African American Infant Mortality in Colorado: Creating Solutions Together

A Summit from the Community Action Network
June 13, 2015
Welcome

Tim Byers, Colorado School of Public Health
Kim Desmond, Denver Office on Women and Families
Cerise Hunt, Colorado School of Public Health
Virginia Visconti, Families Forward Resource Center
Summit Planning Committee

- Kim Desmond (Co-Chair) -- Denver Office on Women and Families
- Cerise Hunt (Co-Chair) - Colorado School of Public Health
- Rita Beam — Tri-County Health Department
- Dave Bechhoefer — Families Forward Resource Center
- Susana Calderon — Office on Women's Health, US Dept. of Health & Human Services
- Gloria DeLoach- Denver Public Health
- Mia Grevious — Families Forward Resource Center, Healthy Start Program
- Lorenzo Olivas — Office of Minority Health, US Dept. of Health & Human Services
- Chanell Reed -- Healthier Beginnings & City of Aurora
- Tiffany Robinson — Mental Health Center of Denver
- Shawn Taylor — Families Forward Resource Center, Healthy Start Program
- Kellie Teter — Denver Public Health
- Virginia Visconti — Families Forward Resource Center, Healthy Start Program
Summit Sponsors
Purpose & Overview

• Raise awareness about African American infant mortality rates
• Present the Community Action Network (CAN) - Infant Mortality Collective Impact initiative
• Call to action! How YOU can help reduce African American infant mortality rates.
Keynote Address

Lauren Smith, MD, MPH
Executive Project Director
National Institute for Child Health Quality
Infant Mortality Collaborative Improvement and Innovation Network:

Harnessing Collective Impact to Reduce Infant Mortality

African American Infant Mortality in Colorado: Creating Solutions Together Summit
June 13, 2015

Lauren Smith, MD, MPH
Executive Project Director
NICHQ
A National Disgrace

The U.S. has one of the worst infant mortality rates of all industrialized countries.
Disturbing Numbers

For every 1,000 babies born in the U.S. in 2013, 5.96 died before their first birthday.

That’s 23,440 babies.
What Does 23,440 Babies Look Like?
What Does 23,440 Babies Look Like?

The equivalent of about 1,000 kindergarten classrooms of children that will never be filled.
It Gets Worse

Babies born to black mothers in the U.S. die at more than twice the rate of babies born to white mothers.
US Infant Mortality Trends

In 2011, Black Infant Mortality rate 11.5/1000

When was the white US infant mortality rate 11.5?

The white Infant mortality rate was 11.0 in 1980

The New England Journal of Medicine

PROPHYLACTIC TREATMENT OF VERY PREMATURE INFANTS WITH HUMAN SURFACTANT

T. Allen Merritt, M.D., Mikko Hallman, M.D., Barry T. Bloom, M.D., Charles Berry, Ph.D., Kurt Benirschke, M.D., David Sahn, M.D., Thomas Key, M.D., David Edwards, M.D., Anna-Lisa Jarvinen, M.D., Maija Pohjavuori, M.D., Kaisa Kanakanpaa, M.D., Marjatta Kunnas, M.D., Heikki Paatero, M.D., Juhani Rapola, M.D., and Jaakko Jaaskelainen, M.D.

Abstract We undertook a randomized, controlled trial to determine whether human surfactant administered endotracheally at birth to very premature infants (gestational age, 24 to 29 weeks) would prevent the respiratory distress syndrome or reduce its severity. Thirty-one treated infants (birth weight, 939±206 g) were compared in a blinded fashion with 29 control infants (birth weight, 964±174 g). The lecithin/sphingomyelin ratio was less than 2 in all infants, and phosphatidylglycerol was not present in amniotic fluid or tracheal fluids at birth, indicating a deficiency of surfactant in the lungs. The principal dependent variables were neonatal death, the incidence of bronchopulmonary dysplasia, and the infant's requirement for respiratory support (and its complications). The surfactant-treated group had significantly fewer deaths than the control group (16 percent vs. 52 percent, P<0.001), fewer cases of bronchopulmonary dysplasia (16 percent vs. 31 percent), and significantly fewer cases of pulmonary interstitial emphysema (P<0.001) and pneumothorax (P<0.02). Prophylactic treatment with human surfactant also substantially reduced the period of neonatal intensive care.

We conclude that treatment with human surfactant offers promise for improving the survival of very premature infants with a surfactant deficiency and for reducing the pulmonary sequelae of the respiratory distress syndrome. (N Engl J Med 1986; 315:785-90.)

Since the pioneering observation of Avery and Mead that surface activity of pulmonary surfactant was decreased in the airways of infants dying of hyaline membrane disease, and the finding by Adams and coworkers that airway secretions from such infants were deficient in surface active phospholipids, neonatologists have sought to restore surfactant sufficiency in infants with the respiratory distress syndrome. Thus “rescued” from the respiratory distress syndrome, had a lower incidence of pneumothorax, pulmonary interstitial emphysema, death, and bronchopulmonary dysplasia than infants in a randomly selected control group. These results suggested that “prophylactic” administration of surfactant (i.e., before the onset of ventilatory failure) at birth in infants with a documented pattern of lung surfactant phospholipids consistent with impending respiratory distress might
There are significant economic and social impacts to ignoring our infant mortality problem.
The annual societal economic burden associated with preterm births (a leading cause of infant mortality) in the U.S. in 2005* was >$26 BILLION

The average total direct cost of medical care to the family with a preterm infant in the U.S. in 2005.*

The average direct cost once maternal medical care, early intervention, special education services and loss of household productivity are considered.*

Now, imagine what these numbers must be today with 10 years of healthcare cost inflation.
The Social Impact

The social burden infant mortality has is profound as well.

– Grieving families are potentially unable to work and experience mental and physical health issues
– Public health and other organizations must focus on providing grief counseling
– The inherit message the disparities send to affected populations about their value to U.S. society is disheartening
How does Colorado compare to the national rate?
How Does **Colorado** Stack Up?

In **Colorado**, the overall infant mortality rate in 2011 was **5.6**.

Source: *Infant Mortality in Colorado, Maternal and Child Health Issue Brief #2*, February 2013, CO Department of Public Health and Environment
This translates to about **400** babies dying in Colorado each year.
But not for everybody or every baby....

Source: Infant Mortality in Colorado, Maternal and Child Health Issue Brief #2, February 2013, CO Department of Public Health and Environment
We must not simply *reduce* this disparity. We must *eliminate* it.
National Infant Mortality CoIIN Common Agenda: More first (++++) birthdays
Why a Collaborative Improvement and Innovation Network (CoIIN)?

• **Dilemma**: highly complex, persistent problems with multiple causes and multiple potential levers for action.

• **Need**: approaches that facilitate success in novel ways

• **Solution**: combine 4 key methods for change
  - Collaborative learning
  - Collaborative innovation networks
  - Quality improvement
  - Collective impact
## Key Elements of Collective Impact

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Health Equity
An Explanatory Model for Conceptualizing the Social Determinants of Health

Public Health’s Role in Addressing the Social Determinants of Health
- Advocating for and defining public policy to achieve health equity
- Coordinated interagency efforts
- Creating organizational environments that enable change

- Data collection, monitoring and surveillance
- Population-based interventions to address health factors
- Community engagement and capacity building
The Role of Public Health

• Advocating for and defining public policy to achieve health equity
• Coordinated interagency efforts
• Creating supportive environments to enable change
• Data collection, monitoring and surveillance
• Population based interventions to address individual factors
• Community engagement and capacity building
Socioeconomic Factors

Changing the Context
to make individuals’ default decisions healthy

Long-lasting Protective Interventions

Clinical Interventions

Counseling & Education

Examples

Largest Impact

Smallest Impact

CDC “Health Impact Pyramid”
Shifting our Emphasis

Poverty, education, housing, inequality

Immunizations, brief intervention, cessation treatment, colonoscopy

Fluoridation, trans fat, smoke-free laws, tobacco tax

Ed for high blood pressure, high cholesterol, diabetes

Eat healthy, be physically active
Advantages of CoIIN

• Rapid-cycle quality improvement approach
• Focus on common strategies and collective impact principles
• Standardized measureable indicators using datasets in common
• Collaborative, transparent multi-state network to share information and ideas
• Support and technical assistance
• Data-driven decision making
• It engages federal, state and local leaders, public and private agencies, professionals and communities
Results from previous IM CoIN efforts in HRSA regions IV and VI:

- 30% reduction in non-medically indicated early elective deliveries
- 14% reduction in white/black IM disparity rates
- 12% reduction in women smoking in pregnancy
- 3% reduction in overall IM rate
- 7% reduction in non-Hispanic black IM rate
### 6 CoIIN-Wide Aims by July 2016

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<tr>
<td>Decrease Infant Mortality Rate</td>
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<tr>
<td>Decrease Neonatal Mortality Rate</td>
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<tr>
<td>Decrease Postneonatal Mortality Rate</td>
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<tr>
<td>Decrease Preterm-related mortality rate</td>
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<tr>
<td>Decrease SUID mortality rate</td>
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<tr>
<td>Decrease Preterm birth</td>
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*Data source: Provisional state vital statistics data reported quarterly (rolling averages)*
Collaborative Interest Network

Who? Includes all who are interested in improving birth outcomes and reducing infant mortality.

What is done? Actions range from learning, to sharing ideas and questions, to trying out ideas on their own.
National Infant Mortality CoIIN

6 Collaborative Learning Networks

Who? Members commit to shared aims and measures.
1. Improve Safe Sleep Practices
2. Smoking Cessation
3. Women’s Health Before and Between Pregnancies
4. Social Determinants of Health
5. Perinatal Regionalization
6. Prevent Preterm and Early Term Births
National Infant Mortality CoIIN

Collaborative Innovation Network (COIN)

Who? Members of CoIIN create, test, and improve an innovation. There are multiple COINs that form and disband.

What is done? Members collaborate to develop promising concepts that can be tried. New COINs form when a collective interest is identified. A COIN can disband when it produces the working prototype. New COINs can continually form to create solutions.
The 6 Learning Networks

**SIDS/SUID/Safe Sleep**  
(N=37)  
Improve safe sleep practices

**Smoking Cessation**  
(N=21)  
Reduce smoking before, during and/or after pregnancy

**Preconception/Interconception Health**  
(N=29)  
Promote optimal women’s health before, after and in between pregnancies, including a focus on postpartum visits (content and frequency), and adolescent well visits (content and frequency).

**Social Determinants of Health**  
(N=23)  
Incorporate evidence-based policies/programs and place-based strategies to improve social determinants of health and equity in birth outcomes

**Prevention of Preterm and Early Term Births**  
(N=21)  
Increase appropriate utilization of 17 OH progesterone and/or reduce early elective deliveries.

**Risk-appropriate Perinatal Care**  
(perinatal regionalization)  
(N=14)  
Increase the delivery of higher-risk infants and mothers at appropriate level facilities
### Key Elements of Collective Impact

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<td>All participants have a <strong>shared vision for change</strong> including a common understanding of the problem and a joint approach to solving it through agreed upon actions.</td>
<td>“Ensure every child reaches his or her first birthday and beyond.”</td>
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<td><strong>Collecting data and measuring results</strong> consistently across all participants ensure efforts remain aligned and participants hold each other accountable.</td>
<td>Each Learning Network will have a <strong>family of shared measures</strong> to ensure progress towards individual aims.</td>
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<td>Participant activities must be <strong>differentiated while still being coordinated</strong> through a mutually reinforcing plan of action.</td>
<td>State teams <strong>apply innovation and quality improvement methods to coordinated activities</strong> within their states that advance their state action plans on reducing infant mortality and eliminating health disparities.</td>
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<td><strong>Consistent and open communication</strong> is needed across the many players to build trust, assure mutual objectives, and create common motivation.</td>
<td>The <strong>Infant Mortality online community</strong> is a “collaboration engine” that provides continuous communication to enable participants to work together</td>
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<tr>
<td>Creating and managing collective impact requires a separate organization(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and <strong>coordinate participating organizations and agencies</strong>.</td>
<td>The <strong>National Institute for Children's Health Quality</strong> (NICHQ), in conjunction with the <strong>Maternal and Child Health Bureau</strong> (MCHB) and <strong>partners</strong>, provide the infrastructure and supports required to advance the work of states.</td>
</tr>
</tbody>
</table>
Your help and support is critical to our success.
Getting Involved

CoINN is a vehicle that works best with everyone onboard, but any level of participation is a means to move forward.
Who needs to be at the table: Broad, cross-sector engagement

- **Within public health department**
  - WIC
  - Family Planning
  - Adolescent Health
  - Chronic disease prevention
  - Tobacco control
  - Substance abuse prevention and treatment
  - Violence and Injury prevention

- **Within state, county & city government**
  - Medicaid
  - Office of Health Equity or Minority Health
  - Social Service agency
  - Housing agency
  - Child Welfare agency
  - Legislative committees

- **Regional federal staff**, eg, Indian Health Service
Who needs to be at the table: Beyond government

- **Community based organizations, coalitions and networks**
  - Chambers of Commerce and business organizations
  - March of Dimes
  - Healthy Start community grantees
  - Faith-Based organizations
  - Refugee & Immigrant support organizations
  - Early education and care groups
  - Sororities and fraternities

- **Clinical provider organizations** – ACOG, AAP, AAFP, AWHONN, NMA, NHMA and others

- **Payers** – private and public

- **State/local initiatives**
  - Perinatal Quality Collaboratives
  - National Governor’s Association Improving Birth Outcomes Learning Network
  - Home visiting groups
Colorado’s children deserve the best start possible. To provide that, prioritizing infant health is critical and essential.
My goal, our goal, THE ONLY goal

ONE number!
Imagining the impossible
Creating a new reality
What's the one word to describe how you're feeling about what you've achieved here?

Text **TRULY** and your message to **22333**

Submit responses at PollEv.com/nichq
Intergenerational Reaction Panel

Moderator: Cerise Hunt

-Thelma Craig, Colorado Black Health Collaborative
-Demetrious Jenkins, Healthy Start Program, Families Forward Resource Center
-Kahlea Khabir, University student
-Terri Richardson, Kaiser Permanente
-Angela White, Healthy Start Program, Families Forward Resource Center
Infant Mortality: State and Local Perspective

Moderator: Cerise Hunt

-Karen Trierweiler, Colorado Department of Public Health & Environment
-Chanell Reed, Healthier Beginnings
-Gloria DeLoach & Kellie Teter, Denver Public Health
Infant Mortality in Colorado: State Perspective

Creating Solutions Together

June 13, 2015
Infant Mortality

Infant mortality rates, Colorado and US, 2007-2013

Deaths per 1,000 live births

Year

2007 2008 2009 2010 2011 2012 2013

6.8 6.6 6.4 6.1 6.0 6.0 6.0

6.1 6.2 6.3 5.9 5.6 4.6 5.1

CO Infant US Infant HP2020 Target (6.0)
Infant Mortality by Race/Ethnicity

Infant mortality rates by race/ethnicity, Colorado, 2013

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Deaths per 1,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>5.1</td>
</tr>
<tr>
<td>White, non-Hispanic</td>
<td>4.0</td>
</tr>
<tr>
<td>White, Hispanic</td>
<td>7.9</td>
</tr>
<tr>
<td>Black/African American</td>
<td>10.3</td>
</tr>
<tr>
<td>Asian American/Pacific Islander</td>
<td>3.6</td>
</tr>
<tr>
<td>American Indian/Native Alaskan</td>
<td>4.1</td>
</tr>
</tbody>
</table>
Major Causes of Infant Mortality

Major causes of infant mortality among Black/African Americans, Colorado 2012-2013

- Prematurity and related conditions: 42%
- Congenital anomalies: 23%
- SIDS and SUID: 12%
- Injury: 10%
- Other perinatal conditions: 5%
- All other causes: 6%
- Infections: 4%

Vital Statistics Program, Colorado Department of Public Health and Environment
Preterm Birth

Percent preterm births (<37 weeks gestation) by race/ethnicity, Colorado, 2013

- White, NH: 8.2%
- White Hispanic: 8.8%
- Black: 11.4%
- Asian: 9.2%
- American Indian: 8.0%

Vital Statistics Program, Colorado Department of Public Health and Environment
Colorado’s Collaborative Improvement & Innovation Network (CoIIN) Goal:

By 2020, reduce (the infant mortality rate among African Americans from 10.3 to the current White, non-Hispanic rate of 4.0
**CoIIN Initiatives**

- Work to increase understanding of the importance of reducing infant mortality among African Americans and its significance to the health and well-being of all Colorado infants and families.

- Develop statewide preterm birth prevention and reduction recommendations and work with providers to ensure implementation.

- Work with local public health partners in Denver, Arapahoe, and Adams counties and the Healthy Start project to implement evidence-based, community initiatives focused on reducing infant mortality among African Americans.
CoIIN Initiatives

• Increase awareness of the burden of infant mortality on the African American population and the effectiveness of current efforts through data collection and communication

• Promote business-sector policies shown to impact social determinants of infant mortality and improve perinatal outcomes
Social Isolation

Percent of adults who always or usually got needed social and emotional support by race/ethnicity, Colorado, 2010

- Overall: 83.2%
- White, NH: 86.4%
- Hispanic: 74.1%
- Black, NH: 73.8%
- Other, NH: 78.3%
Racism

Percent of adults who felt upset as a result of how they were treated based on their race and/or ethnicity by race/ethnicity, Colorado, 2011

- Overall: 6.3%
- White, NH: 3.3%
- Hispanic: 13.5%
- Black, NH: 36.7%
- Other, NH: 12.1%

Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment
Health Insurance

Uninsured by race/ethnicity, Colorado, 2013

Race/Ethnicity: White, NH, Hispanic, Black, NH, Other, NH

Percent: 11.7, 21.8, 19.6, 10.0

Colorado Health Access Survey

Department of Public Health & Environment
Thank you!

Karen Trierweiler, MS, CNM
Deputy Division Director Prevention Services Division
4300 Cherry Creek Drive South, Denver, CO 80246
karen.trierweiler@state.co.us
www.colorado.gov/cdphe
303.692-2481
Putt it into Practice: How the community can participate

Moderator: Virginia Visconti

- Shawn Taylor & Family Advocates, Healthy Start Program, Families Forward Resource Center
- Virginia Visconti, Community Action Network, Families Forward Resource Center
- Glynis Williams-Thompson, Denver Pan-Hellenic Council
WELCOME TO THE

HEALTHY START

“HEALTHY BABIES, STRONG FAMILIES”

NEW FAMILY ORIENTATION
MEET THE HEALTHY START TEAM

Shawn Taylor - Program Manager
Felicia Allen – Family Advocate
Jeri Bass – Family Advocate
Kimble Darby – Family Advocate
Mia Grieveous – Family Advocate
Demetrious Jenkins – Family Advocate
Pamela Richards – Family Advocate
Angela White – Family Advocate
1) INDIVIDUAL FAMILY LEVEL: FAMILY DEVELOPMENT DELIVERED THROUGH HOME VISITATION IF POSSIBLE, INCORPORATING PARTNERS FOR HEALTHY BABY CURRICULUM AND VARIOUS SCREENINGS (PERINATAL DEPRESSION & ASQ.). CONNECTING FAMILIES TO EXISTING FFRC SERVICES (FATHERHOOD, PARENTING EDUCATION, HEALTH PROGRAMS ETC.) AND PARTNER PROGRAMS (MHCD, RMBC.). CONTRACTING WITH INFANT MENTAL HEALTH SPECIALIST. INVITATION TO ENGAGE PARTICIPANTS AT EVERY LEVEL.
2) Group Level: “Course Catalog” with certification to include trauma-informed parenting, resiliency, mindfulness, yoga, birthing, mental health first aid, and more. Other social connections such as breastfeeding workshops, expecting mom’s day out, chat and chew social groups and mom-to-mom mentoring.
3) Community Level: The Healthy Start Program operates at the community level through the work of the Community Action Network (CAN). You’ll hear more about the CAN this morning from Virginia Visconti, the CAN’s Collective Impact Coordinator.
YOUR LOCAL HEALTHY START PROGRAM “Healthy Babies, Strong Families”

“Infant mortality refers to the death of an infant before his or her first birthday.” (State of Colorado, 2015)

WHY? “Although the U.S. infant mortality rate has declined in recent years, major disparities persist. More than twice as many African American babies do not live to see their first birthdays as their white counterparts. African American women are more likely than white or Hispanic women to deliver their babies before 37 weeks gestation, putting them at risk for infant death."

Infants of Colorado mothers with less than a high school education have higher infant mortality rates than infants of mothers with college degrees.

COLORADO’S BLACK INFANT MORTALITY RATES

Infant mortality rates vary by race/ethnicity in Colorado. Infants of color, with the exception of Asian American/Pacific Islander infants, have higher infant mortality rates than White non-Hispanic infants.

Infants of mothers with less education experience higher mortality rates.

THE HEALTHY START PROGRAM ON A NATIONAL LEVEL...

- **Healthy Start** is a federal program designated to prevent infant mortality in 87 communities with the highest infant mortality rates.

- **Healthy Start** reaches out to pregnant women and new mothers and connects them with the health care and other resources they need to nurture their children. The focus is to:
  - Improve women's health before, during and after pregnancy and
  - Help families care for their infants through their first 2 years so they are healthy and ready to learn.

INDIVIDUAL SERVICES

- Family Advocacy
- Home Visitation
- Resource Referrals
- Infant Resources
- Counseling
- Case Management

GROUP SERVICES

- Parenting Classes
- Fatherhood Support Groups
- Walking Clubs
- Women’s Health Groups
- Mom-to-Mom Mentoring
- Birthing Education
- Pregnancy Support Groups
Participant Outcomes
The Healthy Start Community Action Network
We CAN!

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June 13, 2015
What is the CAN?

- Strength-based
- Action-oriented
- Representative of multiple forms of expertise and lived experience
- Committed to the reduction of the African American infant mortality rate & the promotion of positive birth outcomes
- Determined to achieve collective impact with YOUR participation
What is collective impact?

The commitment of a group of cross-sector actors to a common agenda for solving a targeted social problem through alignment and differentiation of efforts.

Source: http://collectiveimpactforum.org/resources
Why collective impact?

- Making progress addressing this issue at scale (i.e., across the state, region/city) requires the involvement of nonprofits, philanthropy, the public sector, and the private sector.

- Making significant progress requires systems change and greater alignment and connection between many organizations.

- Successfully making progress also requires catalyzing innovative solutions.

Inspired by: http://collectiveimpactforum.org/resources
Who is the CAN?
How does the CAN support grassroots ownership of the collective impact initiative?

**Leadership Body (LB)**

- **Members**: African American mothers, fathers, & families (not exclusively HS Program participants)

  *Fluid membership*

- **Responsibilities**: Provide guidance & feedback to the CAN regarding the direction of the collective impact initiative.

**Community Action Network (CAN)**

- **Members**: Stakeholders from all sectors of society, including African American mothers, fathers, & families

  *Complementary Activities*

- **Responsibilities**: Serve as LB ally, formulating engagement options (i.e., CI objectives & strategies) for LB review & feedback. Also implements strategies.

**Implementation of Common Agenda Strategies to Achieve Collective Impact**
What is the CAN’s scope of work?
Determinants of Equity & Health

Social (Structural) Determinants of Equity

Social Determinants of Health

Individual Behaviors

What is the CAN’s scope of work?

Determinants of Equity & Health

Social Determinants of Health

- Lie outside of the individual, beyond genetic endowment and beyond individual behaviors.
- Include individual resources, neighborhood (place-based) or community (group-based) resources, hazards and toxic exposures, and opportunity structures.
- The contexts that answer the question, “Why do we see this distribution of behaviors?”

Social (Structural) Determinants of Equity

- Systems of power that determine the range of social contexts and the distribution of populations into those social contexts.
- Include the economic system, racism, other “isms”, other axes of difference from those in power.
- The forces that answer the question, “Why do we see this distribution of contexts?”

What has the CAN accomplished thus far?

CAN members have

- Created this Summit!
- Met regularly for 7 months
- Familiarized themselves with collective impact and life-course approaches
- Explored the infant mortality data landscape
- Adopted the principles and practices of authentic engagement
- Applied Results-Based Accountability decision-making to identify “root causes” of African American infant mortality
Root Causes Exercise
Content Analysis: Themes & Areas of Energy

- Social isolation
- Healthcare -- awareness, access, quality, and utilization
- Racism
- Education – content, access, and application
- Built environment – security/safety, transportation, property taxes
What are the CAN’s current priorities?

- Engage stakeholders from all sectors: community, government, business, non-profits, & philanthropy
- Forge a common action plan (a “common agenda”)
- Develop a shared measurement system for tracking progress
Please add your voice to the CAN!

- During your afternoon interactive breakout session, please add your name to the CAN sign-up sheet.

- Please attend the June 25 CAN meeting at Z Place on the Evie Garrett Dennis Campus (4800 Telluride St., Building 5, Denver 80249).

- Please share your questions and ideas with me: Virginia@familiesforwardrc.org.
Thank you!