant women and new mothers.

Pregnant Women and New Mothers

- M.Ed Mentors (helps pregnant women in Essex County enroll in prenatal care and have a healthy pregnancy. Women are paired with trained volunteer care managers, who are supervised by a social worker.)
- Irvington Family Development Center (strengthens and empowers families to reach the goals they have set for themselves. It is also a place where families can go to receive different types of services, including family support, job readiness, workshops, and other general support services) Services also available for consumers.
- Reproductive Health Access and Information Network (RHAIN) (provides an array of services to women of reproductive age and their partners, including information on the importance of prenatal, preconception, and interconception care) Services also available for consumers
- Nurse Family Partnership (partners first-time pregnant moms with nurse home visitors for support, referrals, education, and networking for first time mothers).
- Healthy Families/TANF Initiative for Parents (TIP) (assists families of pregnant women and newborns through home visitations).

Consumers

- Fathers Empowered to Learn, Lead, and Achieve Success (F.E.L.L.A.S.) (helps fathers and fathers-to-be develop the knowledge, attitudes, and skills they need to get and stay involved with their children). Irvington Family Development Center…A Family Success Center
- Nuestra Salud (Our Health) (targets new immigrants enrolled in HIRD's ESL classes and provides five hours of health literacy content during a 40-hour ESL course)

CC. Operation Healthy Home (Memphis)

http://www.aap.org/commpeds/grantsdatabase/searchDetail.cfm?gID=1779

This project was started to introduce and strengthen the medical home concept and identify barriers to health care for inner-city African American children in Memphis, TN. They developed a partnered the program Operation Smart Child (OSC) of Neighborhood Christian Centers (NCC). OSC focuses on teaching parents about the optimization of a child development in the first years of life. OSC relates physical health and the medical home concept to optimal brain development.

This project seeks to identify barriers to health care access, develop a medical home (Healthy Home) and insurance referral process for those in need, and develop tools and messages that will encourage brain and physical health by trained messengers.

Operation Healthy Home Goals & Objectives include**:**

- Identifying barriers to the access of child health services and determine awareness among the community of the importance of overall child health & brain development.
- Introduce and promote the concept of a medical home (Operation Healthy Home) to the NCC
- Collaborate with potential providers to develop plans for developing a referral process for participants who might need a Healthy Home and/or health insurance.
- Based upon 1 and 2 develop an informative communications approach informative community message

The Healthy Homes Project Results/Outcomes**:**

- Through a strong partnership with Operation Smart Child (OSC), inner-city parents participated in focus groups to share experiences on the pediatric care of their children.
- Community actively participation in the planning process, recruiting, and facilitation helped strengthen outcomes.
- Automated response system (i.e.-clickers) significantly enhanced and facilitated data collection and analysis.
- Despite the high concentration of poverty, results from the focus groups indicated a relatively high level of satisfaction among parents with their children's medical home.
- Single parents, unemployed or whose children are on public health insurance continue to experience increased barriers to health care for their children.
- Electronic communication may be under-utilized in inner-city communities. Medical providers should consider email as an option for enhancing communication with inner-city parents.
- Medical providers should encourage, recognize and support father involvement in the medical home.
- Discussion of prescription and over-the-counter medication options, appropriate referrals to health services in the community and a comfortable, child-friendly environment are all necessary components of a comprehensive and coordinated medical home.

DD. Safety Net Medical Home Initiative

http://www.qhmedicalhome.org/safety-net/about.cfm

In May 2008, The Commonwealth Fund, Qualis Health and the MacColl Institute for Healthcare Innovation at the Group Health Research Institute initiated a demonstration project to help safety net primary care clinics become high-performing patient-centered medical homes (PCMHs) and achieve benchmark levels of quality, efficiency and patient experience. The goal of the Safety Net Medical Home Initiative (“the Initiative”) is to develop and demonstrate a replicable and sustainable implementation model for medical home transformation.

The Initiative calls for partnerships between safety net providers and community stakeholders to work together towards a new model of primary care delivery that is recognized and rewarded for its holistic approach to patient care. Policy activation is critical in this transformation, and all partners in this Initiative are expected to participate in Medicaid and other policy reform efforts in their respective regions.

Five Regional Coordinating Centers were selected to participate in the demonstration project, and each partnered with 12-15 safety net clinics in their state. These collaboratives receive technical assistance on practice re-design topics such as enhanced access, care coordination, and patient experience as well as receive funding to support a Medical Home Facilitator (who will lead clinic-based quality improvement projects). The work of the Regional Coordinating Centers began in April 2009 and will continue through April 2013.

*Safety net hospital: provides a significant level of care to low-income, uninsured, and vulnerable populations. They vary from publicly owned and operated by local or state governments and some are non-profit.

http://literacyworks.org/hls/hls_conf_materials/WhatIsASafetyNetHospital.pdf

EE. Sentencing Project

http://www.sentencingproject.org/template/page.cfm?id=2

The Sentencing Project is a national organization that has been working for a fair and effective criminal justice system by promoting reforms in sentencing law and practice for over 20 years. It has become a leader in the effort to bring national attention to trends and inequities in criminal justice system and reform in sentencing law and practice. The organization has drawn attention to injustices in felon voting rights and provides some resources about felon voting laws in different states.

FF. Transitional Jobs

http://www.heartlandalliance.org/ntjn/

http://www.clasp.org/admin/site/publications_states/files/0081.pdf

http://dcf.wi.gov/w2/tj/default.htm

Transitional Jobs is an employment strategy that seeks to overcome employment barriers (such as little or no work experience, lack of basic skills, lack of a high school degree, having a criminal record, disability, homelessness, lack of transportation, or lack of workplace and social skills) and transition people with labor market barriers into work using wage-paid, short term employment that combines real work, skill development and supportive services.

Transitional Jobs program participants earn a paycheck, learn skills, may become eligible for the Earned Income Tax Credit, and receive intensive mentoring and support. This is the first step toward permanent employment and economic opportunity for many people who would otherwise not be working.

Transitional Jobs programs can yield significant cost savings for States. The Fiscal Policy Institute projected that the cost savings for New York state in serving longtime public assistance recipients and the formerly incarcerated through TJ programs together equaled over $106 million over 3 years after subtracting the state's initial $47 million funding investment in Transitional Jobs programs.

Transitional Jobs are effective in helping low-income people with barriers to employment enter the workforce, avoid re-incarceration, and reduce receipt of public benefits. The evidence for the effectiveness of Transitional Jobs programs has been built by numerous program evaluations and rigorous random assignment studies (http://www.heartlandalliance.org/ntjn/research--evaluation/evaluations-of-the-tj-model.html).

The Wisconsin Department of Children and Families (DCF) is partnering with 17 organizations across the state to provide transitional jobs. The Transitional Jobs program was established to provide low income adults who are not receiving W-2 and not eligible for Unemployment Insurance Benefits with an immediate income, an opportunity to develop the skills and experience their local labor market demands, and a positive work history. It provides those without other options with longer-term career preparation and support to move to unsubsidized employment. Additionally the program provides businesses with needed workers at no risk or expense to the business. Transitional workers add the most value to businesses that want to either stay open or expand, but cannot immediately hire and pay new employees due to reduced revenue or reduced access to short-term credit lines. By completing projects and sustaining operations when cash is tight, transitional workers help position businesses to hire more permanent employees.

GG. Work and Family Center

http://www.acf.hhs.gov/programs/cse/pubs/2001/best_practices/co_work_family_center.html

The Work and Family Center provides an array of coordinated services to paroled and released offenders who have minor children. Its goal is to successfully reintegrate prisoners into the community through employment opportunities and re-establishing family ties. The ex-offender receives the personal attention and support from a variety of different sources:

- A full-time intake coordinator works with parole officers and community correction agents to generate referrals, schedule appointments and supervise and coordinate the provision of legal services.
- A full-time child support technician meets with clients and reviews their child support status.
- An employment case manager helps clients develop interview skills, search for jobs and perform well post-employment.
- A case manager provides support services such as bus tokens, clothing vouchers and referrals to agencies for food, housing and other support services.
- A part-time senior worker maintains files and performs various clerical and secretarial duties.
- A part-time attorney works with ex-offenders to understand custody and visitation rights.
- A family therapist provides free individual, couples, family and peer group therapy to facilitate reintegration.

The program experienced a 43 percent job placement rate and the child support technician was able to make substantial child support changes in 52 percent of the cases in Denver, Colorado and 25 percent of the cases outside the Denver area.

G. Policy Ratings

In June of 2011, the Milwaukee LIHF Steering Committee was asked to consider to what extent Milwaukee LIHF currently has the capacity to impact decisions about policies related to the three Lifecourse domains. At the same time, the Task Forces were asked to prioritize the policies. The results are summarized in the tables below, in which existing policies are separated from policies the members would like to see created. Within these two broad categories, the policies are sorted so that those prioritized "high" by 75% or more respondents come first, additionally sorted so that those which Milwaukee LIHF was thought to have the most capacity to impact are at the top.

Related to the goal to "Expand healthcare access over the Lifecourse" the existing policy that members rated as a high priority and which they also felt Milwaukee LIHF has some capacity to impact was "Maintain BadgerCare." For needed policies, there were two that were rated as both high priorities and some capacity to impact: "Increase health literacy" and "Provide post-natal health insurance for pregnant minors."

Policies that support expansion of healthcare access for African Americans in Milwaukee over the lifecourse

	Policy	Prioritization†	Milwaukee LIHF's Capacity to Impact‡
EXISTING POLICIES	Maintain BadgerCare	HIGH*	Some Capacity
	Maintain federal funding for WIC	HIGH*	No Capacity
NEEDED POLICIES	Increase health literacy	HIGH*	Some Capacity
	Provide post-natal health insurance coverage	HIGH*	Some Capacity
	Provide health insurance for pregnant minors	HIGH*	No Capacity
	Require healthcare providers to participate in BadgerCare Plus HMOs	HIGH	Some Capacity
	Increase provider reimbursement	HIGH	Some Capacity
	Create standards for medical providers working with pregnant women	HIGH/MEDIUM (tied)	Some Capacity
	Improve access to insurance information	MEDIUM	Great Deal of Capacity
	Expand BadgerCare	MEDIUM	Some Capacity
	Incentivize medical providers to provide culturally competent services	MEDIUM	Some Capacity

† Options were high, medium, low or don't know
‡ Options were great deal of capacity, some capacity, no capacity, or don't know
** Indicates at least 75% of respondents ranked this priority as "high"*

There were two existing policies for the goal to "Reduce poverty among African Americans" that members rated as both high priority and also some capacity to impact: "Maintain funding for WIC" and "Maintain funding for workforce development/transitional jobs pilot." For needed policies, just one was rated as both a high priority and some capacity to impact: "Change rules governing probation and parole."

Policies that reduce poverty among African American families in Milwaukee

	Policy	Prioritization†	Milwaukee LIHF's Capacity to Impact‡
EXISTING POLICIES	Maintain funding for WIC	HIGH*	Some Capacity
	Maintain funding for Workforce Development/Transitional Jobs pilot	HIGH*	Some Capacity
	Maintain funding for Birth to Three	HIGH*	No Capacity/Some Capacity (tied)
	Maintain funding for rent assistance	HIGH*	No Capacity
	Maintain funding for education programs (primary, secondary, higher)	HIGH*	No Capacity
	Encourage organizations to work together	HIGH	Great Deal of Capacity
	Maintain funding for EITC	HIGH	Some Capacity
	Maintain funding for Milwaukee Fatherhood Initiative	HIGH	Some Capacity
	Maintain funding for Planned Parenthood	HIGH	Some Capacity/ No Capacity (tied)
	Maintain funding for W2	HIGH	Some Capacity/ No Capacity (tied)
	Maintain funding for HUD programs that promote home ownership	HIGH	No Capacity
	Maintain funding for first-time home buyers credit	HIGH	No Capacity
	Maintain funding for driver's license recovery	HIGH	No Capacity
	Maintain funding for violence prevention	MEDIUM	Some Capacity
	Wraparound approach to services	MEDIUM	Some Capacity
	Maintain funding for Federal Bonding program	MEDIUM	No Capacity
NEEDED POLICIES	Change rules governing probation and parole (i.e. minor offense leads to jail)	HIGH*	Some Capacity
	Incentivize businesses to work with people with a record	HIGH*	No Capacity
	Expand services that currently exist (WIC, Birth to 3, transitional jobs, etc)	HIGH	Some Capacity
	Change allocation of resources	HIGH	Some Capacity
	Enforce current laws (i.e. no discrimination by employers against people with a record)	HIGH	Some Capacity
	Educate human resources reps to follow employment laws	HIGH	Some Capacity
	Enact sick leave laws	HIGH	Some Capacity
	Expand health clinics	HIGH	Some Capacity
	Increase college requirements for acceptance into education programs	HIGH	Some Capacity
	Limit access to personal information (i.e. criminal records)	HIGH	No Capacity
	TANF/W2 provide access to higher education	HIGH	No Capacity
	Require certification of Choice & charter school teachers	MEDIUM	No Capacity
	Provide tax incentives for teaching in public schools	MEDIUM	No Capacity

† Options were high, medium, low or don't know
‡ Options were great deal of capacity, some capacity, no capacity, or don't know
** Indicates at least 75% of respondents ranked this priority as "high"*

For the goal to “Strengthen father involvement in African American families” members rated just one existing policy as a high priority and also some capacity to impact: “Maintain funding for reduction of past child support.” Three needed policies were rated as both high priorites and some capacity to impact: “Co-custodial guardianship for separated parents,” “Respect fathers’ rights to their children,” and “Expand transitional jobs programs.”

Policies that influence the strengthening of father involvement in African American families in Milwaukee

	Policy	Prioritization†	Milwaukee LIHF’s Capacity to Impact‡
EXISTING POLICIES	Maintain funding for reduction of past child support	HIGH*	Some Capacity/ No Capacity (tied)
	Maintain funding for driver’s license recovery	HIGH	Some Capacity
	Maintain funding for current jobs programs	HIGH	Some Capacity/ No Capacity (tied)
NEEDED POLICIES	Co-custodial guardianship for separated parents	HIGH*	Some Capacity
	Respect fathers’ rights to their children	HIGH*	Some Capacity
	Expand transitional jobs programs	HIGH*	Some Capacity
	Create ability for incarcerated fathers to sustain contact with families	HIGH*	Some Capacity/ No Capacity (tied)
	Increase placement of children w biological father when not w mother	HIGH*	Some Capacity/ No Capacity (tied)
	All fathers (incl non-custodial dads) should be eligible for BadgerCare	HIGH	Some Capacity/ No Capacity (tied)
	Create user-friendly navigational system for ex-offenders to find family-sustaining employment	HIGH	Some Capacity
	Change penal system for successful reintegration of ex-offenders	HIGH	Some Capacity/ No Capacity (tied)
	Increase efforts to establish father paternity (no recognized paternity without name on birth cert)	HIGH	No Capacity
	Increase clarity of eligibility of felons to vote	HIGH/MEDIUM (tied)	Some Capacity
	Increase the minimum wage	HIGH/MEDIUM (tied)	No Capacity

† Options were high, medium, low or don’t know
‡ Options were great deal of capacity, some capacity, no capacity, or don’t know
** Indicates at least 75% of respondents ranked this priority as “high”*

H. Workplan/Evaluation Plan

Project Goal(s) Statement:	**Community Buy-in and Commitment to the Community Action Plan**
Objective(s):	**Broad community buy-in and support will be built for the Milwaukee LIHF Community Action Plan by March 2013**
Outcome measure(s):	• A majority of community members surveyed will demonstrate awareness of the CAP priorities and rationale • A majority of Milwaukee LIHF Collaborative members will agree that the local activities, programs and funding decisions made by the Collaborative reflect the priorities outlined in the CAP • **All new stakeholders who joined the Collaborative during the grant period will publicly commit to the CAP** • **All existing Collaborative members will publicly re-affirm their commitment to the CAP** • Members of the AATF will work to build the strategies and provide guidance

Activity	Timeframe	Responsible Person	Anticipated Outcomes
What activities will the program be doing?	***In what timeframe?***	***Who is the primary or key person responsible?***	***What are the anticipated outcomes of these activities?***
1. Educate community members and leaders, the media and other stakeholders about the Community Action Plan, including its priorities and rationale	Ongoing	Project Director, Milwaukee LIHF Collaborative members	• Community is aware of the CAP priorities and rationale.
2. Advocate for the implementation of programs and policies included in the Community Action Plan	Ongoing	Project Director, Milwaukee LIHF Collaborative members	• Local activities, programs and funding decisions reflect the priorities outlined in the CAP

Activity	Timeframe	Responsible Person	Anticipated Outcomes
3. Organize and lead an annual review process for the Community Action Plan in which: • progress toward goals is reviewed and presented to the community • Collaborative members and other community members and leaders assess current priorities and efforts and provide input on future activities and priorities • Collaborative members publicly re-affirm their commitment to the Community Action Plan	March 2013 & March 2014	Project Director, Milwaukee LIHF Collaborative members	• Number of new stakeholders who publicly commit to CAP • Proportion of existing Collaborative members who publicly re-affirm their commitment to the CAP

Project Goal(s) Statement:	**Strategic Leadership in the Community**
Objective(s):	Milwaukee LIHF will demonstrate strong and strategic leadership to address infant mortality in the community by March 2014
Outcome measure(s):	• A majority of community members surveyed will demonstrate increased awareness of infant mortality and poor birth outcomes • A majority of community members surveyed will agree Milwaukee LIHF is a key information source on infant mortality • A majority of Milwaukee LIHF Collaborative members will have served in a spokesperson role • A majority of local funders and agency executives surveyed will agree that service delivery and coordination of infant mortality programming has improved • A majority of local funders and agency executives surveyed will agree that interagency cooperation on infant mortality programming has improved • A majority of Milwaukee LIHF Collaborative members surveyed will agree that African American Task Force members were active in Collaborative meetings, events and decision-making • A majority of Milwaukee LIHF Collaborative members surveyed will agree that the collaborative is functioning effectively and efficiently • A majority of Milwaukee LIHF Collaborative members surveyed will agree that the capacity of the Collaborative in the four key areas has increased • A majority of Milwaukee LIHF Collaborative members surveyed will agree that the Collaborative has increased its ability to sustain itself beyond the initial funding

Activity	Timeframe	Responsible Person	Anticipated Outcomes
What activities will the program be doing?	***In what timeframe?***	***Who is the primary or key person responsible?***	***What are the anticipated outcomes of these activities?***
1. Raise and maintain public awareness of the issue of high rates of infant mortality and poor birth outcomes among African Americans in Milwaukee	Ongoing	Project Director, Milwaukee LIHF Collaborative members	Increased awareness of infant mortality and poor birth outcomes
2. Serve as an information source in the community about infant mortality; local efforts to improve African American birth outcomes and health; and principles of the Lifecourse model.	Ongoing	Project Director, Milwaukee LIHF Collaborative members	The Collaborative is seen as a key information source in the community and members are consulted about these topics.
3. Coordinate efforts in the community to improve African American infant survival and the health of African American women, infants and families, including efforts of the LIHF project grantees: • encouraging communication between service providers; agency leaders; and community members and advocates • on-going assessment of programs and services for gaps, duplication and barriers • developing strategies to maximize resources, improve service delivery, and meet community needs	Ongoing	Project Director, Milwaukee LIHF Collaborative members	• Improved service delivery and coordination • Increased interagency cooperation

Activity	Timeframe	Responsible Person	Anticipated Outcomes
4. Develop and maintain an organizational and governance structure for the Collaborative that: • encourages participation in the Collaborative by a broad range of stakeholders, and particularly African American Task Force members • facilitates effective and inclusive decision-making • develops consensus and provides direction for future activities and efforts • focuses on building the capacity of the Collaborative to be successful in the four key areas • plans for and ensures sustainability of the Collaborative	Ongoing	Project Director, Milwaukee LIHF Collaborative members	• Active involvement by African American Task Force members in Collaborative meetings, events and decision-making • Ability of the collaborative to function effectively and efficiently • Increased capacity of the Collaborative in the four key areas • Ability of the Collaborative to sustain itself beyond the initial funding

Project Goal(s) Statement:	**Policy and System-level Change**
Objective(s):	**Milwaukee LIHF will advance evidence-based policy, community-level systems, and environmental change strategies that emerged from the Community Action Plan by 2014**
Outcome measure(s):	• **A majority of Milwaukee LIHF Collaborative members surveyed will recognize systemic influences and opportunities** • At least 5 Milwaukee LIHF Collaborative members will become involved in system level change • At least 5 members of the African American Task Force will become involved in system change • At least 5 Milwaukee LIHF Collaborative members will become advocates for selected policies • A majority of community members surveyed will recognize systemic influences/opportunities • At least 5 community members will become active in system level change

Activity	Timeframe	Responsible Person	Anticipated Outcomes
What activities will the program be doing?	***In what timeframe?***	***Who is the primary or key person responsible?***	***What are the anticipated outcomes of these activities?***
1. Based on the priorities of the CAP and relevant information from the research literature, identify policy, community-level and other environmental changes most likely to support and amplify the impacts of other initiatives in the community.	Ongoing	Project Director, Milwaukee LIHF Collaborative members	• Collaborative members will recognize systemic influences and opportunities • Collaborative members will become involved in system level change • Collaborative members will become advocates for selected policies • Community members will recognize systemic influences and opportunities • Community members will become active in system level change
2. Lead efforts to build support for and enact these changes.	Ongoing	Project Director, Milwaukee LIHF Collaborative members	
3. As part of the annual review process for the CAP, ensure that the strategies and changes continue to reflect the priorities of the relevant stakeholders.	March 2014	Project Director, Milwaukee LIHF Collaborative members	

Project Goal(s) Statement:	**Leveraging Resources**
Objective(s):	**Milwaukee LIHF will develop relationships, connections and networks of influence that will commit to providing the resources needed to carry out the Community Action Plan by March 2013.**
Outcome measure(s):	• Milwaukee LIHF stakeholders will contribute in-kind support • Milwaukee LIHF stakeholders will align their resources with the Community Action Planning Council • Milwaukee LIHF stakeholders will contribute financial support or matching funds

Activity	Timeframe	Responsible Person	Anticipated Outcomes
What activities will the program be doing?	***In what timeframe?***	***Who is the primary or key person responsible?***	***What are the anticipated outcomes of these activities?***
1. Assess the Collaborative's current capacity to leverage needed resources.	June 2012	Project Director, Milwaukee LIHF Collaborative members	• Financial resources leveraged • Non-financial resources (e.g., volunteer hours, in-kind donations, pro bono services provided) leveraged • Number of new funders supporting priorities outlined in the CAP
2. With input from all relevant stakeholders, develop a fundraising plan for the Collaborative.	September 2012	Project Director, Milwaukee LIHF Collaborative members	
3. Implement the fundraising plan.	October 2012 going forward	Project Director, Milwaukee LIHF Collaborative members	
4. Regularly assess the fundraising plan and revise as needed.	Annually, in March	Project Director, Milwaukee LIHF Collaborative members	

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