

Michigan Department of Community Health

2012 Health Equity Report



Released February 2013

*Michigan Department
of Community Health*



Rick Snyder, Governor
James K. Haveman, Director

February 28, 2013

It is with great pride that the Michigan Department of Community Health (MDCH) releases its 2012 *Health Equity Report*. In Michigan, similar to the rest of our nation, where you live, how much money you make, and the color of your skin may negatively influence far too many life experiences and health outcomes. MDCH is committed to expand awareness and knowledge, build capacity, and facilitate change to create equitable opportunities and improve the health and well-being of all of Michigan's communities and their residents.

Each year we document our progress as part of the requirements of Public Act 653 of the Michigan Public Health Code. This look back allows MDCH to continuously assess program efforts to improve Michigan minority health demographics. It also allows us to track the success of our efforts to promote and integrate equity practices as part of our everyday department activities. This critical feedback loop informs and facilitates coordinated approaches, evidence-based programs and policies, and best practices that move MDCH toward our goal of achieving health equity.

Michigan's 2012 Health Equity Report demonstrates our departmental alignment with state and national strategic plans, programs and initiatives such as *The Michigan Health Equity Roadmap*, the U.S. Department of Health and Human Services (HHS) *Action Plan to Reduce Racial and Ethnic Health Disparities*, and the HHS *National Stakeholder Strategy for Achieving Health Equity*. In this report, you will see that many of our efforts have resulted in progress. In other areas, it is clear we have either just begun our journey or still have quite a way to go.

It is our hope that information presented throughout this report underscores the importance of community members and public and private organizations, agencies, and academic institutions working together to achieve notable accomplishments and address areas where gaps remain. We extend much appreciation for the continued and expanding commitment of partners across the state, and we look forward to working together in 2013.

Sincerely,

Sheryl Weir, MPH
Manager
Health Disparities Reduction and Minority Health Section
Michigan Department of Community Health

2012 Health Equity Report

Executive Summary

The Michigan Department of Community Health (MDCH) completed its sixth annual assessment of departmental efforts to reduce racial and ethnic health disparities. The 2012 Health Equity Report has dual purposes. Like previous reports, it serves as the MDCH annual report documenting work to address the requirements of Public Act 653 of the Michigan Public Health Code. Additionally, it reports the progress that MDCH and its partners have made in addressing priority recommendations of the *Michigan Health Equity Roadmap: A vision and framework for improving the social and health status of racial and ethnic minority populations in Michigan*. Deborah Riddick, JD, RN, Director of Policy and Planning, School-Community Health Alliance of Michigan and one of the original authors of PA 653 commented on the movement toward meeting the requirements of the legislation, as well as the Roadmap Recommendations. Ms. Riddick said, *“The MDCH Health Disparities Reduction and Minority Health Section has continued to thoughtfully advance PA 653. Through the implementation of their Roadmap, they have notably expanded beyond funding programs to innovations advancing policies and efforts that can be sustained and will have a long term impact.”*

Attachment A provides a cross-walk illustrating the alignment between the Roadmap Recommendations, Public Act 653 requirements and the National Stakeholder Strategy.

Released in June 2010, the Roadmap has five recommendations. Collectively, these stimulate coordinated efforts among government, healthcare, and community partners to address and improve the social and health status of Michigan’s racial and ethnic minority populations. This integrated focus gives MDCH and its partners direction to expand their efforts to reduce health disparities and achieve health equity.

Michigan Health Equity Roadmap Recommendations

- Improve race and ethnicity data collection, systems and access
- Strengthen government and community capacity to improve racial/ethnic health inequalities
- Improve social determinants of health
- Strengthen community capacity, engagement and empowerment
- Ensure equitable access to quality health care

To assure efforts to address health equity in Michigan also impact equity at the national level, MDCH aligns its work with two U.S. Department of Health and Human Services (HHS) plans, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities* and

National Stakeholder Strategy for Achieving Health Equity Goals

- Awareness
- Leadership
- Health Systems and Life Experience
- Cultural and Linguistic Competency
- Data, Research and Evaluation

the *National Stakeholder Strategy for Achieving Health Equity*. Released in 2011, these plans are available at <http://minorityhealth.hhs.gov/npa/>.

Michigan's 2012 Health Equity Report is organized according to the five goals of the *National Stakeholder Strategy*.

As in previous years, MDCH focused its work to reduce health disparities on five racial and ethnic population groups in Michigan: African American, Hispanic/Latino, American Indian/Alaska Native,

Asian American/Pacific Islander, and Arab and Chaldean American. **In 2012, 1,376,109 people from Michigan's racial and ethnic minority populations were served by MDCH-funded programs and services.**

In addition to building upon and continuing its work to address health disparities, MDCH achieved several accomplishments that strengthened the foundation needed to shift from a focus on health disparities to achieving health equity. Among the 2012 accomplishments responsible for this new direction are:

- Continued implementation of the *Michigan Health Equity Roadmap* and alignment with the national health equity strategies.
- Maintenance of a health equity data set.
- Expanded training on social determinants of health and other health equity topics.
- Continued funding of community capacity building grants (CBG).
- Implementation of the *MDCH Health Equity Ambassador* pilot project.

Renée Branch Canady, PhD, MPA, Health Officer, Ingham County Health Department shared her thoughts about the 2012 accomplishments. *"Among the biggest impacts in Michigan in the last year has been the formal introduction of rigorous dialogue giving thoughtful leaders across the state permission to engage in and lead discussions in strategic ways. This is creating the foundation for collective listening, learning and accomplishment. MDCH Health Disparities Reduction and Minority Health Section has provided the leadership and reason for us to express our self-interests, hear about others and coalesce around common goals."*

The 2012 Health Equity Report provides detailed information on the work of the Michigan Department of Community Health to achieve racial and ethnic health equity. For more information on content or focus areas highlighted in this report, contact Sheryl Weir, Manager, Health Disparities Reduction and Minority Health Section (HDRMHS), (313) 456-4355 or at weirs@michigan.gov.

2012 Health Equity Report

The *Michigan Health Equity Roadmap* was created by the Michigan Department of Community Health (MDCH) Health Disparities Reduction and Minority Health Section (HDRMHS) together with residents, public health, community and faith-based organizations, health professionals, researchers and academic institutions. The Roadmap was designed to stimulate coordinated efforts among these partners to address social and economic determinants of health and improve health outcomes. The Roadmap's centerpiece is its recommendations developed after an extensive review of Michigan and national health equity policies and programs, coupled with feedback from the community and stakeholders from many other sectors.

Accomplishing these recommendations requires a sustained commitment and innovative, multi-sector alliance focused on addressing social determinants of health and strengthening community capacity. The HDRMHS widely disseminated the Roadmap, and it is posted at www.michigan.gov/minorityhealth. The recommendations and strategies presented in the *Michigan Health Equity Roadmap* are categorized into five areas: 1) race/ethnicity data, 2) government and community capacity, 3) social determinants of health, 4) access to quality health care, and 5) community engagement and empowerment. A crosswalk with these recommendations, the Public Act 653 requirements, and the National Stakeholder Strategy is provided in Attachment A; this crosswalk illustrates the alignment between the Roadmap recommendations and the legislative requirements.

To assure efforts to address health equity in Michigan also reflect equity efforts at the national level, MDCH aligns its work with two U.S. Department of Health and Human Services plans, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities* and the *National Stakeholder Strategy for Achieving Health Equity*. These documents were released in 2011 and are available at www.minorityhealth.hhs.gov/npa/. The five National Stakeholder Strategy goals are:

- **Awareness:** Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic and underserved populations.
- **Leadership:** Strengthen and broaden leadership for addressing health disparities at all levels.
- **Health Systems and Life Experience:** Improve health and healthcare outcomes for racial, ethnic, and underserved populations.
- **Cultural and Linguistic Competency:** Improve cultural and linguistic competency and the diversity of the health-related workforce.

- **Data, Research, and Evaluation:** Improve data availability and coordination, utilization, and diffusion of research and evaluation outcomes.

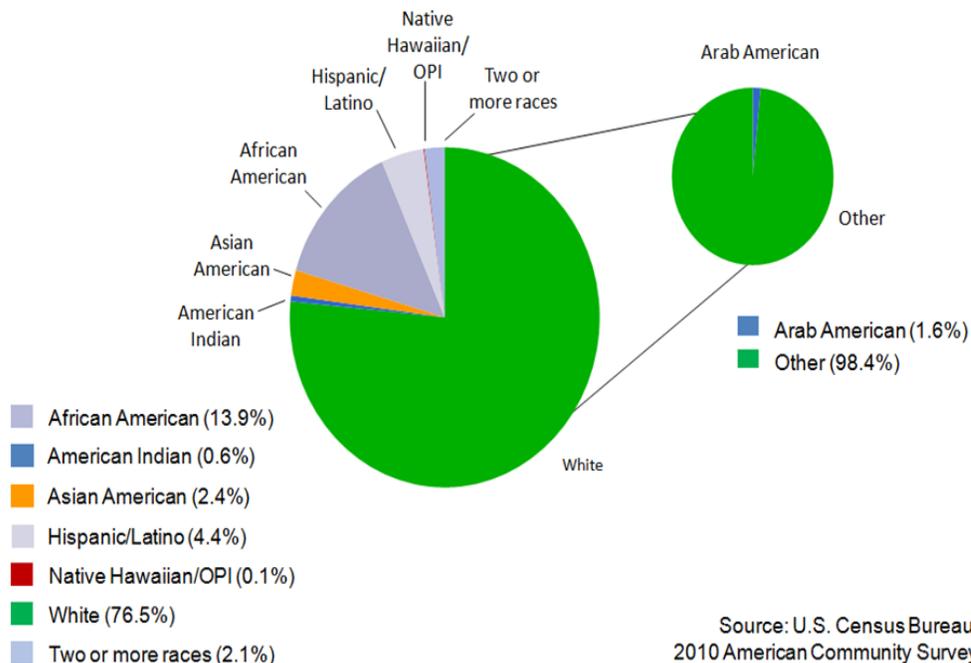
Data presented in this report were obtained from several sources, including an online survey of MDCH administrations and bureaus, key informant interviews, and document review. The 2012 survey data reflect responses from the overarching MDCH organizational units, typically called “administrations” and their sub-units, generally called “bureaus.” The 2012 survey respondents represent seven of the eight administrations and 21 of the 25 bureaus. Attachment B identifies the organizational units responding to the survey. The 2012 Health Equity Report documents progress made by MDCH and its partners toward achieving the Roadmap recommendations. To demonstrate alignment with national efforts, the Report is organized according to the five goals of the *National Stakeholder Strategy*.

The Face of Michigan

In Michigan, as in the nation, racial and ethnic minority populations are expected to grow, especially as the population ages. Figure 1 illustrates the percentage of Michigan’s 9,883,360 population by racial and ethnic population group.

Figure 1

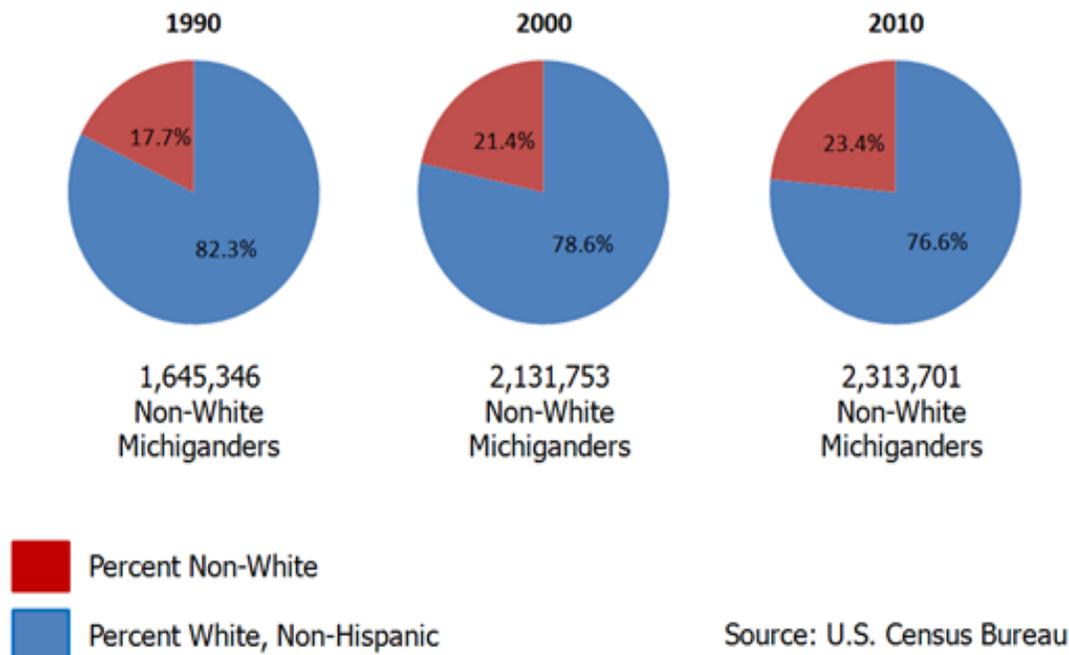
Michigan Population (2010)



Except Hispanic/Latino, all races/ethnicities listed are non-Hispanic and identify as that race alone. The Hispanic/Latino category includes all individuals who identify as Hispanic/Latino, regardless of other races listed. The smaller pie provides data on Arab American individuals identified using the ancestry data in the U.S. Census records. The Arab American category does not exclude individuals who also identify as Hispanic/Latino. These data are presented separately because the category does not necessarily exclude other races/ethnicities.

Figure 2

Michigan Non-White Population Growth



Between 1990 and 2010, the percentage of Michigan’s population that is Non-White increased, showing that Michigan’s Non-White population is growing (Figure 2). Michigan’s Non-White population under the age of 5 increased from 20.3 percent to 34.2 percent between 1990 and 2010, which is a greater increase than the growth in the Non-White population overall (Figure 3)

Figure 3

Michigan Non-White Children Population Growth (Under 5 Years)

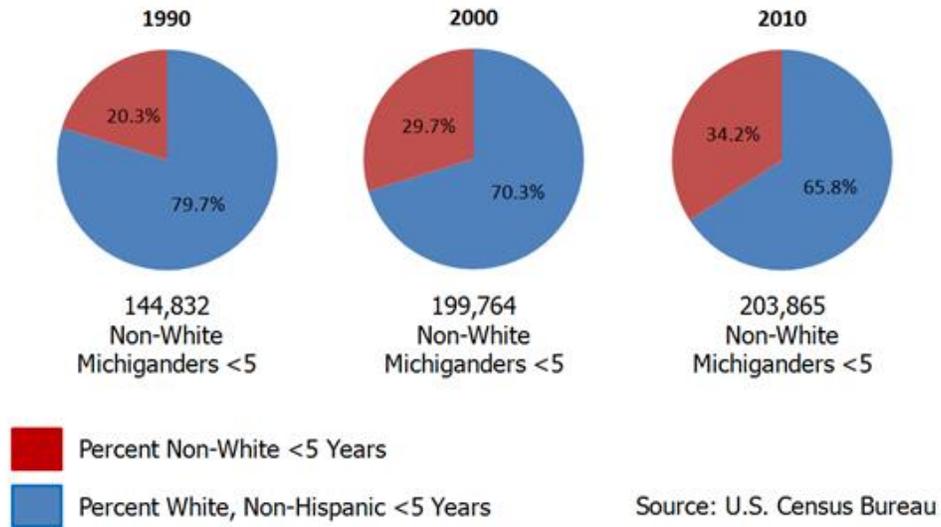
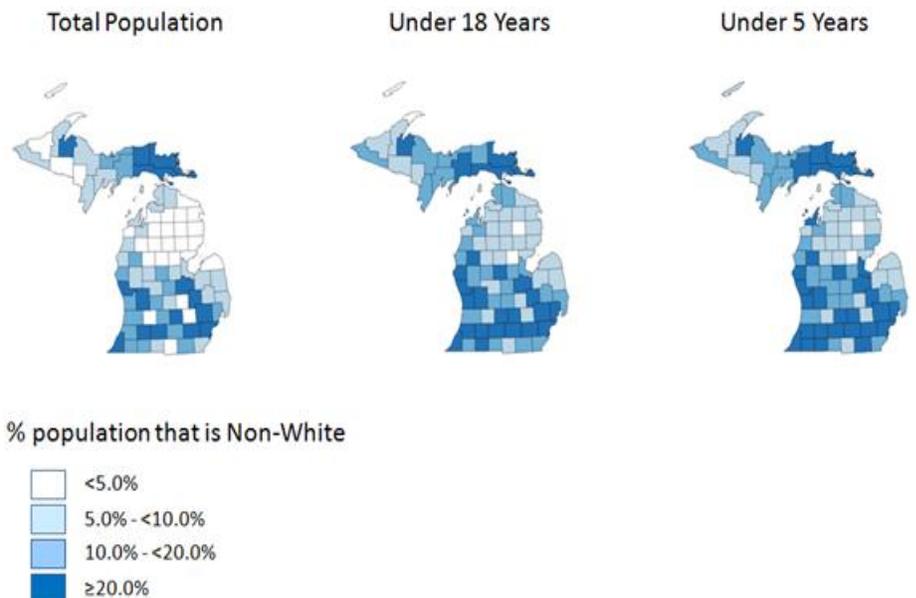


Figure 4 shows the percentage of each county's population that is Non-White. The first map is the total population of each county, the second map shows the percentage of the population under 18 years that is Non-White, and the third shows the percentage of the population under 5 years that is Non-White. The larger percentages of Non-White populations under 18 and under 5 show that Michigan's population is changing, with the Non-White population increasing.

Figure 4

Counties with largest proportions of Non-White populations, by age of population (2010)



Data Source: 2010 Census, U.S. Census Bureau

Data, Research, and Evaluation

National Stakeholder Strategies: Data, Research and Evaluation

Acquire and analyze data to enhance decisions through better research coordination, and promote the translation of evidence-based research into practice.

The *National Stakeholder Strategy for Achieving Health Equity* goals identified four strategies to improve race, ethnicity, and related data availability, coordination, utilization and diffusion. Timely, comprehensive and accurate data are essential to identify problems, formulate solutions, and evaluate impact. It is equally important that data be available in accessible forms to help develop, disseminate, and translate evidence-based models for addressing health inequalities. Developing collaborative relationships with organizations that collect data, coordinating research and evaluation efforts, and involving the community in data collection and research/evaluation initiatives are important strategies to improve data collection, analysis, and dissemination. In accordance with this National Stakeholder Strategy goal, MDCH monitors race and ethnicity, social determinants of health, and health outcome data to assess needs, plan policies and programs, and evaluate success in attaining health equity for racial and ethnic minority populations in Michigan.

Michigan Health Equity Roadmap

Recommendation 1: Improve race/ethnicity data collection/data systems/data accessibility.

In 2012, MDCH continued to track and monitor race, ethnicity, and related data through several mechanisms at the state and local level. These data are collected over time to demonstrate health equity achievement and identify areas needing further improvement.

Of the 27 MDCH administrations and bureaus that responded to the survey, 13 (48%) reported using data to monitor racial and ethnic health disparities in 2012. They used prevalence, incidence, mortality, morbidity, access to services, and utilization data to identify and monitor racial and ethnic disparity trends. Data were also used to identify populations at highest risk or need, plan interventions, and monitor performance and impact of funded programs and contractors. A variety of data collection sources and mechanisms were identified including state surveys and

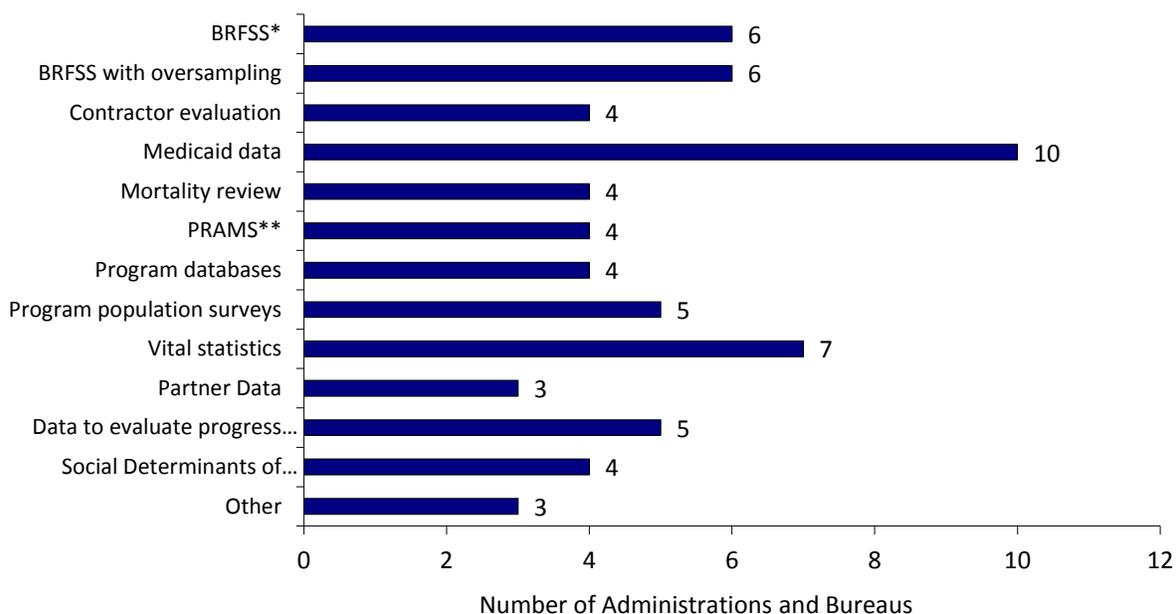
“Because Michigan is so diverse, it is important to capture data that accurately reflect the unique diversity of our residents. Data need to be able to inform about unique heritages and cultures across Michigan.”

Deborah Riddick, School-Community Health Alliance of Michigan

databases, web-based data collection, and use of national data sources. The most commonly used data are identified in Figure 5.

Figure 5

Data used in 2012 to Monitor Health Disparities



*BRFSS: Behavioral Risk Factor Surveillance System

**PRAMS: Pregnancy Risk Assessment Monitoring System

In addition to monitoring data, four bureaus reported using a health equity assessment tool to further assist them in program planning, development, implementation, and evaluation. Specifically, assessment tools determined differences in quality of care among racial/ethnic groups, assessed health equity knowledge and competencies among staff, and identified the public health preparedness and emergency response needs of vulnerable populations. A variety of tools were used including ones developed by state and national groups.

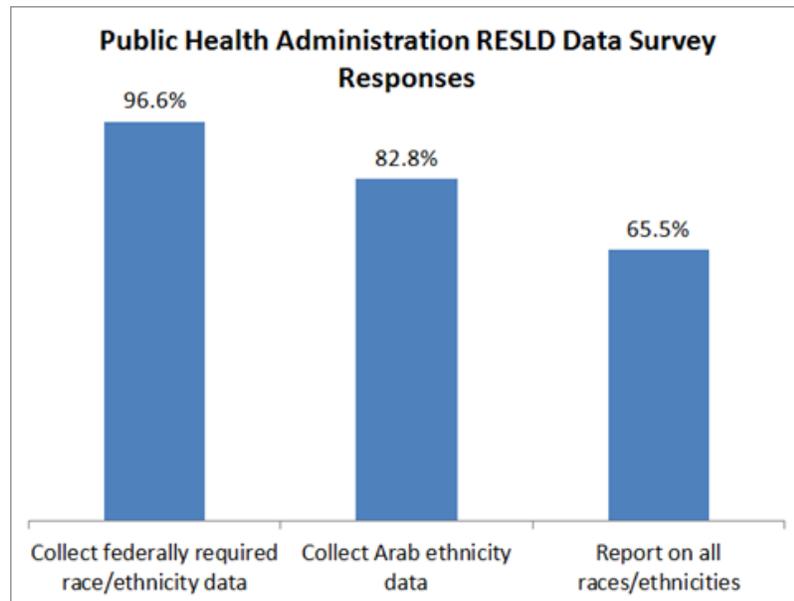
Recommendation 1a: Assure that race, ethnicity, and preferred language data are collected for all participants in health and social services programs.

In 2012, 12 (44%) of MDCH administrations and bureaus reported collecting race and the same 12 reported collecting ethnicity data on participants they served; 6 (22%) collected preferred language data from their participants. The following spotlight presents an MDCH-led effort to improve the Department’s collection of race, ethnicity, preferred language and other related data.

Spotlight

Closing the Gap in MDCH Data Collection Discrepancies

A 2010 MDCH Public Health Administration (PHA) survey of data users shone a light on the discrepancy between race, ethnicity, gender, primary language and disability status (RESLD) data collected and that which is reported. *“Recognizing that without consistent and complete data we cannot effectively address health inequities, a PHA quality improvement project was chosen to both understand: barriers to race and ethnicity data collection across Bureaus and Divisions and how mandates of the Affordable Care Act will impact the process and associated data collection,”* explained Katie Macomber, Bureau of Disease Control, Prevention and Epidemiology and PHA Quality Improvement (QI) Team member.



In 2012, possible points to impact change were elucidated in a fish diagram. Collectively the PHA QI Team determined to initially focus on data collection methods and procedures related to race, ethnicity, gender, primary language and disability status. PHA QI efforts included: surveys to gauge current practices and barriers to change; and targeted educational presentations offered to Bureau and Division level staff at PHA manager meetings. Of the 22 attendees in the initial presentations, there was a 50 percent increase in knowledge in 25 percent of the questions, and two other questions showed a majority of respondents answering correctly after the presentation.

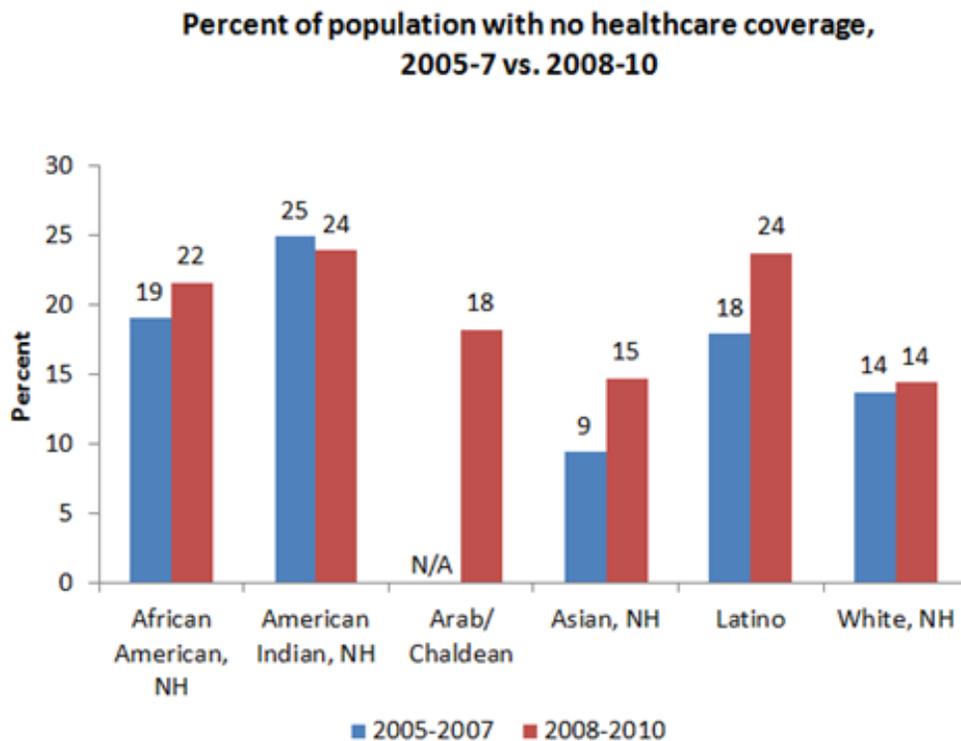
The next steps include expanding this educational campaign to the entire PHA via the MDCH website, collaborating with the MDCH Health Equity Steering Committee on future initiatives, and expanding the membership of the PHA Quality Improvement Team to other PHA areas of interest.

Recommendation 1b: Identify and establish a health equity data set to be maintained within the Health Disparities Reduction and Minority Health Section.

An important requirement for monitoring health equity is standardized, complete, and consistent data collection over time. In 2010 and 2011, the HDRMHS designed the Michigan Health Equity Data Project (MHEDP) to provide these data. In addition to

presenting estimates for each indicator for two time periods, the data set incorporates four measures to monitor racial and ethnic health equity in Michigan. The *Michigan Health Equity Data Tables and Related Technical Documents, 2000-2009*, was prepared and posted on the HDRMHS website in 2011. Figure 6 provides an example of data available through this dataset. In 2012, the MHEDP approach was adapted by the Medicaid Administration to examine health equity among its managed care plans.

Figure 6



Source: 2005-2010 Michigan Behavioral Risk Factor Survey, MDCH

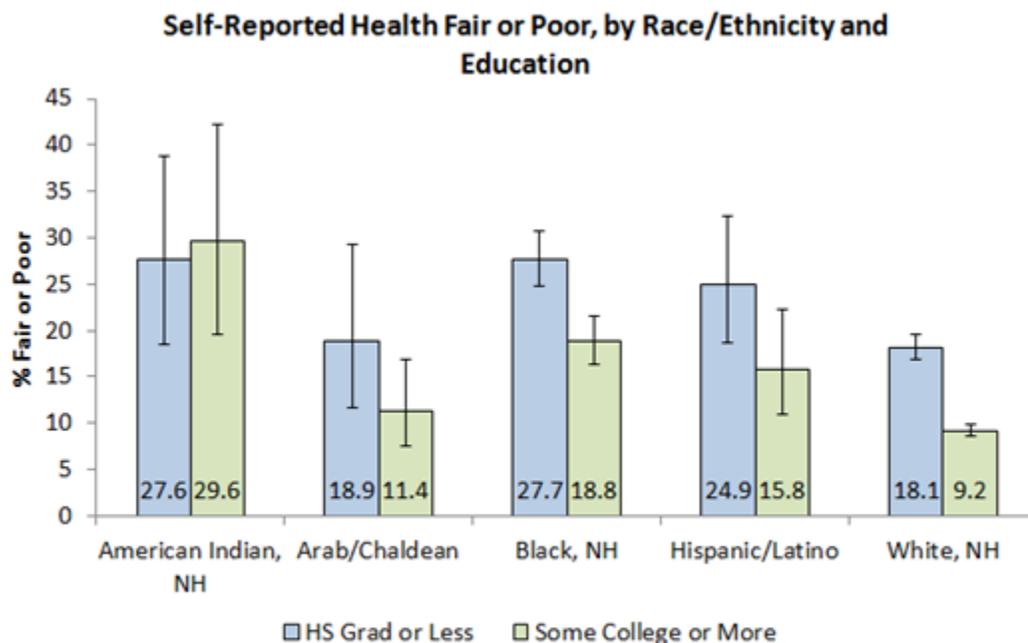
This figure shows the percentage of the population without healthcare coverage, using data from the Michigan BRFSS. Three years of data are combined to produce large enough sample sizes to calculate estimates for each racial/ethnic population. The blue bars show data from 2005-2007 and the red bars show data from 2008-2010. Comparing the blue bars to the red bars shows change between the two time periods. In 2005-2007 the percentage of populations ranged from 9 percent (Asian) to 25 percent (American Indian). In 2008-2010 the percentage of populations with no healthcare coverage ranged from 14 percent (White) to 24 percent (American Indian and Latino). There are two things of note in this figure: 1) The percentage of people with no healthcare coverage varied greatly by race/ethnicity, and 2) The change in

healthcare coverage also varied by race/ethnicity. The American Indian and White populations experienced no change or small declines in the percentage with no healthcare coverage, while the Asian and Latino populations both experienced large increases in the percent with no healthcare coverage.

As part of the Michigan Health Equity Roadmap Recommendation¹, the HDRMHS funded two special Behavioral Risk Factor Surveys (BRFS) in 2012: one to oversample the Asian American population and the other to oversample the Hispanic/Latino population in Michigan. The population-based Michigan BRFS does not capture large enough samples to be able to estimate health for these two populations each year, therefore special projects are required to capture adequate sample sizes. HDRMHS worked in collaboration with the MDCH BRFS program and the Michigan State University (MSU) Office of Survey Research to interview 400 people for each survey. The Hispanic/Latino survey was conducted in English and Spanish. These surveys are not a part of the annual Michigan BRFS. HDRMHS worked with the MDCH BRFS and the MSU Office of Survey Research to ensure that methods would be as comparable to the Michigan BRFS as possible. Data collection was completed in 2012 and will be available to analyze in late 2013. It is hoped that BRFS oversample surveys can continue because they provide more complete, statewide information about the health status of smaller racial and ethnic minority populations in Michigan.

In addition to oversampling, data from multiple years from the MDCH BRFS can be combined to analyze data for Michigan's racial and ethnic minority population. Data presented in Figure 7 is an example of this. This figure shows the percentage of people interviewed in the Michigan Behavioral Risk Factor Survey who report that their health is fair or poor, an indicator of overall health. Three years of data (2008-2010) are combined to increase the sample sizes and allow estimates to be calculated by race/ethnicity. For each race/ethnicity, the data are separated into two groups by education ("high school or less" compared to "some college or more"). The percentage of people reporting fair/poor health is lower for groups with more education, indicating that more education is associated with better health. This pattern is true for all races/ethnicities except American Indians, which may be a result of a small sample size for the American Indian population. However, it is also clear that racial/ethnic disparities in health remain at both levels of education. Education is associated with health, but race plays an independent role. Understanding the role of race in determining health is critical if we are to eliminate racial/ethnic health disparities.

Figure 7



Source: 2008-2010 Michigan Behavioral Risk Factor Survey, MDCH

Awareness

National Stakeholder Strategies: Awareness

Increase public understanding of health disparities by developing partnerships, communications strategies, and new approaches to putting the issues prominently on organizational agendas.

In order to effectively address health disparities, the public, healthcare providers, community partners and other stakeholders must be aware of and understand the problem. Despite a long history of health and healthcare disparities, there continues to be a low level of awareness. Consequently, the four National Stakeholder Awareness Strategies challenge all stakeholders to work together to enhance visibility and awareness of health disparities. Additionally, stakeholders must work in partnership to develop more strategic and coordinated approaches to health promotion and disease prevention that reach all Americans, including racial and ethnic minorities. In Michigan, MDCH and its partners utilize two websites as key tools to increase awareness. Other awareness efforts, at the state and community levels, are documented throughout this Report.

Recommendation 1c: Establish an HDRMHS webpage that will report health-indicator data, health equity data, and other health information related to the five racial/ethnic populations served by the section.

MDCH, Health Disparities Reduction and Minority Health Website

The HDRMHS maintained and expanded the MDCH Health Disparities Reduction and Minority Health webpage as a key strategy to increase awareness. As in previous years, this webpage provided access to the Section’s vision, mission, strategic framework, data, resources, and tools, as

Health Disparities Reduction and Minority Health Website
www.michigan.gov/minorityhealth

well as the *Michigan Health Equity Roadmap*. Several documents posted on the website were available in Spanish and Arabic. The HDRMHS included links to its requests for proposals, minority health month activities, and capacity building grantees, and the Michigan Health Equity Data Set and reports. Links to Michigan’s Minority Health Bill, Public Act 653, and the previous reports to the legislature were maintained on the website. The website also included a link to the *National Partnership for Action (NPA) to End Health Disparities*. NPA, an initiative of the U.S. Department of Health and Human Services, seeks “to mobilize a nationwide, comprehensive, community-driven, and sustained approach to combating health disparities and to move the nation toward achieving health equity.” This national website housed two key documents used to frame this Report, *National Stakeholder Strategy for Achieving Health Equity* and the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*.

In addition to this website, additional information on Michigan’s health equity priorities, including data, resources, and research, were featured on other bureau and program websites, including the Health Statistics and Reports webpage at <http://www.michigan.gov/mdch/0,1607,7-132-2944---,00.html>.

Health Equity Website

In 2012, the community health equity website sponsored by Capacity Building Grantees (CBG) was maintained. This website facilitated community engagement and discussion among grantees. This website can be accessed at www.healthequitymi.com.



Leadership

National Stakeholder Strategies: Leadership

Build the capacity to create community solutions, improve the coordination of funding, and set priorities. Invest in youth, preparing them to be future leaders.

Through its three leadership strategies, the National Stakeholder Strategy recognizes that leadership is a critical component of any effort to mobilize stakeholders, build capacity, create solutions, and coordinate action. Engaging current and nurturing new



leaders is essential in the effort to reduce health disparities and achieve health equity. Involving leaders from populations and communities served provides essential insights to identify the real problems and find the right solutions. However, often the organizations in which these leaders work lack the funding, infrastructure, and technical support required to effectively address health disparities.

Investing resources, including funding, in tools and capacity building is important for ensuring that community leaders are involved as full and equal partners. In 2012, MDCH invested federal and state resources to provide funding, tools, training, and technical assistance to build state and community capacity and leadership to address health disparities and achieve health equity.

Michigan Health Equity Roadmap

Recommendation 2: Strengthen the capacity of government and communities to develop and sustain effective partnerships and programs to improve racial/ethnic health inequities.

In 2012, the Health Disparities Reduction and Minority Health Section (HDRMHS) continued to lead MDCH efforts to achieve health equity and reduce health disparities; to ensure policies, programs and strategies were culturally and linguistically appropriate; and to collaborate with state, local and private partners to advance health promotion

and disease prevention strategies. The HDRMHS developed, promoted, and administered health promotion programs for communities of color, including African American, Hispanic/Latino, American Indian/Alaska Native, Asian American/Pacific Islander, and Arab and Chaldean American.

Health equity programs that have systems approaches and accountability are more likely to be effective and often involve strategic planning and goal setting. Reaching these goals requires diverse partnerships and consumer involvement. Developing capacity requires resources from several sources focused on strengthening infrastructure; cultivating and leveraging partnerships and relationships; and developing, implementing, and evaluating policies, programs, and services.

Several MDCH administrations and bureaus had a structured approach to impacting health equity in 2012. These systems level approaches supported and addressed many of the recommendations of the *Michigan Health Equity Roadmap*. Of the 27 MDCH administrations and bureaus responding to the 2012 survey, 20 (74%) addressed at least one of the priority recommendations of the Roadmap. Specific recommendations addressed by these 20 administrations and bureaus included the following:

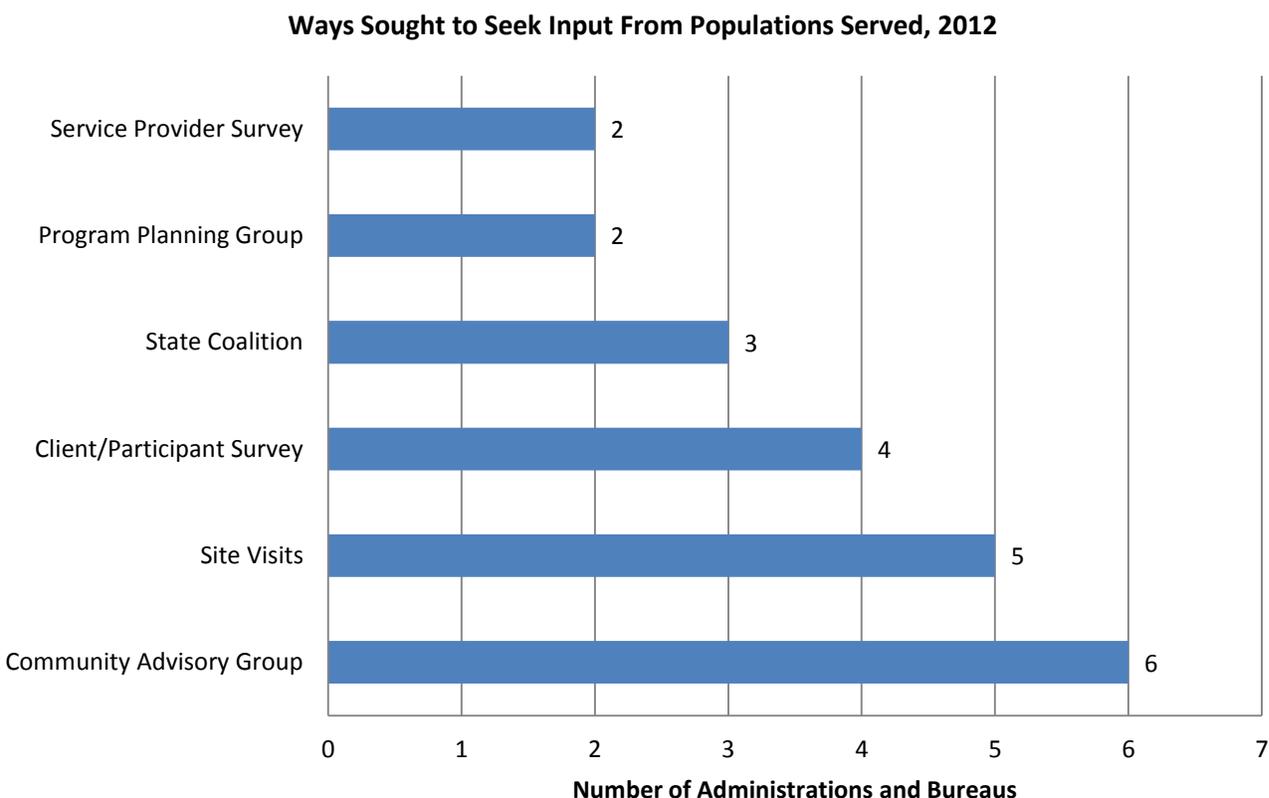
- Improve race and ethnicity data collection, systems, and access: 14 (70%).
- Strengthen government and community capacity to improve racial/ethnic health inequities: 13 (65%).
- Improve social determinants of health: 9 (45%).
- Ensure equitable access to quality health care: 14 (70%).
- Strengthen community capacity, engagement and empowerment: 14 (70%).

“Among the biggest impacts in Michigan in the last year has been the formal introduction of rigorous dialogue. This creates the foundation for collective listening, learning, working and accomplishing. MDCH HDRMHS has provided leadership for us to have productive dialogue, reason and strategically think together. This is the foundational work for all future collective accomplishments. We are really heading somewhere and the reason is the dialogue that is taking place across the state and connecting us all.”

Renée Branch Canady, PhD, MPA,
Health Officer, Ingham County Health
Department

In 2012, MDCH administrations and bureaus continued to seek input from the populations they intended to serve. Of the 27 respondents, 37 percent (10) noted they have mechanisms in place to solicit input and feedback. Common ways to seek input are noted in Figure 8.

Figure 8



The 10 respondents who noted they collected input used the information in many ways:

- 90% (9) enhanced program/service delivery or performance.
- 60% (6) developed or revised education materials.
- 30% (3) tailored technical assistance for service providers.
- 60% (6) identified barriers to participation.
- 30% (3) integrated into state or community strategic or program plans.

In 2012, MDCH programs and services continued to reach a broad array of populations. Of the 27 MDCH administrations and bureaus responding to the survey, 63 percent (17) provided data on the racial and ethnic minority populations they served. The data in Table 1 provide a snapshot of the population groups served in 2012.

Table 1

88% (15) served all racial and ethnic population groups	88% (15) served both females and males
○ African American	1,376,109 individuals served ¹
○ Hispanic/Latino	○ 48,349 African American
○ American Indian/Alaska Native	○ 49,591 Hispanic/Latino
○ Asian American/Pacific Islander	○ 1,214 American Indian/Alaska Native
○ Arab and Chaldean American	○ 3,680 Asian American/Pacific Islander
	○ 1,202 Arab and Chaldean American
82% (14) served all age groups	○ 1,272,073 Race/Ethnicity not specified or other

Recommendation 2a: HDRMHS will review and revise its funding priorities in an effort to strengthen the capacity of state and local agencies to implement evidence-based programs to improve health equity for racial and ethnic minority communities.

In 2012, the HDRMHS continued to fund agencies to build capacity through Phase II of the Capacity Building Grants (CBG) program. Year two funding ranged from \$30,000 to \$55,000 per project. The six funded projects addressed one or more of three focus areas: 1) improvement of minority health data collection and accessibility, 2) curricula or training to improve health equity, and 3) implementation of programs and activities to address social determinants of health.

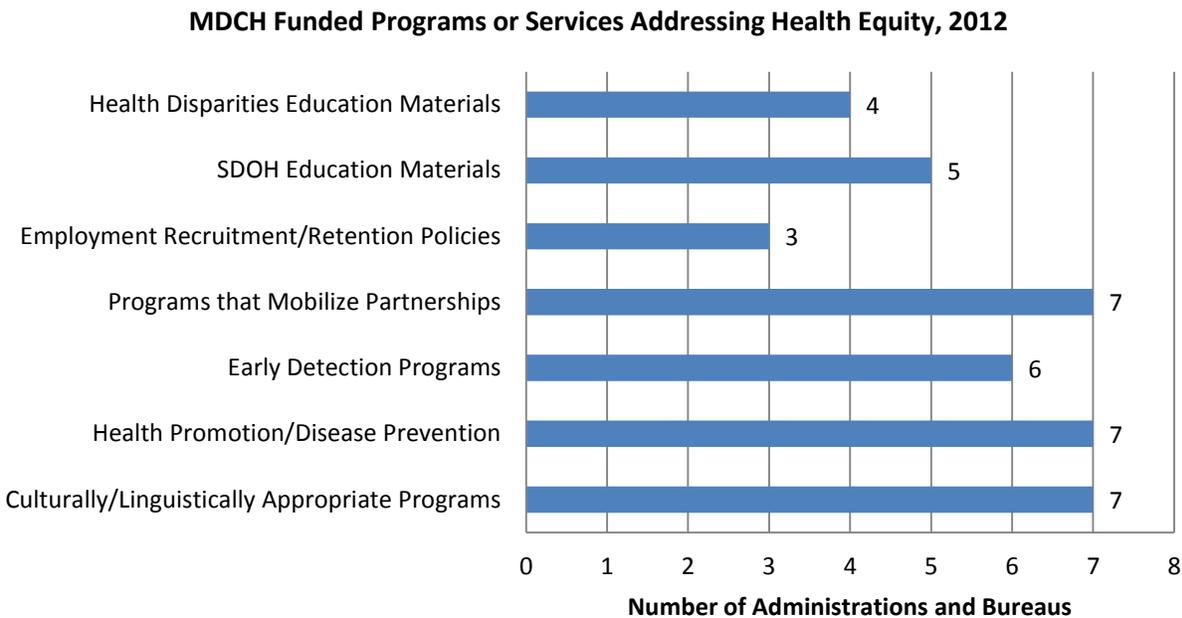
In addition to HDRMHS funding, some MDCH administrations and bureaus dedicated funding to address health equity, health disparities, or social determinants of health. The 2012 survey responses revealed that 30 percent (8) of the administrations and bureaus received or redirected existing funding to improve health equity for racial and ethnic minority populations. Among these 8 administrations and bureaus, funding sources were federal, 88 percent; state, 50 percent; and foundation, 25 percent.

Funding did not necessarily remain level from 2011. Of the 8 administrations and bureaus that *received or redirected* funding, 1 (13%) noted they had less state funding and 4 (50%) noted less federal funding in 2012 as compared to 2011.

Of the 27 respondents, 8 reported they *funded programs, services or activities* to address health equity. The respondents noted using funding as identified in Figure 9.

¹ These data may count the same individual more than once, as individuals may have received more than one service. It is not possible to provide the number of unique individuals who received services through all MDCH administrations and bureaus.

Figure 9



In 2012, two of the 27 responding administrations and bureaus reduced programs or services focused on addressing health equity. Reductions were attributed to changing funder priorities, reduced funding, fewer staff, and challenges with community organization response to a request for proposal.

Recommendation 2b: Cultivate and mobilize partnerships with government agencies, non-profits, community-based organizations, businesses, and healthcare to address root causes of health inequities in racial and ethnic minority communities.

The HDRMHS continued its efforts to build local capacity and mobilize partnerships with various community organizations and sectors. In observance of Minority Health Month, the HDRMHS issued a request for proposal *Exploring Solutions to Violence, Obesity and HIV/AIDS/STDs Among Minority Youth*. A total of 12 local public health departments and community organizations were funded to develop youth driven media projects. Grantee organizations represented or partnered with a youth serving organization, school or community agency. All project activities were led by youth and resulted in a completed media project. The completed projects included YouTube videos, spoken word, songs and short films that explored social and community factors and potential solutions to violence, HIV/AIDS/STDs and obesity from the perspective of minority youth.

Michigan Health Equity Roadmap

Recommendation 5: Strengthen community engagement, capacity, and empowerment.

Engaging and involving community members in determining the best approaches, including ways to draw upon existing strengths, is an effective strategy for achieving health equity. Keys to strengthening community capacity and empowerment are sufficient resources, infrastructures, relationships, and operations that allow for creating and sustaining necessary changes.

Recommendation 5.1: Establish a state-level health equity advisory group that includes consumers, public and private stakeholders, and policymakers in the development of health equity initiatives.

In 2012, the HDRMHS continued to support its Statewide Health Equity External Advisory Group (EAG). Established in 2011, this group provided guidance and expertise to the HDRMHS in identifying priorities, data needs, strategic initiatives and best practices to achieve health equity. The EAG membership was a diverse group of individuals representing multiple organizations throughout the state (Attachment C). In 2012, the HDRMHS manager conducted one to one meetings with each EAG member to identify priorities for statewide health disparities reduction and health equity activities. The recommended priority activities included:

- **Increase** availability of health disparities data; work with local health departments to provide/obtain local data; disseminate health and social determinants related data; develop “equity fact sheets”.
- **Focus** on addressing language and cultural barriers; emphasize cultural and linguistic appropriate services (CLAS) training.
- **Develop** authentic, ongoing relationships with tribal organizations.
- **Collaborate/Partner** with agencies on events that target the populations served by the HDRMHS; faith-based community as collaborators.
- **Outreach** to those who do not share our interests or points of view; more focus on framing health equity messages; use it as an opportunity to educate leaders.
- **Increase** visibility; develop HDRMHS brochure; engage health systems; better marketing of the MDCH health equity data methodology.
- **Increase** funding to organizations and of the HDRMHS; identify collaboration opportunities, i.e., other organizations engaged in similar work.
- **Address** barriers to health care access.

- **Provide** technical assistance and training resources to local organizations such as cultural competency, CLAS standards, community assessment, health equity-based program development/implementation/evaluation, etc.
- **Expand** the External Advisory Group; include EAG members in strategic planning.

In addition to the EAG, the HDRMHS continued to coordinate an intra-departmental Health Equity Steering Committee. As in previous years, members represented a cross-section of MDCH administrations and bureaus (Attachment D). In 2012, among the accomplishments of the Health Equity Steering Committee was an internal pilot to document equity-focused successes and challenges among department programs; disseminate best practices; and consider how to address the challenges. A detailed description of this pilot is noted in the following Spotlight.

Spotlight

Ambassadors Extending MDCH Best Practices

The MDCH *Health Equity Steering Committee* initiated an internal pilot project in 2012 to identify and recognize efforts throughout the Department aimed at advancing health equity. The goals were to document equity-focused successes and challenges among department programs; disseminate best practices; and address challenges. The *Ambassador Subcommittee* of the Health Equity Steering Committee led the pilot that identified several common themes and promising practices. Among the exemplary practices captured in the three pilot interviews conducted with MDCH sections/units were:

- ✓ **Requiring** inclusion of target population in program decision-making at the state and local level.
- ✓ **Including** questions in interview processes that focus on understanding of and experience with health equity and health disparities.
- ✓ **Using** data to target communities with greatest needs for funding opportunity eligibility.
- ✓ **Expanding** data collection among disproportionately impacted populations.
- ✓ **Implementing** program innovations “of value” to populations with health disparities.

These practices and other national examples will be formatted as “success stories” and disseminated throughout MDCH so they may be replicated.

On-going challenges identified by pilot sites related to recruiting diverse applicant pools and assessing knowledge about and sensitivity to health equity during employment screening and interviews. Other struggles related to funding entities that effectively served the communities that experience disproportionate levels of negative health outcomes.

The Ambassador Subcommittee deduced, based on post assessment surveys, that the pilot sites and Subcommittee alike benefited from the process. Amy Peterson, Ambassador Subcommittee member and STD Program Specialist, Division of Health, Wellness and Disease Control, STD Section, indicated that *“there are numerous lessons to be learned and shared across MDCH regarding how to incorporate the principles of health equity into our daily work.*

Extending this process will facilitate that learning.” Assessments with other MDCH Sections/Units will take place in 2013. Lessons learned from the pilot will be shared with others in MDCH to extend productive practices and present practical solutions to challenges identified.

Recommendation 5.2: Increase funding, training, and collaboration to enhance the granting and service capacity of existing coalitions and organizations with positive track records of mobilizing community members.

Of the 27 administrations and bureaus responding to the survey, 10 indicated they worked with local or community organizations:

- 60% (6) assisted with capacity development.
- 80% (8) helped mobilize partnerships.
- 80% (8) provided technical assistance on program design and implementation.
- 40% (4) developed evidence-based interventions.
- 90% (9) provided data or analyzed data.
- 50% (5) provided program/service funding.
- 40% (4) provided training on cultural competency and related topics.

Recommendation 5.3: Support and expand local programs and partnerships that are community-driven and innovative.

Of the 27 MDCH administrations and bureaus that responded to the survey, ten noted they worked with local health departments, minority health coalitions, or community organizations to support their work in health equity, health disparities, and social determinants of health. (See recommendation 5.2 for additional information.)

Health System and Life Experience

National Stakeholder Strategies: Health System and Life Experience

Improve access to quality care, including: children’s services for mental health, oral health, vision, hearing, nutrition, and physical activity; and services for older adults. Address social determinants of health through work on issues such as improved high school graduation rates and policies intended to create social, physical, and economic environments in which children can succeed.

Health disparities, including healthcare disparities, are influenced by complex, inter-related factors including health systems factors; social, economic, and physical environments; and individual characteristics and behaviors. Health system factors

include lack of cross-cultural education, absence of policies and infrastructure to address diverse client needs, poor patient-provider communication, inadequate provision of culturally relevant care, and lack of trust of and access to healthcare organizations and providers. Social, economic, and environmental factors include lack of availability of nutritious food, transportation, affordable housing, safe living conditions, quality air and water; inaccessibility of education and poor job opportunities; and stress caused by perceived racial discrimination. Individual factors include lack of health-related knowledge or low health literacy, lack of understanding of patient rights and responsibilities, and lack of participation in personal care. The six health system and life experience strategies in the National Stakeholder Strategy reflect that these factors affect individuals across the lifespan and require multi-factorial solutions, coordination across sectors, and supportive policies. MDCH and its partners have begun to work together to address inter-related factors that impact health equity in Michigan.

Michigan Health Equity Roadmap

Recommendation 3: Improve social determinants of racial/ethnic health inequities through public education and evidence-based community interventions.

As described above, many systemic, environmental, and individual factors contribute to the overall health of individuals and communities. Among these, social determinants of health play a pervasive and significant role in influencing health disparities and outcomes. Therefore, in order to effectively reduce health inequities, it is necessary to raise awareness of and address the social determinants of health, which include the following factors:

- *Social*: political influence, social connectedness, racial/ethnic discrimination.
- *Economic*: income, education, employment, wealth.
- *Environmental*: living and working conditions, transportation, and air and water quality.

Recommendation 3a: Develop materials to educate public health professionals, policymakers, community health workers, and healthcare providers about the social determinants of health and about racial and ethnic health equity.

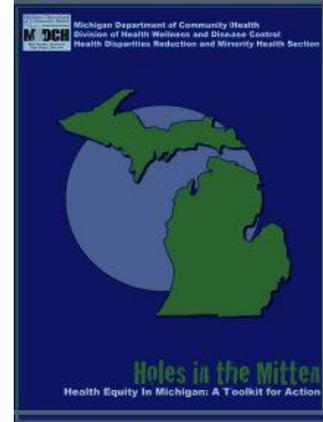
In 2012, the HDRMHS finalized *Health Equity in Michigan: A Toolkit for Action*. This toolkit was developed to raise awareness about the social and environmental factors that play a role in the health outcomes of racial and ethnic minority populations in Michigan. The toolkit is described in the following Spotlight.

Spotlight

Inciting Community Action Focused on Health Equity

“What started as the production of a video exploring root causes of health disparities in Michigan has blossomed into a toolkit to inform and incite action in communities across the state,” shared Holly Nickel, Health Equity Coordinator and Toolkit Team lead in the Health Disparities Reduction and Minority Health Section (HDRMHS). *“We hope the toolkit sparks action through information, guidance, and confidence so every Michigan community becomes a place that supports optimal health for all residents,”* Holly continued.

Health Equity in Michigan: A Toolkit for Action focuses on the social, economic, and environmental health factors and their influence on community health. Among the topics explored in the video and toolkit are root causes of racial and ethnic health disparities, including education inequities, limited access to quality healthcare, and nutritious foods. The impact of chronic stress and discrimination on disease occurrences and the overall well-being of communities is also explored. The toolkit offers guided discussion questions, fact sheets, a customizable PowerPoint presentation, and suggested group activities designed to increase community-member discussion around the topics of health equity and the multiple determinants of health.



A series of regional unveiling events will be held in 2013 in Detroit, Ann Arbor, Lansing, and Grand Rapids. The public events will be hosted in partnership with local health departments and community-based organizations. If you would like information on how to obtain a toolkit, email colormehealthy@michigan.gov.

In addition, MDCH administrations and bureaus continued to work on social determinants of health in a variety of ways. Of those responding to the survey:

- 15% (4) used social determinants of health related data sources.
- 19% (5) used funding for educational materials focused on social determinants of health.
- 26% (7) funded programs that mobilized partnerships to address social determinants of health among racial and ethnic minority populations.

Of the 10 administrations and bureaus that worked with local public health, minority health coalitions, or community organizations, 80 percent (8) supported community-based efforts to help mobilize partnerships to address social determinants of health.

Cultural and Linguistic Competency

National Stakeholder Strategies: Cultural and Linguistic Competency

Improve diversity in the workforce, increasing opportunities to recruit minorities into the health professions. Also, improve cultural competency by supporting better interpreting and translation services and training more community health workers to serve as liaisons between patients and clinicians.

Cultural and linguistic competency is based on the premise that clear and understandable communication and the ability to relate to the patient from a cultural perspective are necessary in the delivery of quality health care. This requires communication in a language that the patient understands as well as knowledge and accommodation of cultural factors. Providers who share the same culture or speak the same language as those they serve, or who have appropriate training in cultural and linguistic competency can be particularly effective in providing services. The National Stakeholder Strategy encourages recruitment and retention of racial and ethnic minorities into healthcare and related fields, which serves as one important strategy for fostering cultural and linguistic competency. Recruitment of community health workers can also help to facilitate effective communication and mutual understanding. In addition, the National Standards on Culturally and Linguistically Appropriate Services (CLAS) focus on the need for healthcare organizations to provide and assure competent language assistance services, inform patients of their rights to those services, and make available linguistically appropriate patient related materials and signage. MDCH and its partners have focused their efforts in this area through training to provide culturally competent care, language access services, and organizational supports.



Recommendation 3b: Develop and implement a social justice, anti-racism, and cultural competence curriculum for implementation with MDCH staff.

Promoting Equity through Cultural Understanding

In January 2012, the Health Disparities Reduction and Minority Health Section in collaboration with the MDCH Diversity Workgroup and the Health Equity Steering Committee hosted the 10th annual MDCH Dr. Martin Luther King Jr. commemoration. Over 90 MDCH employees attended the event which

featured welcoming remarks by then Director Olga Dazzo. Dr. Gottfried Oosterwal who

holds advanced degrees in medical anthropology, philosophy, economics, religious studies and international health, served as the keynote speaker. Dr. Oosterwal shared his insights regarding the critical importance of understanding how culture shapes the health and health care experience for both consumers and for healthcare providers. The focus of his message was that, “Racial and ethnic health equity cannot be achieved without cultural understanding.”

Collectively, MDCH administrations and bureaus offered 11 trainings or other continuing education sessions for MDCH staff. Eight (73%) of these trainings focused on health equity and 2 (18%) focused on the social determinants of health. Survey respondents reported training that collectively reached 172 participants.² Some MDCH staff also participated in external events noted elsewhere in this Report.

Of the 27 MDCH administrations and bureaus responding to the survey, 56 percent (15) expressed an interest in providing or sponsoring health equity staff training in 2013.

Michigan Health Equity Roadmap

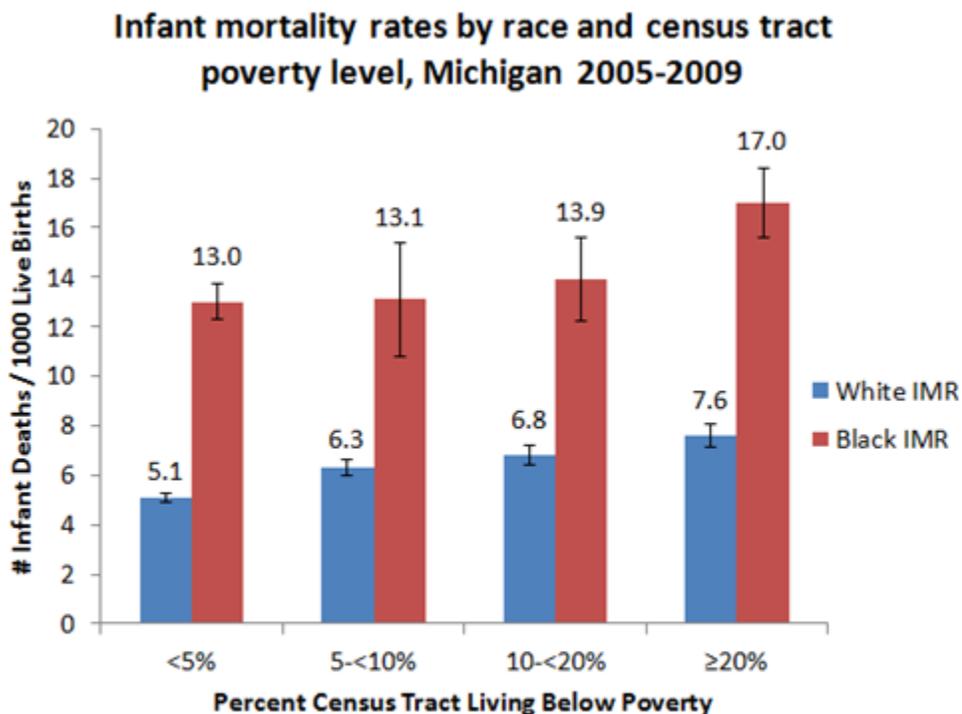
Recommendation 4: Ensure equitable access to quality health care.

Health disparities experienced by racial and ethnic minority populations are widespread in the healthcare system. In order to achieve health equity, efforts must be made to increase access to affordable health care, as well as assuring the health care provided is high quality and culturally acceptable. Figure 10 illustrates Michigan data related to infant mortality inequities, and Figure 11 demonstrates infant mortality inequities associated with access to health care.



² Individuals participating in more than one continuing education/training event would be counted more than once. It was not possible to provide a total number of unique individuals receiving continuing education through all MDCH administrations and bureaus.

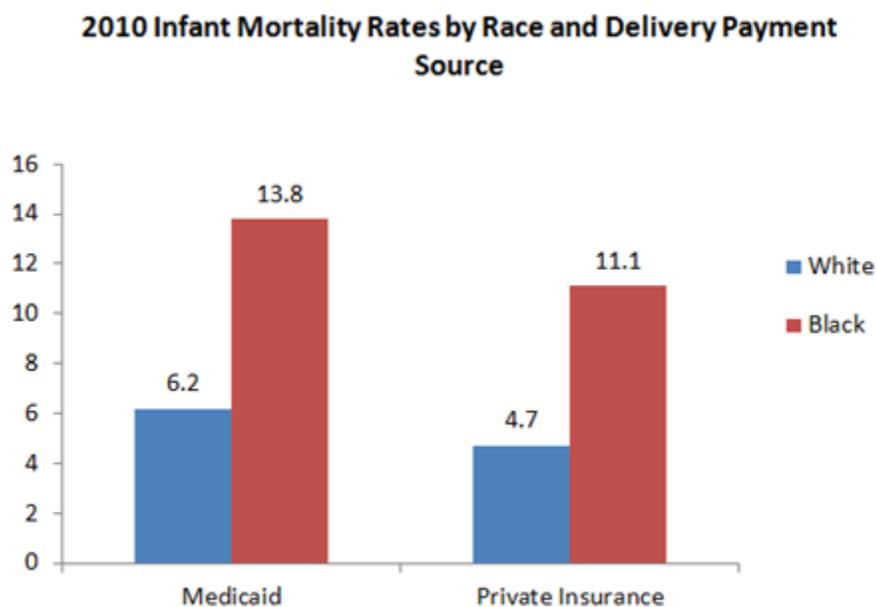
Figure 10



Source: Glenn Radford, 2005-2009 Michigan Resident Birth and Death Files, Division for Vital Records & Health Statistics, MDCH

Figure 10 shows infant mortality rates for White and Black infants in Michigan, 2005-2009 data combined. In addition to showing different infant mortality rates by race, this figure also shows infant mortality rates by census tract poverty level. The left-most bars represent infant deaths in census tracts where less than 5 percent of the population was living below the poverty level (highest SES). The right-most bars represent infant deaths in census tracts where 20 percent or more of the population was living below the poverty level (lowest SES). This figure shows two important things: 1) For both Black and White infants, infants are more likely to die if they live in a census tract with higher levels of poverty than if they live in a census tract with lower levels of poverty. 2) Regardless of poverty level, a Black infant is at least twice as likely to die as a White infant. Most sobering, the infant mortality rate for Black infants in the highest income census tracts is 13.0, nearly twice as large as the infant mortality rate for White infants living in the lowest income census tracts (7.6). Poverty and income are important determinants of health, but do not alone explain the enormous disparities in Black and White infant mortality rates. Race remains an important independent predictor of survival.

Figure 11



Source: 2010 Michigan Resident Birth and Death Files, Division for Vital Records & Health Statistics, MDCH

Figure 11 shows infant mortality rates for White and Black infants in Michigan in 2010. In addition to showing different infant mortality rates by race, this figure also shows infant mortality rates by type of healthcare coverage (Medicaid or private insurance). The bars on the left show mortality rates for infants whose birth was paid for by Medicaid, and the bars on the right show mortality rates for infants whose birth was paid for by private insurance. Similar to the previous figure, this figure shows two important things: 1) For both Black and White infants, mortality rates are slightly higher for infants whose birth was paid for by Medicaid, showing that SES is an important determinant of survival. 2) For both Medicaid and private insurance births, Black infants had much higher mortality rates than White infants. Black infants whose births were covered by private insurance were still nearly twice as likely to die as White infants whose birth was covered by Medicaid. Healthcare coverage does not explain the disparity in infant mortality rates. A dedicated focus on the role of race in determining survival is required to reduce the disparities in infant mortality rates.

In 2012, MDCH initiated the *Partnership to Eliminate Disparities in Infant Mortality Action Learning Collaborative (PEDIM-ALC)*, a statewide collaborative of seven Healthy Start projects, MDCH, local health departments and coalitions. The following Spotlight highlights this exemplary effort to ensure equitable access to quality health care, specifically in relationship to reducing infant mortality.

Spotlight

Taking on Racism To Reduce Infant Mortality

2012 marked significant collaborative efforts to reduce infant mortality disparities and associated negative impacts of racism on maternal and child health. Driving this focus were 2000-2010 data documenting Black, Latino and Native American babies dying at two to three times the rate of White infants. Further, focus groups and community conversations among several hundred women across the state in 2005 and 2006 captured extensive experiences of racism related to pregnancy and birth.

“The prevalence of reports of racism from focus group participants and the persistent data on disparities in birth outcomes, made it very clear that to eliminate health disparities we must address the inter-related root causes of racism and poverty.” expressed Peggy VanderMeulen, Director Strong Beginnings (federal Healthy Start) and PEDIM-ALC Co-Lead. *“We recognized it was time we started placing as much emphasis on ‘social responsibility’ as we have on ‘personal responsibility’.”* To that end, Michigan applied for and was among five awardees of an 18-month technical assistance grant from the W.K. Kellogg Foundation to support efforts to dismantle racism and eliminate health disparities.



The *Partnership to Eliminate Disparities in Infant Mortality Action Learning Collaborative (PEDIM-ALC)* is a project funded by the Association of Maternal and Child Health Programs, CityMatCH and the National Healthy Start Association. The PEDIM-ALC includes seven Healthy Start* projects, MDCH, local health departments and coalitions. PEDIM-ALC primary strategies focused on:

- Trainings that address racism, health equity, and social justice.
- Provision of tools and resources to undo existing practices and policies that maintain racism and do not promote health equity.
- Improvement in health system data collection related to race and ethnicity.

Outcomes to date included:

- 25 trained facilitators and over 1,000 participants in workshops addressing racism, health equity, and social justice. Evaluation results show significant changes in knowledge and attitudes among participants.
- 500 toolkits distributed to health systems, healthcare providers and communities.
- Initiation of a statewide consortium to improve reporting of race.
- Development of a survey to collect information from Native Americans related to multiple determinants of health and experiences in accessing health care.
- Creation of a new position at the Department of Human Services to oversee racial issues.
- Alignment of efforts and sharing of lessons learned to broaden health equity work across several infant mortality projects.

*Healthy Start projects are focused on improving birth outcomes and family well-being through direct services and systems-level work. They are community-driven efforts located in the poorest communities in the country.

Recommendation 4a: Adopt and enforce Department-wide standards for culturally and linguistically competent (CLAS) services.

A variety of MDCH efforts continued that will inform the future process(es) to develop the department-wide standards for CLAS services. In 2012, a CLAS Workgroup, convened by the MDCH Division of Health, Wellness and Disease Control:

- Expanded the CLAS workgroup to include Training Unit staff with curriculum development and training expertise.
- Identified a curriculum, 'Providing Quality Health Care with CLAS,' into which the HIV/sexual minority specific cultural competency curriculum can be integrated.
- Worked with *Providing Quality Health Care with CLAS* curriculum developers to conduct a webinar for CLAS workgroup members.

Cultural competent care: recruitment of diverse staff; staff ongoing education and training.

In 2012, MDCH administrations and bureaus conducted a variety of activities that helped to increase culturally competent care. These included the following:

- Of the 8 survey respondents that offered programs, services or activities, 38 percent reported employment policies to enhance minority employee recruitment and retention.
- Administrations and bureaus responding to the survey collectively held 23 education sessions focused on **health equity** reaching 1,714 state and local public health professionals, healthcare providers, and community-based organizations.
 - 8 sessions were offered to MDCH staff, with respondents reporting 112 participants.
 - 15 sessions were offered to MDCH and other state staff as well as local public health department employees, other public health and healthcare professionals, community-based organizations, and the general public, with 1,602 participants.
- Survey respondents reported 9 workshops offered on the **social determinants of health** with 439 participants.
 - 2 sessions were held for MDCH staff, with 60 participants.
 - 7 sessions were offered to state employees plus local public health department staff, other public health and healthcare professionals,

community-based organizations, and the general public, with 379 participants.

- Survey respondents reported 3 workshops offered on **cultural competency and cultural sensitivity**, reaching 155 people. Participants included MDCH and other state employees, local health department and other public health professionals, healthcare providers and community-based organizations.
- Survey respondents reported 1 workshop offered that focused on **racism**, with 125 participants, including MDCH and other state employees, local public health department staff, healthcare providers, and community-based organizations.

Language access services: language assistance services; verbal and written notices and offers in patient/consumer preferred language; easily understood patient-related materials and signs.

Three HDRMHS-funded Phase II Community-Based Grantees (CBG) implemented plans for their 2012 projects that focused on addressing language barriers to accessing health care.

- Washtenaw County Public Health Department translated Ann Arbor Transit Authority materials into Spanish to facilitate use by Spanish speakers.
- Muskegon Community Health Project Oceania translated healthcare materials in Spanish for use in Muskegon and Oceania counties.
- The Asian Center – Southeast Michigan translated materials for and addressed health literacy for non- or limited-English speaking Asian Americans.

Organizational supports: data on the individual patient's/consumer's race, ethnicity and spoken and written language are collected in health records and integrated into organization's management information systems; maintain a current demographic, cultural and epidemiological profile of the community.

Several HDRMHS-funded Phase II CBG implemented projects in 2012 to increase collection and use of individual and community data on race, ethnicity, preferred language, and other demographic, cultural and epidemiological data.

- The Asian Center – Southeast Michigan: Analyzed data from Phase I to understand Asian Americans' health and healthcare matters; and developed detailed sub-group specific profiles of social determinants and health for Chinese, Filipino, Korean, Vietnamese, and Indian communities.
- Berrien County Health Department: Developed BRFSS questions in order to collect new health disparity data on race and social context.
- Grand Rapids African American Health Institute: Conducted health equity data mapping to assess community needs and assets and to plan interventions.

- Muskegon Community Health Project: Improved the collection of race, ethnicity and preferred language and other healthcare information, especially involving patient experience and barriers to access.
- Washtenaw County Public Health: Developed a community-level health equity data set used to develop a Health Equity Report Card to increase knowledge/awareness of health disparities and to influence resource allocation decisions.

In addition to these efforts, 8 of the 27 MDCH administrations and bureaus indicated they provided programs, services or activities designed to achieve health equity, address health disparities, or impact social determinants of health. Several of these are related to the CLAS standards. Of the 8 that provided programs, services or activities:

- 75% (6) provided programs or interventions that assured or provided access to early detection services.
- 88% (7) provided programs or interventions that included health promotion and disease prevention strategies.
- 88% (7) provided programs or services that were culturally/linguistically appropriate.

Accomplishments and Conclusion

In 2012, the Michigan Department of Community Health (MDCH) served 1,376,109 people from targeted racial and ethnic minority groups through a variety of programs and services. In addition to building upon and continuing its work to address racial and ethnic health disparities, the MDCH Health Disparities Reduction and Minority Health Section (HDRMHS) made significant accomplishments towards supporting activities that focus on health equity as the long term outcome. Among the accomplishments responsible for the progress were:

- Continued implementation of the *Michigan Health Equity Roadmap* and alignment with the National Stakeholder Strategy goals.
- Maintenance of a health equity data set.
- Expanded training on social determinants of health and other health equity topics.
- Continued funding of community capacity building grants (CBG).
- Implementation of the *MDCH Health Equity Ambassadors* pilot.

In addition, the following activities from the 2011 Health Equity Report in the *2011 Minority Health Related Activities and Timeline Section* were completed.

- ✓ Behavioral Risk Factor Surveillance Survey Oversample (Hispanic/Latino and Asian American).
- ✓ HDRMHS Phase II Capacity Building Grants.

- ✓ HDRMHS Phase II Capacity Building Grant Evaluation.
- ✓ Health Equity and Cultural Competency Training (MDCH staff, HDRMHS Grantees).
- ✓ Health Equity Toolkit/Video Series Finalized.
- ✓ Minority Health Month Mini-Grant Activities Conducted.
- ✓ Health Equity Fact Sheets Produced and Online.

In 2012, MDCH experienced both challenges and opportunities related to its work to eliminate racial and ethnic health disparities. The alignment of the Michigan Public Act 653, the *Michigan Health Equity Roadmap*, and the National Stakeholder Strategy goals provided a consistent focus for meeting the opportunities to improve racial and ethnic health equity in Michigan. On the other hand, MDCH HDRMHS experienced reduced funding for these activities. This funding reduction challenged MDCH to identify fundamentally different ways to approach its work and assure health equity for all Michigan citizens. Some of the new efforts included the Public Health Administration Quality Improvement Project and the Health Equity Ambassador pilot to identify MDCH health equity best practices. Both of these were spotlighted in this Report.

In 2012, the CBGs focus on partnership and collaboration successfully resulted in broadened community engagement and an increase in leveraged resources. Each of the six funded programs reported significant impact. Among the reported outcomes were:

- Improved systems for on-going data collection for race, ethnicity and preferred language.
- The establishment of mechanisms for on-going community education and training on social determinants of health, health and safety issues.
- Engagement of community members in community gardening, nutrition and healthy eating initiatives and volunteer, community patrols with documented decreases in crime incidents.
- The expanded dissemination of health disparity and equity data through reports and web pages.

Further, the use of learning collaboratives provided a vehicle through which to explore and apply best practices across divisions and bureaus and with local public health and community-based organizations. Sharing best practices and lessons learned with others across the country has added to our “toolkit” of effective health equity approaches that can be shared with MDCH staff and others across the state.

As we look ahead to 2013, the following efforts are planned to address health equity in Michigan.

2013 Minority Health Related Activities and Timeline

Behavioral Risk Factor Surveillance Survey Oversample Analysis and Report (Hispanic/Latino and Asian American)	April – August 2013
Behavioral Risk Factor Surveillance Survey Oversample (Arab/Chaldean American)	March – December 2013
HDRMHS Phase III Capacity Building Grants	January 2013 – October 2013
HDRMHS Phase II Capacity Building Grant Evaluation	January 2013 – December 2013
Health Equity and Cultural Competency Training (MDCH staff, HDRMHS Grantees)	January 2013 – December 2013
Health Equity Toolkit/Video Series Distribution	January 2013 – December 2013
Minority Health Month Mini-Grant Activities	April 2013
Health Equity Factsheets Produced and Online	Ongoing
Health Equity Steering Committee – Ambassador Pilot	January 2013 – December 2013
Race, Ethnicity, Gender, Primary Language and Disability Status data project	January 2013 – December 2013

We thank all MDCH staff who took the time to complete the survey and the following individuals for their time and support in developing the Spotlights and offering perspectives on Michigan health equity issues.

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Program Director
Strong Beginnings

Attachment A: Cross-walk between Michigan Health Equity Roadmap Recommendations and Michigan Public Act 653 Requirements and National Stakeholder Strategy

Roadmap Recommendation	PA653 Requirement	HHS National Stakeholder Strategy
<p>1. IMPROVE Race/Ethnicity data collection, data systems, and data accessibility</p>	<ul style="list-style-type: none"> • Monitor health progress • Establish a web page on the department’s website 	<p>DATA, RESEARCH, and EVALUATION Improve data availability and coordination, utilization and diffusion of research and evaluation outcomes.</p>
<p>2. STRENGTHEN the capacity of government and communities to develop and sustain effective partnerships and programs to improve racial/ethnic health inequities</p>	<ul style="list-style-type: none"> • Develop structure to address health disparities • Establish minority health policy • Develop and implement an effective statewide strategic plan • Develop and implement awareness strategies targeted at health and social service providers • Utilize resources to fund minority health programs AND provide funding to support evidence-based programs • Identify and assist in the implementation of culturally and linguistically appropriate programs (non-health care) 	<p>LEADERSHIP Strengthen and broaden leadership for addressing health disparities at all levels.</p>
<p>3. IMPROVE social determinants of racial/ethnic health inequities through public education and evidence-based community interventions.</p>	<ul style="list-style-type: none"> • Develop structure to address health disparities • Develop and implement awareness strategies targeted at health and social service providers • Identify and assist in the implementation of culturally and linguistically appropriate programs (non-health care) 	<p>AWARENESS Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes or racial, ethnic and underserved populations.</p>

<p>4. ENSURE equitable access to quality health care</p>	<ul style="list-style-type: none"> • Identify and assist in the implementation of culturally and linguistically appropriate programs (focused on health care) • Develop and implement recruitment and retention strategies 	<p>HEALTH SYSTEM AND LIFE EXPERIENCE Improve health and healthcare outcomes for racial, ethnic, and underserved populations.</p>
<p>5. STRENGTHEN community engagement, capacity, and empowerment</p>	<ul style="list-style-type: none"> • Establish a web page on the department's website • Utilize resources to fund minority health programs AND provide funding to support evidence-based programs [specific to coalitions] • Provide the following through interdepartmental coordination: data and technical assistance and measurable objectives to minority health coalitions and other local health entities AND provide technical assistance to local communities • Promote the development and networking of minority health coalitions • Appoint a department liaison to provide services to local minority health coalitions 	<p>CULTURAL AND LINGUISTIC COMPETENCY Improve cultural and linguistic competency and the diversity of the health-related workforce.</p>

Attachment B: 2012 Health Equity Survey Respondents by Administration

Bureau	Division
OFFICE OF THE DIRECTOR	
Health Information Technology*	
Policy and Planning*	
	Office of Nurse Policy
Office of Recipient Rights*	
Michigan Developmental Disabilities Council*	
Bureau of Legal and Policy Affairs*	
	Crime Victims and EMS
	Office of Legal Affairs and FOIA
MEDICAL SERVICES ADMINISTRATION	
Bureau of Medicaid Policy and Health Systems Innovation*	
	Program Policy
Bureau of Medicaid Financial Management & Administrative Services*	
	Third Party Liability
	Hospital and Clinic Reimbursement
Bureau of Medicaid Program Operations and Quality Assurance*	
	Managed Care Plan
Health Care Reform*	
Office of Medicaid Health Information Technology*	
OPERATIONS ADMINISTRATION	
Bureau of Budget and Purchasing*	
	Budget
Accounting Division*	
Medicaid, Mental Health and MAIN Support Division*	
PUBLIC HEALTH ADMINISTRATION	
Bureau of Local Health and Administrative Services*	
	Vital Records and Health Statistics
Bureau of Family, Maternal and Child Health*	
	Family and Community Health
	Children's Special Health Care Services
Bureau of Disease Control, Prevention and Epidemiology*	
Bureau of Laboratories*	
	Quality Assurance
Division of Health, Wellness and Disease Control*	
Division of Chronic Disease and Injury Control *	
Office of Public Health Preparedness*	

Bureau	Division
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION	
Bureau of Hospital, Center and Forensic Mental Health Services*	
HUMAN RESOURCES*	
	Human Resources
OFFICE OF HEALTH SERVICES INSPECTOR GENERAL*	

*The asterisk indicates that this was the "Bureau-level" categorization used for data analysis

**Attachment C: MDCH, Health Disparities Reduction and Minority Health Section,
External Advisory Group**

Tom Costello
Michigan Roundtable

Monty Fakhouri
Beaumont Hospitals

Dr. Arthur Franke
National Kidney Foundation of Michigan

Dr. Herbert Smitherman, Jr.
Detroit Medical Center/Wayne State University

L. John Lufkins
Inter-Tribal Council of Michigan

Ruben Martinez
Michigan State University – Julian Samora Research Institute

Dr. Khan Nedd
Grand Rapids African American Health Institute

Dr. Othelia Pryor
Michigan Minority Health Coalition

Debra Riddick, JD, RN
School-Community Health Alliance of Michigan

Karen Schrock
Adult Well Being Services

Shenlin-Chen
Association of Chinese Americans

Pam Smith
Urban Regeneration, LLC

HDRMHS Staff
Sheryl Weir, HDRMHS Manager

Jacquetta Hinton
Program Coordinator

Attachment D: 2012 MDCH Health Equity Steering Committee

Name	Bureau	Division/Section/Unit
Alethia Carr	Family, Maternal & Child Health	
Amna Osman		Health, Wellness & Disease Control
Amy Peterson		Health, Wellness & Disease Control
Anne Esdale		Chronic Disease & Injury Control Diabetes & Kidney Unit
Ann Garvin		Chronic Disease & Injury Control Breast/Cervical Cancer Control
Brenda Fink	Family, Maternal and Child Health	Family and Community Health
Brenda Jegede	Family, Maternal and Child Health	
Carol Callaghan		Chronic Disease & Injury Control
Debra Duquette	Disease Control, Prevention and Epidemiology	
Emily Moreno	Laboratories	Chemistry and Toxicology Analytical Chemistry
Fawzia Ahmed	Local Health and Administrative Services	Division for Vital Records and Health Statistics Vital Records and Health Data Services Section/Health Data Analysis Services Unit
Frances Pouch Downes	Laboratories	
Holly Nickel		Health, Wellness & Disease Control Health Disparities Reduction and Minority Health Section
Jacquetta Hinton		Health, Wellness & Disease Control Health Disparities Reduction and Minority Health
Janet Kiley		Chronic Disease & Injury Control Tobacco Prevention & Control
Jean Chabut	Public Health Administration	
John Dowling		Chronic Disease & Injury Control Diabetes & Other Chronic Diseases
Judi Lyles		Chronic Disease & Injury Control Diabetes & Other Chronic Diseases
Karen MacMaster	Disease Control, Prevention and Epidemiology	

Name	Bureau	Division/Section/Unit
Kari Tapley	Disease Control, Prevention and Epidemiology	
Karla McCandless	Family, Maternal and Child Health	
Kathleen Stiffler	Medicaid Program Operations and Quality Assurance	
Kathryn Macomber	Disease Control, Prevention and Epidemiology	
Konrad Edwards	Disease Control, Prevention and Epidemiology	
Michelle Byrd	Disease Control, Prevention and Epidemiology	
Monica Kwasnik	Medicaid Program Operations and Quality Assurance	
Patricia McKane	Disease Control, Prevention and Epidemiology	
Paulette Dobyne Dunbar	Family, Maternal & Child Health	Family and Community Health
Paulette Valliere		Chronic Disease & Injury Control Breast/Cervical Cancer Control
Rebecca Couglin	Disease Control, Prevention and Epidemiology	
Rhonda Bantsimba		Health, Wellness & Disease Control HIV/AIDS Prevention/ Intervention
Robert Cochran		Health, Wellness & Disease Control Sexually Transmitted Disease
Rose Mary Asman	Family, Maternal and Child Health	Family and Community Health
Sheila Embry	Medical Services Administration	
Sheryl Weir		Health, Wellness & Disease Control Health Disparities Reduction and Minority Health Section
Shronda Grigsby		Health, Wellness & Disease Control Health Disparities Reduction and Minority Health Section
Sophia Hines	Family, Maternal & Child Health	Perinatal Health
Terry Hunt	Michigan Development Disabilities Council	
Viki Lorraine		Chronic Disease & Injury Control Breast/Cervical Cancer