STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

April 23, 2018

Dear Legislators:

In recognition of the 10th anniversary of Public Act 653, the Michigan Department of Health and Human Services (MDHHS) is pleased to present the 2017 MDHHS Health Equity Report as required by this legislation.

Included in this packet are the 2017 MDHHS Health Equity Report which documents the Department's health equity efforts over the past 10 years along with a data brief that features a 10-year look at key indicators (i.e. poverty, employment, housing quality, etc.) that impact health disparities among racial and ethnic minorities in Michigan.

We continue to acknowledge that Public Act 653 would not have become a reality without the dedication and hard work of Michigan legislators and others. As we continue this important work, we look to strengthen our partnerships with you, our legislators. These partnerships are vital to understanding factors that contribute to increased health disparities for racial and ethnic minorities and, for developing effective strategies and policies to address them.

We hope this report provides information that is useful for you and for the communities you serve. We look forward to your review and feedback on this report.

Sincerely,

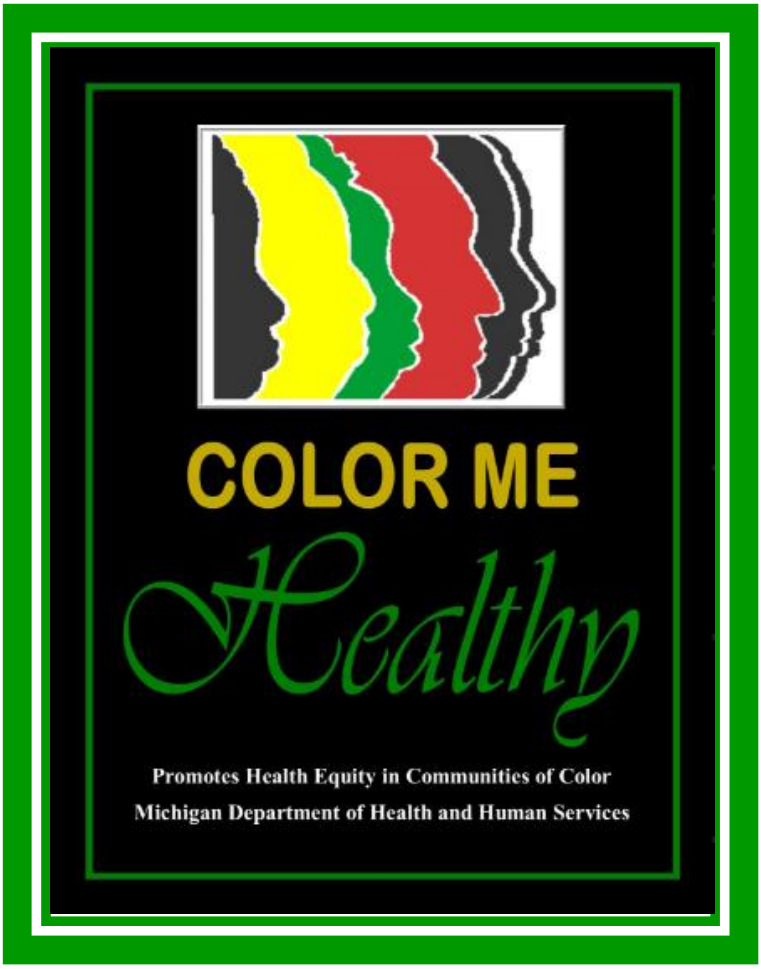
Sheryl Weir, MPH
Manager
Health Disparities Reduction and Minority Health Section
Michigan Department of Health and Human Services

Michigan Department of Health and Human Services

2017 Health Equity Report

Moving Health Equity Forward

10 Year Anniversary Report



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MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

2017 Health Equity Report

Moving Health Equity Forward

10 Year Anniversary Report

Executive Summary

The Michigan Department of Health and Human Services (MDHHS) 2017 Health Equity Report, *Moving Health Equity Forward,* serves as the annual report on the Department's efforts to address racial and ethnic health disparities as required by Public Act 653 of the Michigan Public Health Code. Public Act (PA) 653 was passed by Michigan's 93rd Legislature in 2006 and became effective in January 2007. It amends the Public Health Code (1978 PA 368). (See Attachment A.)

Public Act 653 focuses on five racial, ethnic, and tribal population groups in Michigan: African American, Hispanic/Latino, American Indian/Alaska Native, Asian American/Pacific Islander, and Arab and Chaldean American. In accordance with this law, MDHHS has the responsibility to develop and implement a departmental structure to address racial and ethnic minority health disparities, establish minority health policy, promote workforce diversity, and implement various actions to advance health equity as specified in the provisions of the act.

The year 2017 marked the 10 year anniversary of the enactment of PA 653. In recognition of this, the 2017 Report highlights accomplishments of the Department over the past 10 years, presents data (see attached brief), and outlines recommended next steps for further advancing health equity in Michigan. Accomplishments and next steps were gleaned from key informant interviews and a focus group with mid- and upper-level MDHHS leadership. Noteworthy health equity-related activities and accomplishments within the past decade include the following:

- Implementation of programs and initiatives that address health and social equity for racial and ethnic minority populations.
- Increased awareness, understanding, and discussion about health and social equity that is leading to a change in how the Department approaches its work.
- Development and support of departmental structures and processes to advance health equity.
- The merger of MDCH and DHS to create MDHHS, resulting in better coordination of health and human services and increased capacity to address the comprehensive needs of underserved populations.

- Implementation of strategies to promote workforce diversity.
- Increased health and social equity training and professional development opportunities for staff, facilitating growth in understanding and capacity to address health disparities.
- Advancements in data collection and utilization around health disparities and health and social inequities.
- Commitment to fostering community stakeholder and client engagement in programs, service-delivery, and policy efforts.
- Implementation of policies to advance health and social equity.
- Applying an equity lens, which involves looking at the potential impact that programs and policies have on populations that traditionally experience the greatest inequities (i.e. racial and ethnic minorities, LGBTQ persons, persons with disabilities, and persons with limited English proficiency, etc.) and redesigning them to achieve a more positive impact and outcome.
- Recognition of health equity as a departmental priority and inclusion of equity, diversity, and cultural competency in the MDHHS 2016-2018 Strategic Plan.

Moving forward, the Department's health and social equity efforts should be continued and enhanced. Suggested next steps include:

- Strengthen efforts to increase awareness, foster integration, and work collaboratively across the entire Department.
- Further integrate equity into departmental policies, operations, and procedures; identify actionable steps that can be taken and make equity integral to how the Department operates.
- Continue to provide training and professional development opportunities around health and social equity for staff, contractors, and partners.
- Continue and expand efforts to promote workforce diversity.
- Strengthen community relationships and involvement of stakeholders; be more client-centered and locally-driven.
- Continue to expand data collection and analysis to advance health and social equity.
- Further elevate health and social equity as a departmental priority and strengthen leadership support.
- Foster a culture of health and social equity across state government and implement a Health in All Policies (HiAP) Approach.
- Invest in a departmental plan around health and social equity; finish the Diversity, Equity, and Inclusion Plan and implement recommendations.

For more information on these and other health equity efforts, contact Sheryl Weir, Manager, Health Disparities Reduction and Minority Health Section, 517-284-4760 or weirs@michigan.gov.

2017 Health Equity Report

10 Year Anniversary Report

Introduction

In January 2007, Public Act (PA) 653 of the Michigan Public Health Code was approved by the Governor and enacted into law. PA 653, also known as Michigan's Minority Health Law, amends the Public Health Code (1978 PA 368) and includes provisions for addressing racial and ethnic health disparities and improving health equity throughout the state (see Attachment A). It also requires the Michigan Department of Health and Human Services (MDHHS) to submit an annual report on the "status, impact, and effectiveness" of the act.

The 2017 Health Equity Report, *Moving Health Equity Forward*, serves as the annual report documenting work to address racial and ethnic health disparities as required by PA 653. However, with 2017 marking the 10th anniversary of the enactment of PA 653, this year's report more broadly discusses the notable accomplishments of the Department over the past decade, as well as the future direction for advancing health and social equity for Michigan's racial and ethnic minority populations.

Information presented in this report was obtained through 15 key informant interviews with select members of MDHHS's Executive Leadership Team and Bureau/Division Directors, as well as a focus group with the Department's Strategic Alignment Team – Supporting Leaders. The purpose of these interviews and the focus group was to:

- Gather information about the Department's notable accomplishments over the past 10 years, as well as current efforts to address health and social equity for racial and ethnic minority populations;
- Identify factors or events that have helped to facilitate or hinder these efforts; and
- Reflect on the future direction and next steps of the Department in addressing health and social equity for racial and ethnic minority populations.

Responses to interview and focus group questions were summarized and reviewed for common themes and salient points. Overarching themes and insights are described in this report, including departmental leadership's thoughts on past and current successes, along with reflections on the future direction of MDHHS's health and social equity efforts. Next steps for moving forward are also presented.

Accomplishments and Efforts

Key informants and focus group participants noted that the Department has demonstrated growing efforts to address health equity over the past 10 years. This started with awareness of racial and ethnic minority health disparities and has progressed to a greater understanding of social and economic inequities as root causes of disparities.

The Department's work in this area began in 1988 with an executive order, which established the Office of Minority Health (OMH) within the Michigan Department of Public Health. The formation of the Michigan Department of Community Health (MDCH) in 1996 provided a broader application of this work. In 2004, MDCH took a more focused approach to addressing minority health when it created the Health Disparities Reduction and Minority Health Section. The result has been a greater awareness of health inequities throughout the Department and increased efforts to work collaboratively on these issues. The merging of MDCH and the Department of Human Services (DHS) in 2015 further advanced these efforts by creating a department that provides linkages across health and human services. This merger presents the opportunity to integrate systems to more holistically address the health and social needs of populations facing the greatest inequities.

When MDHHS leaders were asked about the Department's most notable accomplishments (past and present) related to addressing health and social equity for racial and ethnic minority populations, a number of common themes emerged. These are highlighted in Figure 1 and further summarized below.

Key Terms and Definitions

Health Equity: A fair, just distribution of the health and social resources and opportunities needed to achieve optimal health and well-being.[1]

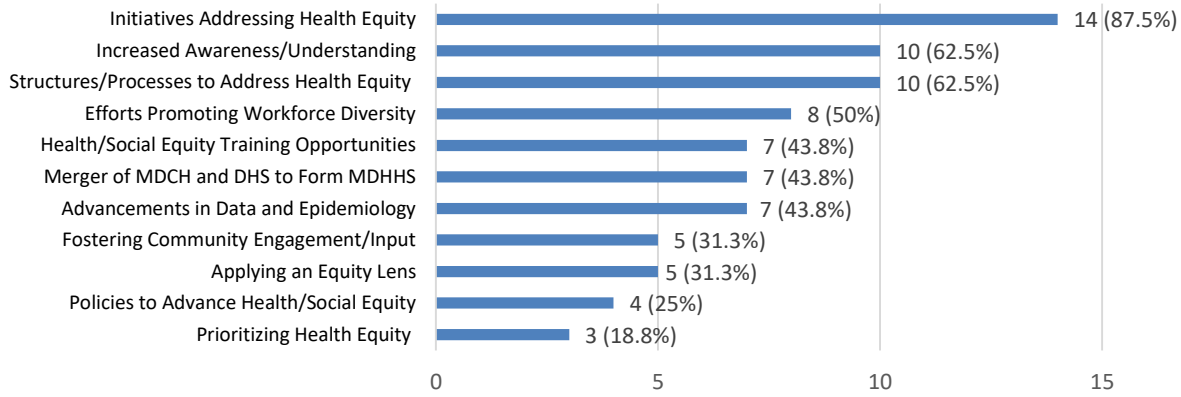
Health Inequities: Differences in health across population groups that are systemic, avoidable and actionable, and are therefore considered unfair and unjust.[2]

Social Determinants of Health/Equity: Economic and social conditions that influence the health and well-being of individuals and population groups. Examples include: safe and affordable housing, quality education, job security, social connection and safety, living wage, access to transportation, availability of nutritious food, etc.[3]

Social Equity: The fair, just and equitable distribution of public services and implementation of public policy.[4]

[1] Adapted from: MDHHS – Health Equity Web-Based Training
[2] Adapted from: Michigan Equity Practice Guide for State-Level Public Health Practitioners, and MDHHS – Health Equity Web-Based Training
[3] Adapted from: MDHHS – Health Equity Web-Based Training
[4] National Academy of Public Administration

Figure 1
MDHHS' Most Notable Accomplishments in Advancing Health and Social Equity for Racial and Ethnic Minority Populations
as Identified by Key Informants/Focus Group Participants
Number (Percent)



* Numbers represent the number of interviews, including the focus group, in which the accomplishment was mentioned. Percentages are based on a possible total of 16 (15 key informant interviews and 1 focus group).

I. Implementation of programs and initiatives that address health and social equity was the most frequently cited accomplishment of the Department. This includes programs specifically designed to address health and social inequities for racial and ethnic minority populations; as well as initiatives that serve, but do not directly focus on these populations. Key informants and focus group participants noted the following:

- Over the years, programs have been strengthened by the Department's ability to identify communities with the greatest need and focus efforts in these areas.
- Efforts have also been enhanced by customizing and tailoring programs to specific racial and ethnic populations.
- There has also been an increase in initiatives that take a systems-based approach, thus extending and sustaining program impact.

Specific initiatives most often mentioned by key informants and focus group participants include:

- Expanded health care coverage through the Healthy Michigan Plan;
- State Innovation Model (SIM), which is working with community health innovation regions (CHIRs) to test an innovative model for health care delivery that includes a health equity component;
- Medicaid Health Plan Health Equity Project, which offers incentives for contracted health plans to reduce health disparities among their benefit populations; and
- Practices to Reduce Infant Mortality through Equity (PRIME), a program from 2010-2017, which focused on reducing racial disparities in infant mortality.

II. Increased awareness, understanding, and discussion about health and social equity was another commonly cited accomplishment. Specifically noted was having conversations within the Department about the social determinants of health (SDOH) and recognition of the enormous impact social and economic factors (figure 2) have on racial and ethnic minority health inequities. This increased awareness, coupled with a greater willingness within the Department to discuss and think more deeply about health and social equity issues, has led to changes in the way MDHHS approaches its work. Such changes include:

- More organizational areas and programs applying a social determinants of health (SDOH) perspective to their efforts.
- Increased conversations with local partners, contractors, and community stakeholders, about SDOH in order to align goals and strategies.
- Increased efforts to identify linkages and work collaboratively across the Department to address social determinants (e.g., issues of poverty, employment, housing, safety, access to food, etc.).
- Greater consideration and exploration of root causes of health and social inequities, leading to development of integrative frameworks to better guide efforts.
- Increased efforts to educate legislative partners and policy-makers about the importance of addressing social determinants in order to improve the health of racial and ethnic minority populations and the health of Michiganders overall.

Figure 2

Applying a Social Determinants of Health Framework

"Public health programs have traditionally focused on individual behavior change – an approach that has had limited impacts. By broadening the focus to include the physical and social environments where people live, work and play, public health programs can affect both health behavior and health status. A 'social determinants of health' framework involves partners from a variety of settings and sectors working together to improve the health of populations that experience health inequities. Using this framework, programs can be designed across sectors to address issues that affect health, including access to healthy foods (such as fresh fruits and vegetables), quality health care, affordable housing, and safe places for physical activity and recreation."

From: Michigan Department of Health and Human Services. (2016). Michigan equity practice guide for state-level public health practitioners. Lansing, MI: Michigan Department of Health and Human Services; Health Disparities Reduction and Minority Health Section.

III. Developing, implementing, and supporting departmental structures and processes to advance health equity emerged as another common theme. This includes how the Department is organized and functions, the alignment of organizational areas, and implementation of operating procedures. Key informants and focus group participants noted the following equity-promoting structures:

- Establishment, support, and ongoing work of the Health Disparities Reduction Minority Health Section (HDRMHS), which serves as the primary coordinating body within MDHHS to address racial and ethnic health disparities.
- The formation and continued efforts of MDHHS' Diversity, Equity, and Inclusion Workgroup -- a department-wide workgroup tasked with developing a departmental diversity and inclusion plan addressing 1) Leadership, 2) Work Culture/Climate, 3) Workforce Recruitment, Retention, and Training; and 4) Service Delivery.
- Development and implementation of an Integrated Service Delivery (ISD) system, which is designed to facilitate the seamless delivery of services through a 'one-stop shop' platform that allows access to comprehensive resources across multiple services sectors. The goal of ISD is to increase the Department's capacity to address clients' needs in a comprehensive, effective, and efficient way.

In addition, several key informants cited structures within their specific organizational area that help ensure health and social equity are integrated into their work. Examples include:

- Staff positions dedicated to fostering cultural competency and/or addressing health equity issues;
- Including health and social equity objectives in state and program plans; and
- Having health equity committees or leadership teams to guide health and social equity efforts of their organizational area.

IV. The merger of the MDCH and DHS to create MDHHS in 2015, was another commonly cited accomplishment. Essentially, the merger has provided a platform and opportunities to better address health and social equity issues through the integration of health and human services. It has also brought a heightened focus on addressing the socio-economic needs of low-income populations. As noted by key informants:

- Bringing MDCH and DHS together under the same department has helped to define mutual priorities and goals, as well as provide access to broader expertise and resources.
- The merger has led to a better understanding of how the respective health and human services sides of the agency operate. This has resulted in increased coordination, collaboration, and integration, including with the field offices

throughout the state, which provide front-line services to those populations most in need of health services and human services.
- As a combined department, MDHHS is able to take a more comprehensive approach to addressing clients' needs by delivering more streamlined and coordinated services, which is important to advancing health and social equity for racial and ethnic minority populations.

V. Promoting workforce diversity was also frequently cited as an overarching accomplishment of the Department, both past and current. This includes increased recognition of the importance of valuing diversity and fostering a culture of respect and appreciation, as well as the importance of having a workforce that is reflective of populations served. In particular, key informants noted:

- Having a diverse workforce is not only important for ensuring varying perspectives are represented in the workplace, but also for ensuring health and human services staff are sensitive to and understanding of cultural differences among people served.
- Diversity in the workforce may also help staff relate to communities served in a way that builds positive relationships.

Current efforts to advance workforce diversity noted by key informants and focus group participants include:

- Increased efforts to reach out to and recruit racial and ethnically diverse job candidates;
- Assembling diverse interview panels;
- Including equity-related questions in position postings and job interviews; and
- Fostering cultural competency to ensure all staff are committed to providing quality services to everyone regardless of racial or cultural background.

VI. Health and social equity training and professional development opportunities were also often mentioned by key informants. Over the years, these opportunities have helped to raise awareness, deepen understanding, build capacity, and change the way health and social service providers approach their work. Training and professional development opportunities cited most frequently include:

- PRIME (Practices to Reduce Infant Mortality through Equity) Trainings
    - Undoing Racism™ Community Organizing Workshop
    - Health Equity and Social Justice Workshop
    - Native American History, Culture & Core Values Workshop
    - Learning Labs Series
- Understanding Systemic Racism
- Cultural Competency Training

- Health Equity Online Training, which was recently launched by HDRMHS and offered to all MDHHS employees. It is also open to contractors and the public at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2985_79566---,00.html.

VII. Advancements in data collection and utilization related to health disparities and health and social inequities was identified as another accomplishment, particularly the Department's ability to better monitor minority health over the past decade. As noted by key informants, this is due in part to:

- Advancements in technology that allow for more precise data collection, analysis, and reporting.
- More recognition within epidemiology of the importance of understanding the social and economic context in which people live.
- Expansion of data to include social determinants of health and other root causes of inequities, such as adverse childhood experiences and experiences of racism.
- Improvements that have enabled the Department to better identify where disparities and inequities exist, understand factors underlying these disparities, define specific needs, implement equity-promoting strategies, and track progress.

Specific data-oriented activities and accomplishments include:

- Addition of health and social equity-related questions on the statewide Behavioral Risk Factor Survey (BRFS) and Pregnancy Risk Assessment Monitoring System (PRAMS).
- Conducting specialized BRFS on Michigan's racial and ethnic populations (including Asian Americans, Hispanics, and Arab and Chaldean Americans – see http://www.michigan.gov/mdhhs/0,5885,7-339-71550_5104_5279_39424_39429-134736--,00.html).
- Ongoing maintenance of the Michigan Health Equity Data Project, which presents data for racial/ethnic populations in Michigan in order to monitor progress towards health equity (reports available at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2985_78954---,00.html).
- Medicaid Health Equity Project Annual Report, which publishes data on contracted Medicaid health plan quality performance measures by race and ethnicity to help identify disparities in Medicaid health plan enrollees and areas for improvement (reports available at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2985_81249---,00.html).
- Maintenance of a comprehensive data warehouse, which includes Medicaid and human services data.

VIII. Fostering stakeholder/client engagement and input has also been essential to moving the Department's health equity efforts forward over the years. Involving communities and populations served is crucial to advancing health equity by allowing the Department to better identify needs, understand clients' experience, and foster shared decision-making that will ultimately lead to more appropriate and effective systems, procedures, policies, and programs. Several key informants and focus groups participants noted ways they reach out to and engage community stakeholders, as well as solicit input and feedback from populations served. Examples include:

- The Field Operations Administration involves local field offices and clients in testing new policies, procedures, and applications in order to improve the implementation and success of programs and services.
- The Aging and Adult Services Agency (AASA) works closely with local communities to provide input on and modify policies so that they best meet the needs of those being served.
- The Medical Services Administration (MSA) provides opportunities for public input and engagement on policies via public hearings, public comment, policy promulgation, and the Medical Care Advisory Council (MCAC).
- Within the Division of Chronic Disease and Injury Control (DCDIC), staff engage funded organizations to ensure participation of racial and ethnic minority members in their networks; and develop collaborative partnerships with local contractors representing racial and ethnic minority populations.

IX. Implementing policies to advance health and social equity for racial and ethnic minority populations was another notable accomplishment identified by key informants and focus group participants. PA 653 was cited as a state-level accomplishment. PA 653 was credited with helping to create awareness of and bringing attention to this issue, as well as specifying activities the Department should do to address health disparities and promote equity. Other policy-related accomplishments include:

- Review and revamping of the Public Health Code, including assessing if it is reflective of health equity;
- Modifying eligibility requirements to extend Medicaid coverage through the Healthy Michigan Plan; and
- Department-wide policies to promote workforce diversity.

In addition, various organizational areas and programs within the Department have implemented policies that advance racial and ethnic equity. For example:

- AASA's funding formula for Michigan's Area Agencies on Aging (AAA) is based on federal legislation that targets services to those that are economically and socially disadvantaged, including racial and ethnic minority seniors.

- MSA requires contracted health plans to implement cultural and linguistically appropriate services (CLAS) standards.
- Medicaid health plans are also contractually required to develop, implement, and evaluate population health management programs that address SDOH and health disparities within their beneficiary population.
- The Division of Chronic Disease and Injury Control (DCDIC) has a policy that requires Request for Proposals (RFPs) include a health equity component.
- DCDIC also requires division staff to take the online health equity training.
- Additionally, several programs within DCDIC require that health equity and social justice activities are written into funded agencies' work plans.

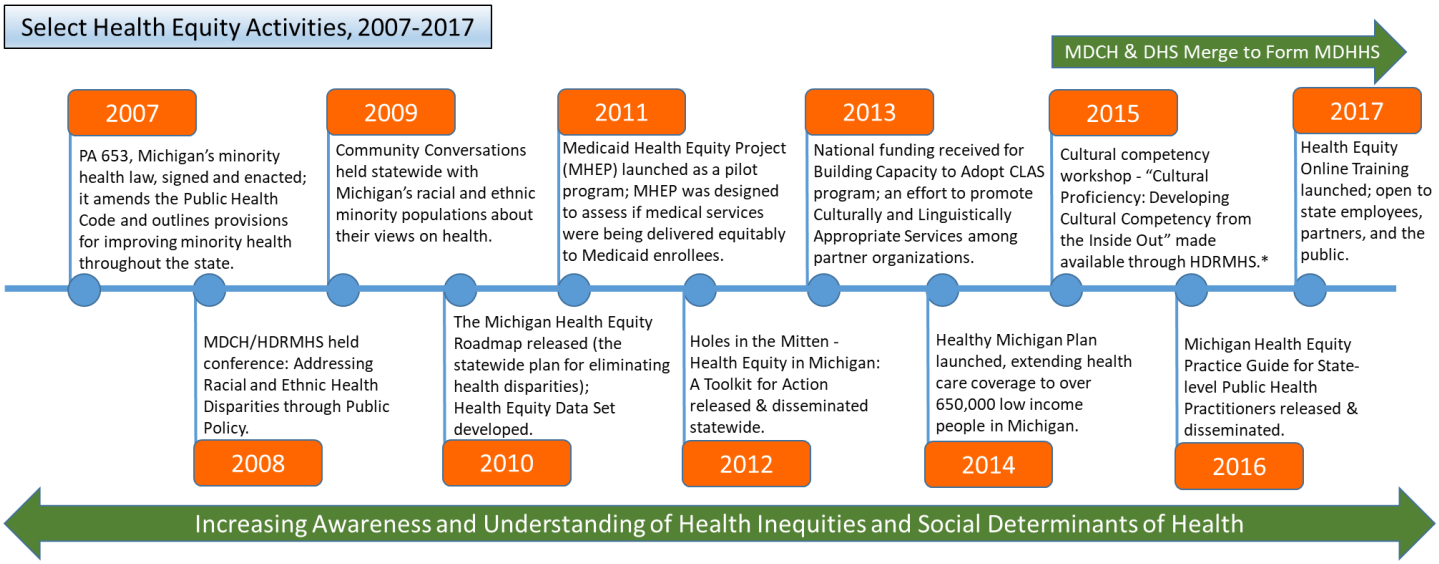
X. Applying an equity lens was identified by several key informants and focus group participants as something that has gained increased attention over the years. This involves considering and assessing the unintended impact of policies and programs on racial and ethnic minorities and other populations that experience inequities. Some areas within MDHHS have started to apply an equity lens into their work. For example:

- The Children's Services Agency (CSA) has updated their policy development and review cover letter to instruct policy staff to consider the impact of the policy on racial and ethnic minorities and women.
- CSA has also begun reviewing specific policies with an equity lens and making clarifications and modifications as necessary.
- Other areas within human services are also becoming more aware of the importance of applying an equity lens and looking for ways to build this into their policy-making process.
- Several areas within the Population Health Administration noted that health equity is infused into their area's approach and built into the programmatic process.
- Applying an equity lens to analyzing data was also noted. This involves a 'deeper dive' into the numbers to consider what factors underlie the data and outcomes being seen.

XI. Prioritizing health equity - Key informants and focus group participants acknowledged that the Department has recognized equity as a priority and taken it on as a responsibility to address. They further noted that equity as a priority has received increased visibility within the Department, as evidenced by the inclusion of equity-related language in the MDHHS 2016-2018 Strategic Plan. Having supportive leadership has also helped to advance efforts. This includes:

- Recognition and support of programs addressing health and social equity.
- Support for health equity and social justice training.

- Enabling staff to have conversations that focus on issues of racial and ethnic disparities.
- Communication from management regarding the importance of health equity and social justice, and the central role it plays in their work and improving the health and well-being of communities served.



Moving Forward

MDHHS has demonstrated growth in its efforts to promote health equity since enactment of PA 653. However, key informants and focus group participants noted a number of actions the Department must take to achieve more equitable outcomes for racial and ethnic minority populations in Michigan. These are summarized below.

I. Strengthen efforts to increase awareness, foster integration, and work collaboratively across the entire Department - Key informants and focus group participants expressed that the Department needs to ensure equity is a priority for all of MDHHS. These efforts need to be better integrated into the work of the Department. Salient points include:

- Do more to communicate the importance of health and social equity.
- Do more to increase awareness and further equity conversations as a way to continue momentum.
- Increase understanding about how an equity approach improves outcomes for all people served.
- Work to breakdown silos within the Department.
- Continue efforts to work collaboratively with various areas of the Department to meet the full spectrum of clients' needs.

- Look for opportunities to integrate and streamline processes in an effort to improve efficiency and effectiveness of services.
- Foster more awareness and understanding of what it means to deal with racism at various points in the system.

II. Further integrate equity into departmental policies, operations, and procedures - Several organizational areas have integrated health and social equity into their structure, policies, and procedures as noted by key informants and focus group participants. Going forward these efforts need to be instituted department wide. Specific suggestions include:

- Build health and social equity requirements into contracts and grants.
    - Look at existing contractual and grant requirements for ways to create awareness and address health and social disparities for racial and ethnic minority populations.
    - Build a health equity and social justice component into Request for Proposals, and require that health equity activities be included in grantee proposals and work plans.
    - Cultivate relationships with partners, contractors, and providers to ensure they share health and social equity principles and values.
- Expand the Department's capacity to address social determinants of health in a systematic way, i.e. the Integrated Services Delivery (ISD) efforts and the newly implemented streamlined public assistance application process.
- Identify ways to integrate equity into the policy-making process:
    - Conduct a health equity impact review when making new policies or changing existing policies.
    - Provide time and resources to field test policies as a way to solicit input and gather diverse perspectives.
    - Consider how policies can be developed/adapted to best meet community needs.
- Develop equity-related metrics to track policy, program, and service outcomes.
- Establish integrated, department-wide health and social equity policies (e.g., require training for all staff; integrate health and social equity-related questions into job postings and interviews; require each area to have a representative on the HDRMHS Health Equity Steering Committee; etc.).

III. Continue to provide training and professional development opportunities around health and social equity - Key informants and focus group participants strongly recommended requiring health and social equity training for all new staff, as well as continuing to provide ongoing professional development opportunities for all employees, including departmental leadership. Specific suggestions include:

- Create and implement an integrated, sequential health and social equity training curriculum for the Department.
- Train policy staff to ensure they have the skills and tools needed for applying equity in the policy-making process.
- Provide ongoing training to increase management and administration level understanding and knowledge of institutional racism and social justice.
- Continue and expand health and social equity training for contractors and grantees to increase their capacity to better serve populations that experience the greatest inequities.

IV. Increase workforce diversity - The Department is working to promote the recruitment and retention of a diverse workforce but challenges remain. Suggested next steps for addressing workforce diversity include:

- Ensure the Department's staff and leadership are reflective of populations served:
    - Do more to actively recruit a diverse job candidate pool.
    - Adopt hiring policies and practices that will help the MDHHS workforce better reflect communities served.
    - Develop leadership opportunities for historically underrepresented groups within MDHHS.
    - Have more people of color in leadership positions.
- Require all areas to include health equity-related questions in job interviews. Equity is part of the Department's vision and strategic priorities, and therefore needs to be understood and supported throughout the Department.
- Include equity-related knowledge and experience as criteria in the hiring process.
- Develop a department-wide initiative around workforce diversity that includes strategies that have been effectively used in the Department.

V. Strengthen community relationships and involvement of stakeholders; be more client-centered and locally-driven - Key informants and focus group participants expressed that many areas actively solicit input and feedback from the communities they serve. They also said that more could be done to involve and engage clients and community stakeholders in a meaningful way. Salient points include:

- Identify ways to better involve stakeholders to help the Department enhance its understanding of client experiences and needs.
- Identify ways to better involve stakeholders, including those from racially and ethnically diverse communities, to foster greater client and consumer input in program, service, and policy efforts that affect them.
- Find ways to communicate the importance of involving stakeholders and how it mutually benefits the Department and the people we serve.

- Be more inclusive of communities served as a way to improve our programs and services to advance health and social equity.
- Practice authentic community and stakeholder engagement: engage with communities most affected by health and social inequities; value their input; and include their input to identify issues, influence decisions, and propose solutions.

Suggestions to increase involvement, engagement, and inclusion include:

- Proactively recruit people from communities with the highest burden of disease or greatest need to serve on program- and state-level advisory groups.
- Utilize focus groups and community forums to create programming that addresses community-specific needs.
- Work with local field offices and community partners to develop strategies, activities, and work plans that best fit the specific needs of communities in order to increase effectiveness of programs.
- Expand the diversity of those 'at the table' when developing policies.
- Allow for flexibility in community-driven planning to ensure programs and policies best meet local needs.
- Continue to strengthen existing and build new relationships with organizations that serve racial and ethnic minority communities.
- Support staff efforts to expand community engagement and involvement, e.g., provide time, flexibility, management support, etc.

VI. Continue to expand data collection and analysis to advance health and social equity – Further enhancing data collection and analysis around health and social equity will allow the Department to better identify different needs among racial and ethnic minority populations, pinpoint key aspects of disparities and assets, and develop more focused initiatives using the data. Moving forward, MDHHS should:

- Further develop, expand, and utilize data systems to measure and understand where disparities are occurring.
- Assure that surveillance activities include analyses to identify racial and ethnic minority group needs.
- Consider disproportionate impact; identify where this occurs and explore how to address it.
- Better leverage available data to inform efforts.
- Analyze information in the Department's data warehouse to identify existing disparities among those we serve and implement initiatives to respond accordingly.
- Incorporate surveillance of health inequities into the work of local partners.

VII. Further elevate health and social equity as a departmental priority and strengthen leadership support - Key informants and focus group participants acknowledged that MDHHS has demonstrated efforts to advance health and social equity, but expressed that its commitment needs to be strengthened. Salient points include the following:

- Health and social equity has to continue to be a priority; the Department needs to stay committed to this and continually evolve and move forward in its efforts.
- Health and social equity should be *elevated* as a priority and made an overarching goal to ensure it becomes an integral part of how the Department operates. This includes further developing structures to implement and evaluate this focus.
- MDHHS needs to create a legacy of working towards health and social equity that defines the Department and continues through organizational and administration changes.
- The visibility of health and social equity should be elevated in the Department's strategic plan.
- Continue to support health equity work and acknowledge past and current efforts.
- Acknowledge the impact of systemic racism on health, and develop a strategic approach to dismantle the policies and practices that perpetuate racism.
- Use consistent and clear messaging and demonstrate visible and tangible support for department-wide health equity activities.
- Foster top-level leadership support and commitment to addressing health and social equity across state government; this extends to the Governor as well.
- Make health equity and social justice a priority for the entire State of Michigan and integrate it across all state-level departments.

VIII. Foster a culture of health and social equity across state government, and implement a Health in All Policies (HiAP) Approach – Key informants and focus group participants expressed that in order to truly advance health and social equity, the systems, policies and procedures that perpetuate institutional racism and discrimination need to be addressed. This goes beyond the public health and human services domains. Therefore, there needs to be a more collective effort to foster a culture of health and social equity in the state. Key to this is adopting and applying a Health in All Policies approach throughout state government. As noted:

- MDHHS should adopt a Health in All Policies approach and work with other departments (Department of Technology, Management and Budget; Michigan State Housing Development Authority; Michigan Department of Education; etc.) to encourage policy-making that addresses areas of employment, income, family cohesion, neighborhood safety, housing, education, and other facets of living. All

of these domains need to be approached from an equity perspective in order to truly make an impact for populations that experience the greatest inequities.

- MDHHS should work closely with other state agencies to address the social determinants of health and advance integrated efforts.
- Public health, social services, transportation, housing, and employment all face similar issues related to achieving health equity and social equity for racial and ethnic minority populations, and should not work in isolation. One agency cannot do this alone.
- Continue efforts to create a system for interagency communications within state government.

IX. Invest in a departmental health and social equity plan / Finish the Diversity, Equity, and Inclusion Plan and implement recommendations – Several key informants cited the need to develop and invest in an integrated, department-wide strategic plan around health and social equity. Specifically noted was the following:

- Continue to support the work and planning effort of the Diversity, Equity, and Inclusion (DEI) Workgroup; finalize the DEI Plan and implement recommendations.
- Develop an integrated, department-wide strategic plan.
    - Involve diverse internal and external stakeholders.
    - Identify and adopt key strategies (e.g., training, staffing, metrics, best practices, etc.).
    - Include long and short-term goals, objectives, and a specific work plan (outlining who is responsible for what by when).
    - Hold organizational areas accountable to implement.

Five Key Elements of Health in All Policies (HiAP)

1. **Promote health, equity, and sustainability –** Incorporate health, equity, and sustainability into specific policies, programs, and processes, as well as into government decision-making processes; make this the normal way of doing business.
2. **Support intersectoral collaboration -** Bring together partners from many sectors to identify links between health and other issue/policy areas, break down silos, and build new partnerships to advance health equity and increase government efficiency.
3. **Benefit multiple partners –** Work collaboratively to simultaneously address the goals of public health and other agencies to achieve co-benefits and create efficiencies across agencies (find win-wins).
4. **Engage stakeholders -** Engage a variety of stakeholders - e.g., community members, policy experts, advocates, private sector representatives, funders, etc.
5. **Create structural or procedural change -** Create permanent changes in how agencies relate to each other and how government decisions are made; maintain structures that sustain intersectoral collaboration and mechanisms that ensure a health and equity lens in decision-making processes across the whole of government**.**

Adapted from: Rudolph, L., Caplan, J., Ben-Moshe, K., & Dillon, L. (2013). Health in All Policies: A Guide for State and Local Governments. Washington, DC and Oakland, CA: American Public Health Association and Public Health Institute.

Conclusion

The 10-year anniversary of PA 653 provides MDHHS the opportunity to reflect on its accomplishments, challenges, and future direction towards achieving equity for Michigan's racial and ethnic minorities. Since 2007, PA 653 has served as the guiding policy for the Department's work and its activities to document, assess, and improve equity-related efforts. As described throughout this report, significant strides have been made, yet much remains to be done.

The accomplishments and next steps outlined in this report reflect what was expressed by MDHHS leadership during key informant and focus group interviews. Those leaders recognized that bringing these next steps to fruition will require commitment of human and financial resources, time, and prioritization. This includes the commitment to changing the culture within MDHHS and ideally, throughout state government. It will involve changes in how we develop and implement our policies, our procedures, and our programs and services. This will be a challenge that can only be done through a comprehensive, collaborative, and multi-sectorial effort.

As we embark on the next 10 years, we invite all state, local, and legislative partners to consider how our work impacts social and economic equity for racial and ethnic minorities, other underserved populations, and indeed, all Michigan citizens.

Acknowledgements

The Health Disparities Reduction and Minority Health Section would like to thank all MDHHS administrators and managers who took part in the key informant interviews and focus group.

Attachment A: Public Act (PA) 653

Act No. 653
Public Acts of 2006
Approved by the Governor
January 8, 2007
Filed with the Secretary of State
January 9, 2007
EFFECTIVE DATE: January 9, 2007
STATE OF MICHIGAN
93RD LEGISLATURE
REGULAR SESSION OF 2006

Introduced by Reps. Murphy, Gonzales, Zelenko, Williams, Whitmer, McConico, Leland, Clemente, Condino, Tobocman, Farrah, Lipsey, Alma Smith, Clack, Cushingberry, Plakas, Hopgood, Waters, Anderson, Stewart, Kolb, Meyer, Adamini, Brown, Gaffney, Virgil Smith, Hunter, Kathleen Law, Bieda, Meisner, Wojno, Vagnozzi, Taub, Accavitti, Stakoe, Gleason, Wenke, Ward, Byrum, Sak, Nitz, Moolenaar, Casperson, Dillon, Angerer, Bennett, Byrnes, Caul, Cheeks, Espinoza, Green, Hansen, Rick Jones, Kahn, David Law, Lemmons, Jr., Marleau, Mayes, McDowell, Miller, Polidori, Proos, Sheltrown and Spade

ENROLLED HOUSE BILL No. 4455

AN ACT to amend 1978 PA 368, entitled "An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to provide for the imposition of a regulatory fee; to provide for the levy of taxes against certain health facilities or agencies; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for the implementation of federal law; to provide for penalties and remedies; to provide for sanctions for violations of this act and local ordinances; to provide for an appropriation and supplements; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates," (MCL 333.1101 to 333.25211) by adding section 2227.

The People of the State of Michigan enact:
Sec. 2227. The department shall do all of the following:
(a) Develop and implement a structure to address racial and ethnic health disparities in this state.
(b) Monitor minority health progress.
(c) Establish minority health policy.
(d) Develop and implement an effective statewide strategic plan for the reduction of racial and ethnic health disparities.
(e) Utilize federal, state, and private resources, as available and within the limits of appropriations, to fund minority health programs, research, and other initiatives.

(f) Provide the following through interdepartmental coordination:
(*i*) Data and technical assistance to minority health coalitions and any other local entities addressing the elimination of racial and ethnic health disparities.
(*ii*) Measurable objectives to minority health coalitions and any other local health entities for the development of interventions that address the elimination of racial and ethnic health disparities.
(g) Establish a web page on the department's website, in coordination with the state health disparities reduction and minority health section, that provides information or links to all of the following:
(*i*) Research within minority populations.
(*ii*) A resource directory that can be distributed to local organizations interested in minority health.
(*iii*) Racial and ethnic specific data including, but not limited to, morbidity and mortality.
(h) Develop and implement recruitment and retention strategies to increase the number of minorities in the health and social services professions.
(i) Develop and implement awareness strategies targeted at health and social service providers in an effort to eliminate the occurrence of racial and ethnic health disparities.
(j) Identify and assist in the implementation of culturally and linguistically appropriate health promotion and disease prevention programs that would emphasize prevention and incorporate an accessible, affordable, and acceptable early detection and intervention component.
(k) Promote the development and networking of minority health coalitions.
(*l*) Appoint a department liaison to provide the following services to local minority health coalitions:
(*i*) Assist in the development of local prevention and intervention plans.
(*ii*) Relay the concerns of local minority health coalitions to the department.
(*iii*) Assist in coordinating minority input on state health policies and programs.
(*iv*) Serve as the link between the department and local efforts to eliminate racial and ethnic health disparities.
(m) Provide funding, within the limits of appropriations, to support evidence-based preventative health, education, and treatment programs that include outcome measures and evaluation plans in minority communities.
(n) Provide technical assistance to local communities to obtain funding for the development and implementation of a health care delivery system to meet the needs, gaps, and barriers identified in the statewide strategic plan for eliminating racial and ethnic health disparities.
(o) One year after the effective date of this section and each year thereafter, submit a written report on the status, impact, and effectiveness of the amendatory act that added this section to the standing committees in the senate and house of representatives with jurisdiction over issues pertaining to public health, the senate and house of representatives appropriations subcommittees on community health, and the senate and house fiscal agencies.

This act is ordered to take immediate effect.
Clerk of the House of Representatives
Secretary of the Senate
Approved

For more information about this report, please contact:
Michigan Department of Health and Human Services
Health Disparities Reduction and Minority Health Section
colormehealthy@michigan.gov
Phone: 517-284-4760

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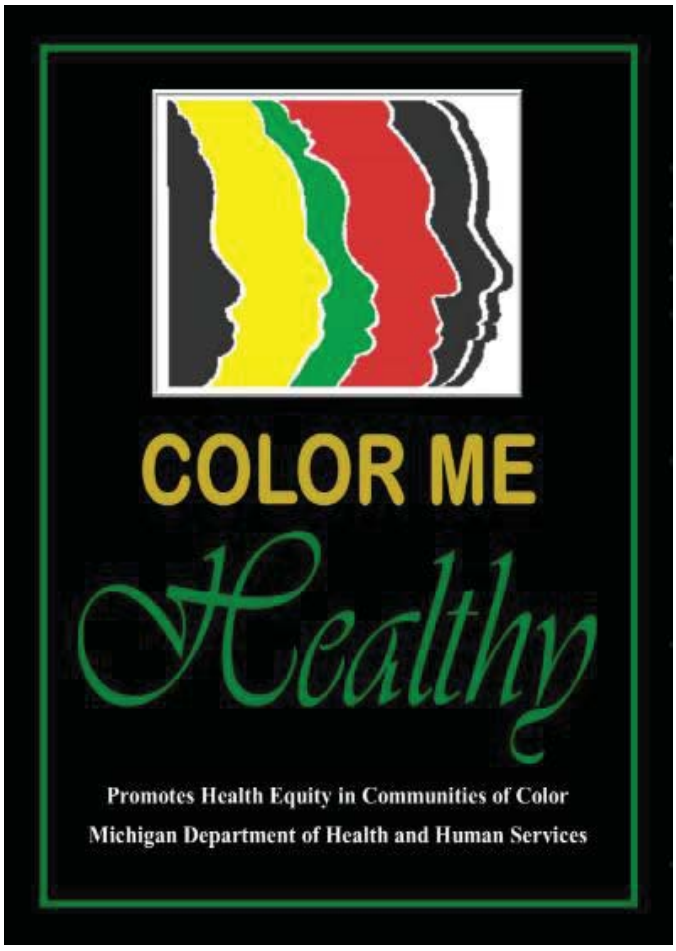
Data Brief

MDHHS 2017 Health Equity Report

Social Determinants of Health Michigan, 2006-2015



MDHHS
Michigan Department of Health & Human Services

April 2018

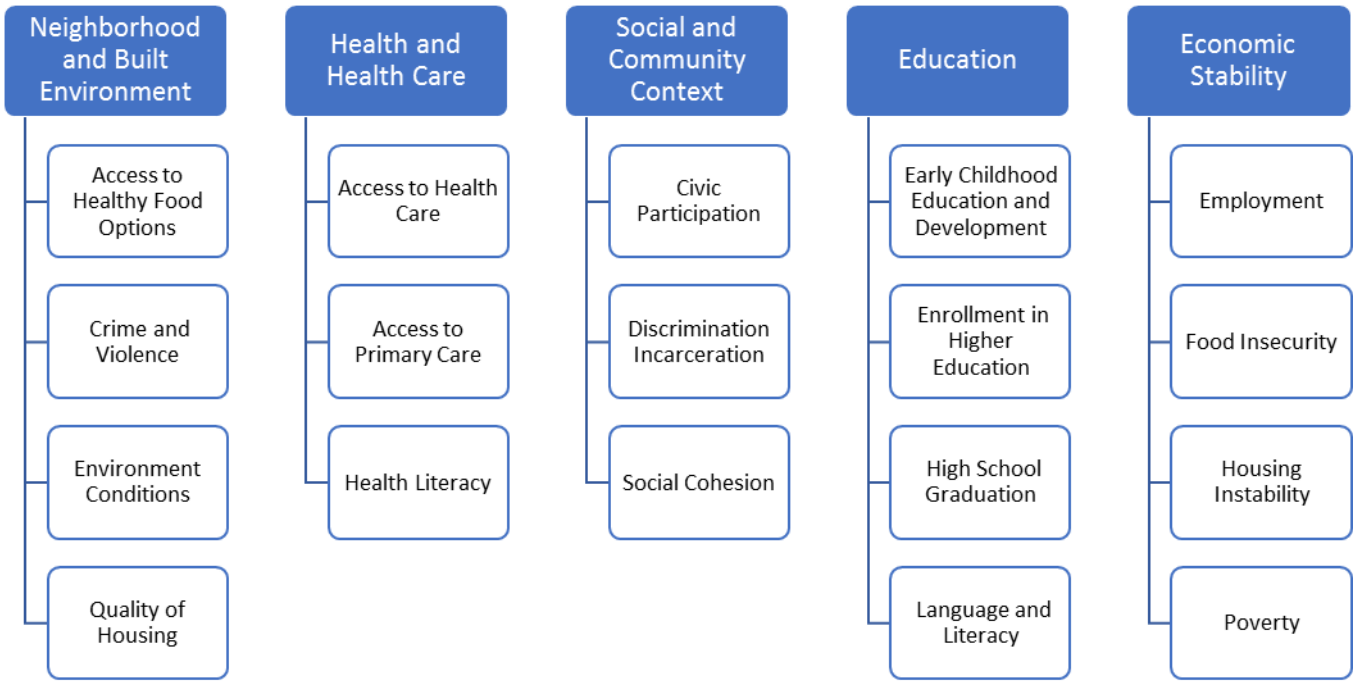
Social Determinants of Health
Michigan 2006-2016

Social Determinants of Health Overview

Social Determinants of Health (SDOH) are the conditions and structural determinants in which people are born, grow, live, work and age that affect health and quality of life outcomes.[1,2] For the first time, Healthy People listed SDOH as a topic area for the Healthy People 2020 (HP2020) report. In fact, HP2020 has listed "create social and physical environments that promote good health for all" as one of the four overarching goals for the decade.[2]

HP2020 SDOH Priority Areas

HP2020 has determined five SDOH priority areas, each of which encompass multiple underlying factors that affect the health outcomes of individuals.[2]



Why Focus on Social Determinants?

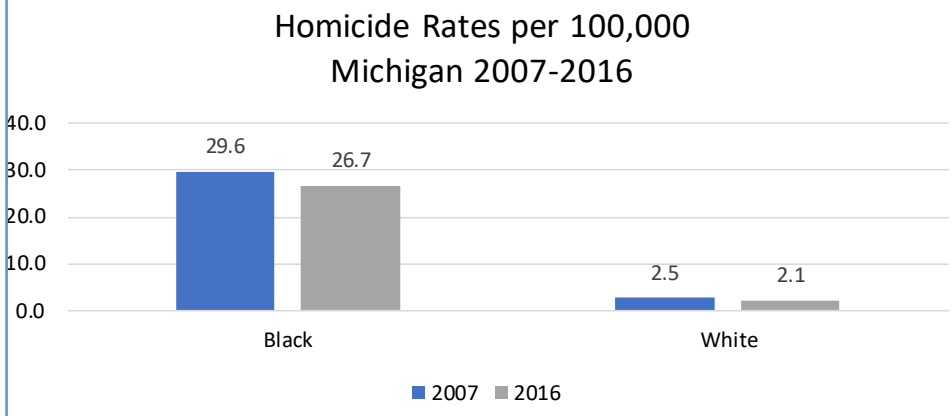
Research has found that social factors, including racial segregation, account for a third of the total deaths in the United States (US) in a year.[3] Achieving health equity requires addressing the social determinants that affect health. In addition, research has shown that reducing health disparities for minority populations in the US would result in a $230 billion direct medical expenditure reduction and indirect costs associated with illnesses and premature death would be reduced by more than $1 trillion.[4]

Note: Due to data methodology and availability, years may differ between graphs in this report.

Neighborhood and Built Environment

Crime and Violence

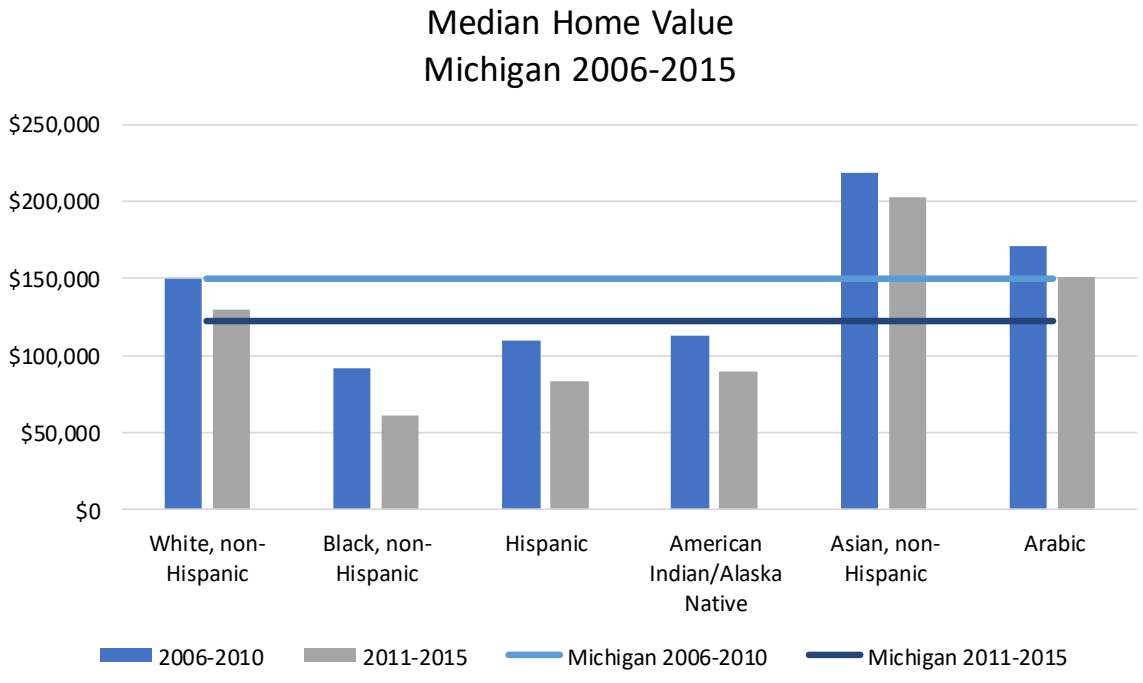
- For both years, African Americans experience higher homicide rates than Whites.
- Homicide rates for both populations decreased between 2007 and 2016.
- African Americans died due to homicide at nearly 12 times the rate of Whites in 2007 and nearly 13 times the rate of Whites in 2016.



Data Source: Michigan Incident Crime Reporting System, 2007, 2016

Quality of Housing

- From 2006 to 2015, median home value decreased for all racial/ethnic groups, as well as for Michigan overall.
- During this time period, the median home value was lower among Black, non-Hispanics, Hispanics and American Indian/Alaskan Native than the overall Michigan population.
- In 2011-2015, the median home value for Michigan overall was 2.5 times higher than the median home value for Blacks, 1.8 times higher than the median home value for Hispanics, and 1.7 times higher than the median home value for American Indians/Alaska Natives.



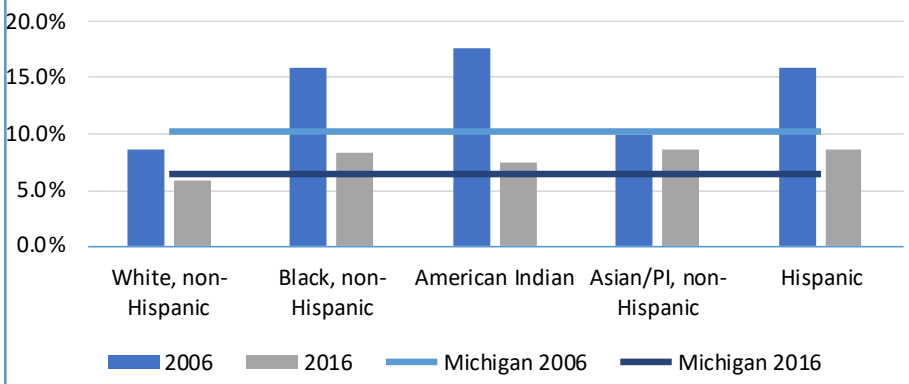
Data Source: American Community Survey, 2006-2015

Health and Health Care

Access to Health Care

- The percentage of the population that was uninsured decreased in 2016 as compared to 2006 for all populations.
- For both years, Whites had the lowest rates of being uninsured.
- According to the Centers for Disease Control and Prevention (CDC) health insurance coverage is a strong indication of access to health care.[5]

Percent Uninsured
Michigan 2006, 2016

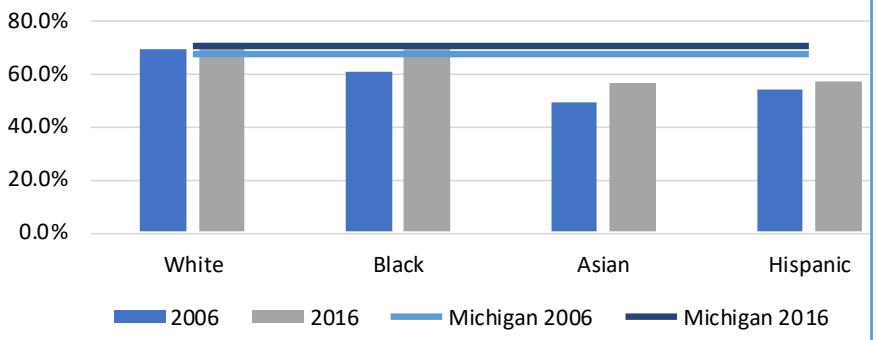


Data Source: Current Population Survey 2006, 2016

- Timely and appropriate access to care may prevent illness and reduce the risk of complications to chronic health conditions.[3]

Social and Community Context

Percent of Citizen Population Registered to Vote,
Michigan 2006, 2016



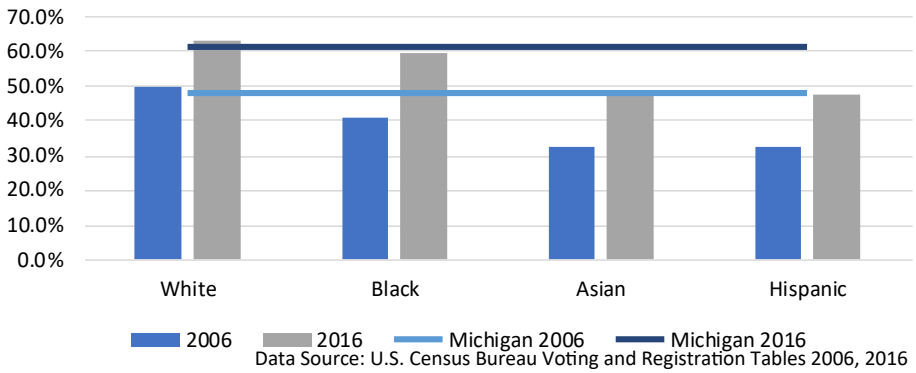
Civic Participation

- Whites had the highest voter registration rates, followed by Blacks, for both years.
- The percentage of Hispanics registered to vote decreased in 2016 as compared to 2006.
- From 2006 to 2016, voter registration increased among Asians.

Civic Participation

- Whites had the highest voting rates, followed by Blacks, for both years.
- During this time period, the percent of population that voted increased for all racial/ethnic groups.
- Note: 2016 was a presidential election, 2006 was not.

Percent of Citizen Population that Voted,
Michigan 2006, 2016

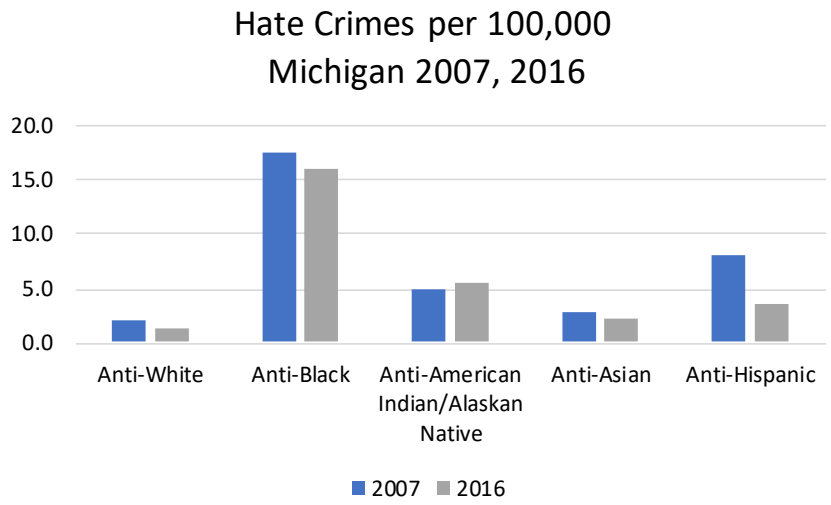


Data Source: U.S. Census Bureau Voting and Registration Tables 2006, 2016

Social and Community Context

Discrimination

- From 2007 to 2016, hate crimes decreased among all racial/ethnic groups, with the exception of American Indians/Alaskan Natives.
- Hate crimes against Blacks were over 8.4 times higher than hate crimes against Whites in 2007 and that increased to 12.6 times in 2016.
- Among Hispanics, hate crimes were 3.8 and 2.7 times that of Whites, in 2007 and 2016 respectively.

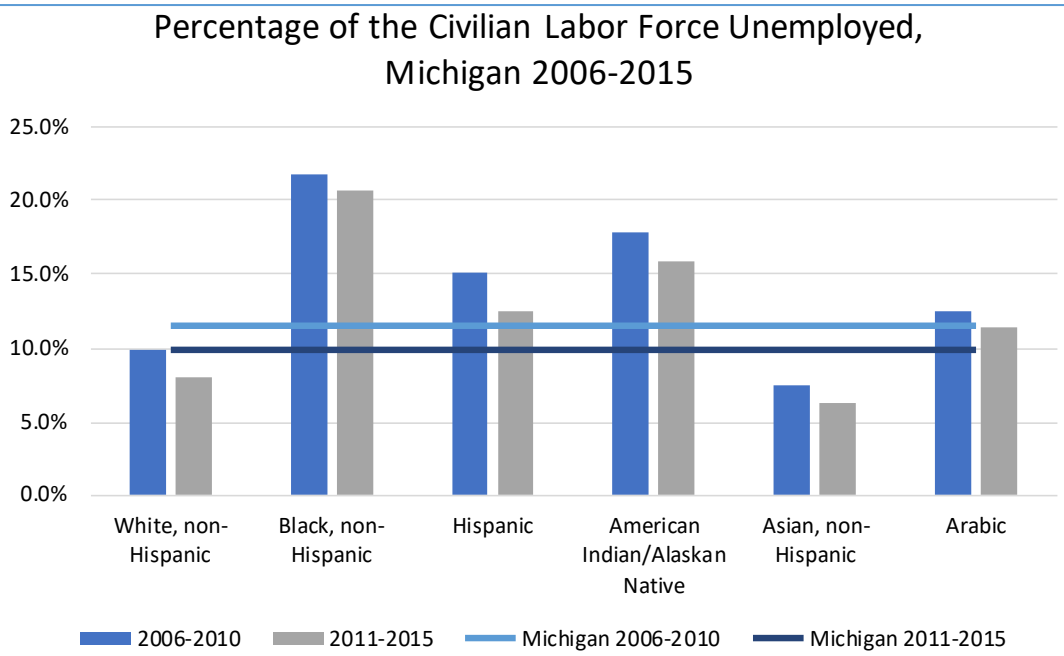


Data Source: Michigan Incident Crime Reporting System, 2007, 2016

Economic Stability

Employment

- Unemployment rate in Michigan decreased from 2011-2015 as compared to 2006-2010.
- Unemployment rates were higher for Blacks, Hispanics, American Indians/Alaskan Natives and Arabs than the overall Michigan population, for both time frames.
- Although each population is experiencing reduction in unemployment rates, for some populations the disparity is worsening. For example, in 2006-2010, unemployment rate for Blacks was 2.2 times the rate of Whites and that increased to 2.6 times in 2011-2015.

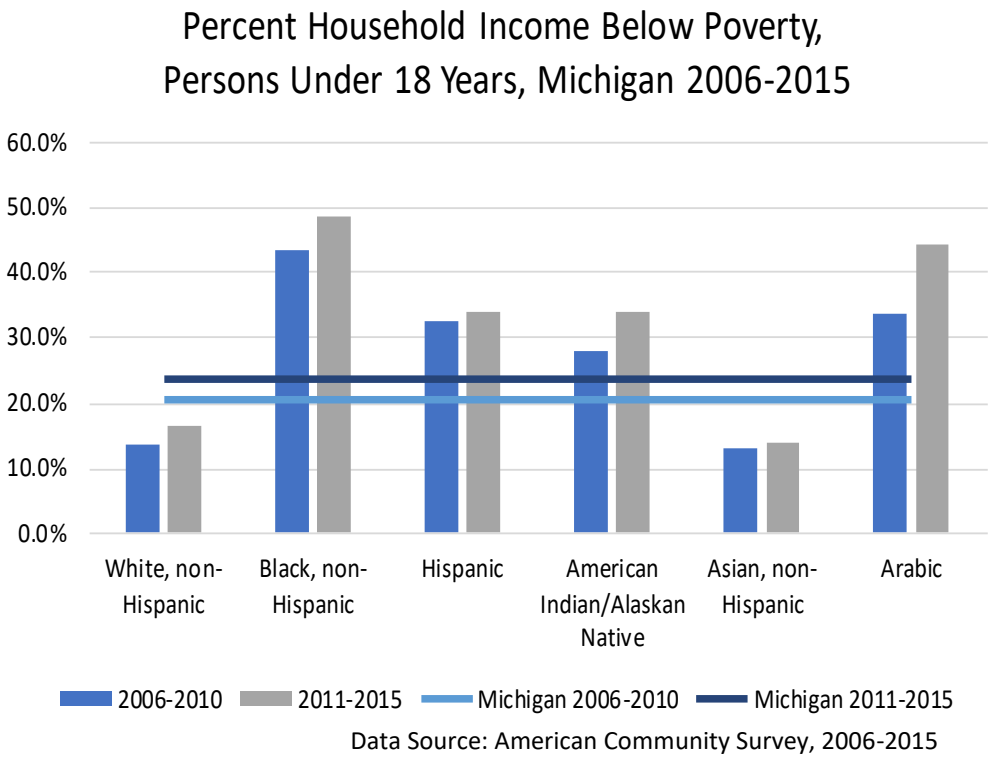


Data Source: American Community Survey, 2006-2015

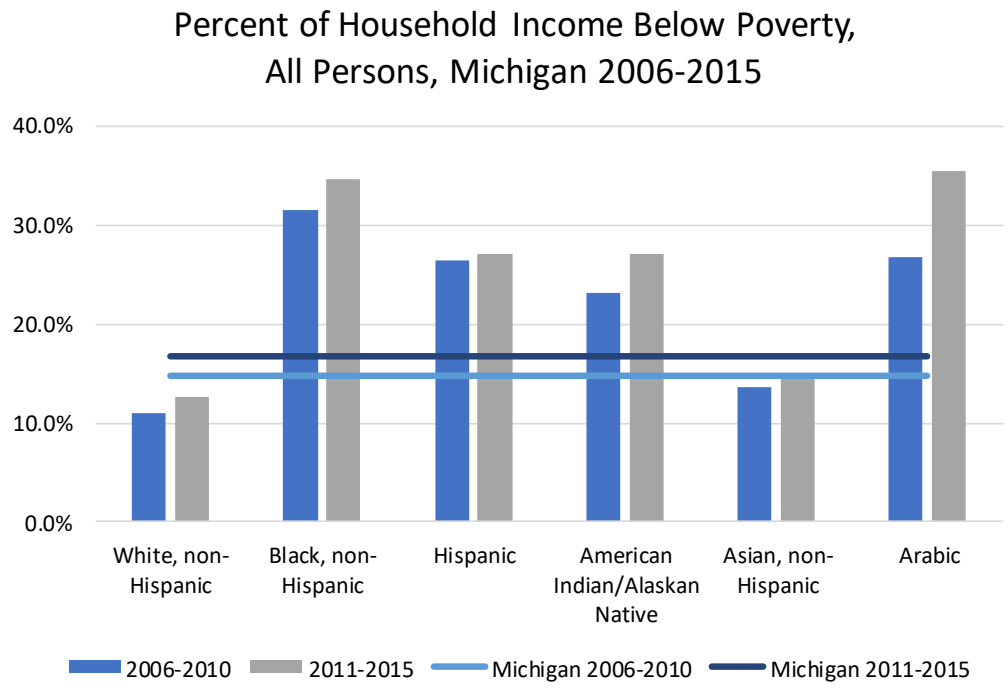
Economic Stability

Childhood Poverty

- Childhood poverty is increasing in Michigan for all racial/ethnic groups.
- African Americans, Hispanics, Arabs, and American Indians/Alaskan Natives experience higher childhood poverty than Michigan overall.
- African Americans experienced childhood poverty at roughly 3 times the rate of whites, for both time frames.



Data Source: American Community Survey, 2006-2015



Data Source: American Community Survey, 2006-2015

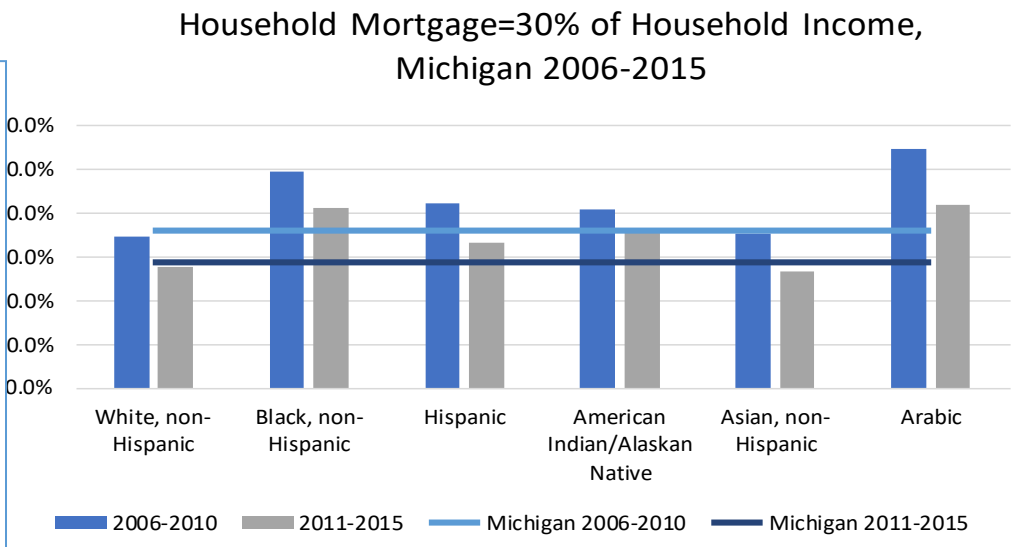
Poverty

- Overall poverty (all persons) is increasing for all racial/ethnic groups in Michigan.
- African Americans, Hispanics, Arabs, and American Indians/Alaskan Natives experience higher childhood poverty than Michigan overall.
- African Americans experience the highest poverty rates for all racial/ethnic populations.

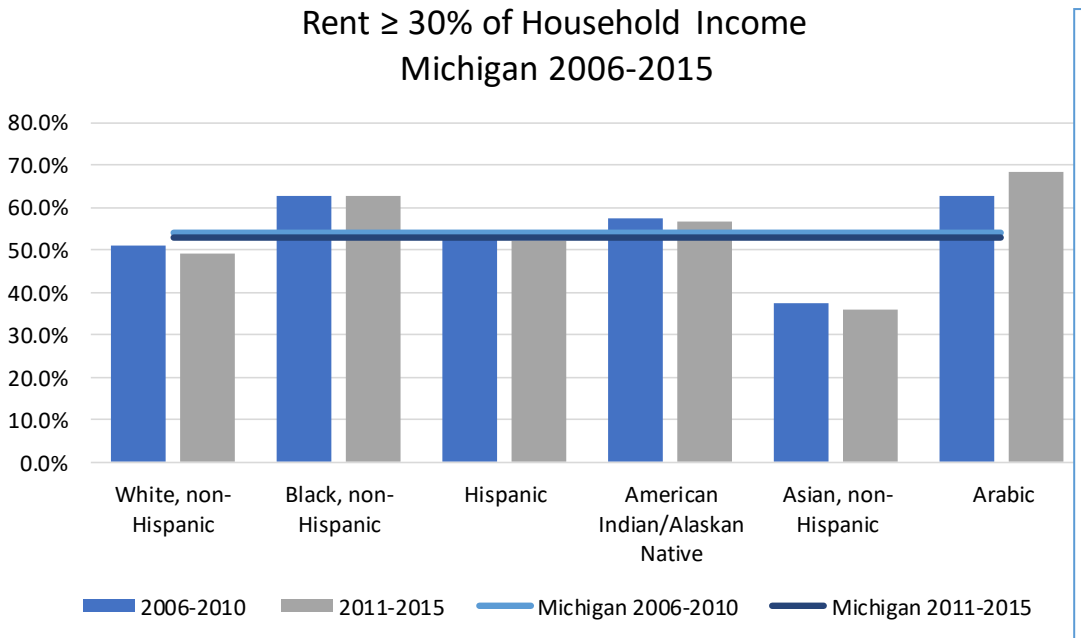
Economic Stability

Housing Instability

- Housing Instability decreased in 2011-2015 as compared to 2006-2010.
- Blacks non-Hispanics, Hispanics, American Indians/Alaska Natives, and Arabs experienced greater housing instability than Michigan overall.



Data Source: American Community Survey, 2006-2015

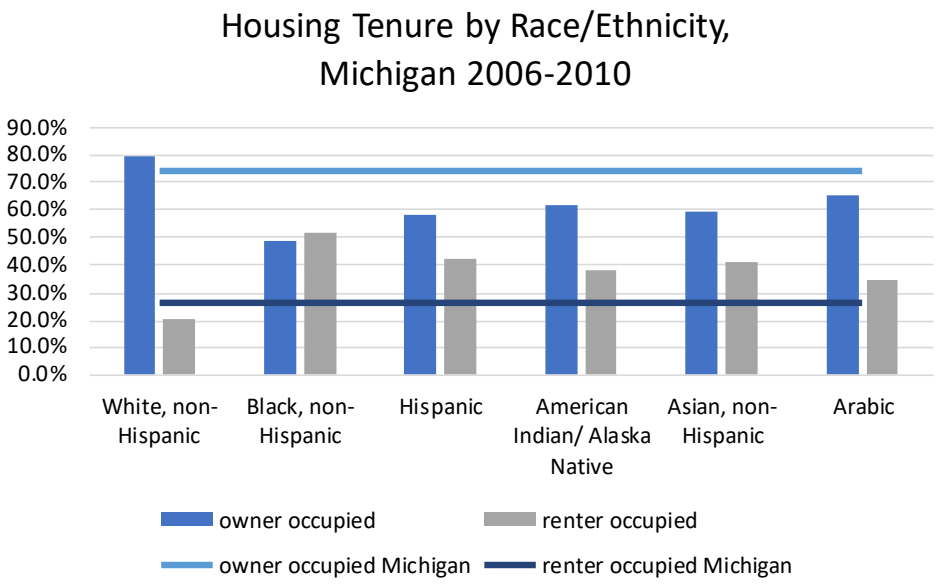


Housing Instability

- Housing Instability has remained relatively stable amongst renters from 2006-2015.
- African Americans, Arabs, and American Indians experienced higher rates of rental cost burden than Michigan overall, for both time frames.

Data Source: American Community Survey, 2006-2015

Economic Stability



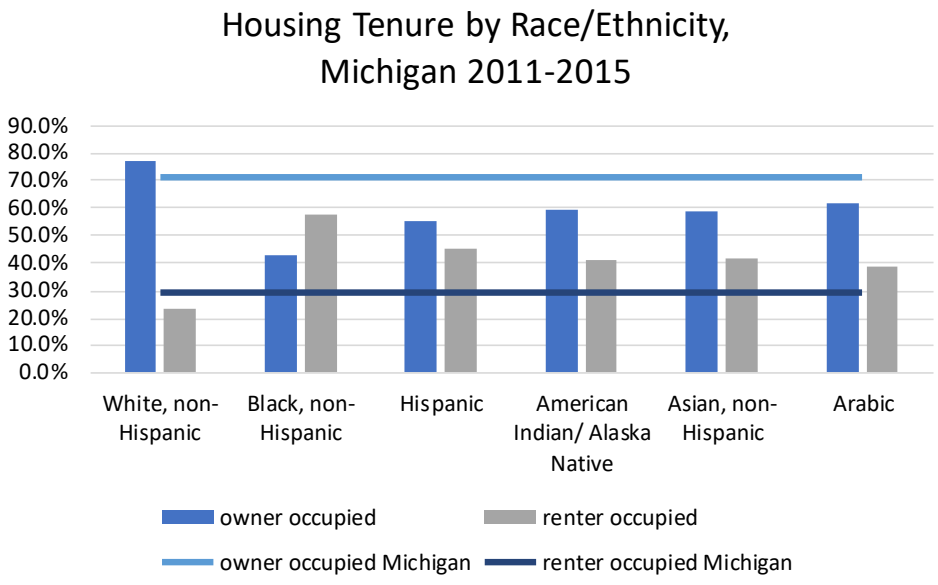
Home Ownership

- From 2006 to 2010, Black non-Hispanics were 31.1% less likely to own the home they were living in as compared to White, non-Hispanics.
- Black non-Hispanics were the only population with a higher prevalence of renter occupied homes than owner occupied homes.

- White, non-Hispanics had a higher percentage of owner occupied homes as compared to all other racial and ethnic minority groups in 2006-2010 and 2011-2015.
- Black, non-Hispanics were the only population to have higher percentages of renter occupied homes as compared to owner occupied homes in 2006-2010 and 2011-2015.
- Michigan experienced a Great Recession between 2007 and 2009, contributing to a 127% increase in foreclosures, equating to 2.8 million foreclosed homes[5].
- Research has shown housing instability to be significantly associated with adverse health outcomes[5].

Home Ownership

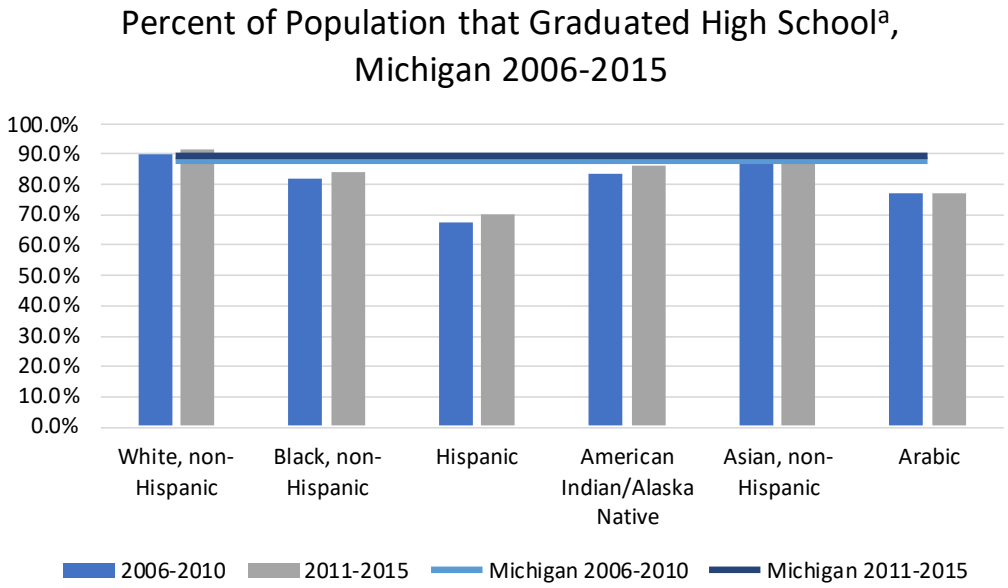
- For each population, the percentage of owner occupied housing tenure decreased from 2011-2015 as compared to 2006-2010.
- Black non-Hispanics experienced the greatest decrease in owner occupied homes at 6.1%.
- From 2011 to 2015, Black non-Hispanics were 2.5 times more likely to rent than White, non-Hispanics.



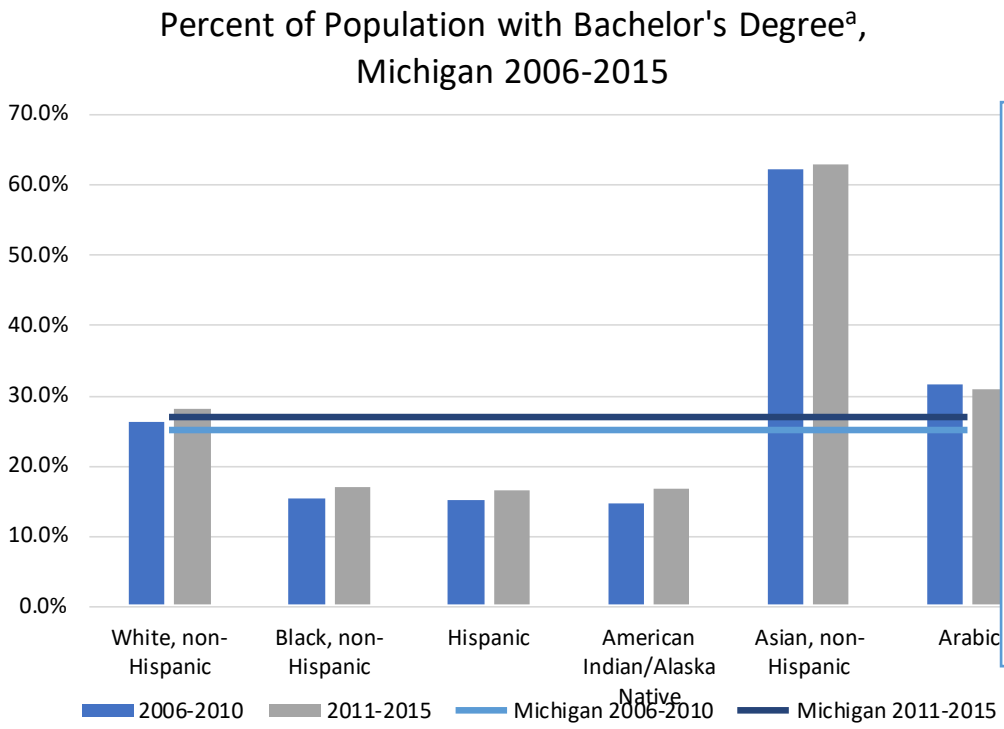
Education

High School Graduation

- From 2006 to 2015, high school graduation increased for all racial/ethnic groups.
- For both time periods, Black, non-Hispanics, Arabs, and Hispanics had lower high school graduation attainment than Michigan overall.



[a] The data includes adults 25 years and older



Enrollment in Higher Education

- From 2006 to 2015, all populations had an increase in college graduates, with the exception of Arabs.
- Black non-Hispanics, American Indians/Alaska Natives, and Hispanics had lower percentages of college graduation than Michigan overall for both time periods.

[a] The data includes adults 25 years and older

Literature Sources: 1. https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity 2. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health 3.Sandro Galea et al., "Estimated Deaths Attributable to Social Factors in the United States" *American Journal of Public Health* 101, no. 8 (August 2011):1456–1465, doi:10.2105/AJPH.2010.300086. 4. https://www.ncbi.nlm.nih.gov/pubmed/21563622 5. https://www.cdc.gov/nchs/data/factsheets/factsheet_hiac.pdf 5. http://www.npc.umich.edu/publications/policy_briefs/brief29/NPC%20Policy%20Brief%20-%2029.pdf