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# **Successful Strategies to Increase Our Focus on Health Equity**



**Michigan Department of Community Health  
Health Equity Steering Committee**

**Success Story Volume 2: November, 2013**

# Successful Strategies for Promoting and Integrating Health Equity in Health Programming

## Volume 2 (Successes 8-13)

Health Equity Steering Committee  
The Ambassador Project

In an effort to identify and promote strategies to ensure that programs and practices are equity focused, both internally and among our contractors, the Michigan Department of Health's *Health Equity Steering Committee* has compiled a series of stories providing specific examples of Departmental initiatives designed to address and remedy issues of equity and diversity.

**This document includes examples of overall strategies and corresponding initiatives/projects that address the most common areas for improvement identified in recent interviews across the Public Health Administration.**

While each strategy and its related initiatives are broadly described and include contact information for the person most familiar with the implementation of that initiative/project. This will allow you to contact that person for additional details on making this strategy work within your Section or Division.

The following strategies and initiatives are outlined in this document:

### **Processes to ensure most at risk/impacted populations are the beneficiaries of services**

- Maternal, Infant and Early Childhood Home Visiting Program Collaborative and Community-Based Exploration and Planning Process
- Implementation of Culturally and Linguistically Appropriate Standards for HIV/AIDS Care and Treatment Service Agencies

### **Interview techniques to identify persons with knowledge of, and commitment to, health equity**

- Health Equity Interview Questions

### **Expertise in data collection and interpretation to insure data which highlights health inequities is utilized by program and stakeholders**

- Special Cancer Behavioral Risk Factor Survey
- Obesity Burden Report (2009) and Surveillance Annual Updates
- Why We Ask Data Improvement Campaign

MDCH staff is encouraged to submit any diversity/equity success you have implemented. For more information on submitting your story, please contact Sheryl Weir, Health Disparities Reduction and Minority Health Section Manager at (313) 456-4314, or [weirs@michigan.gov](mailto:weirs@michigan.gov).

## Health Equity Steering Committee Ambassador Project Success Story 8

**Overall Strategy** – Increasing local input in program funding

**Name of Initiative/Project** – Maternal, Infant and Early Childhood Home Visiting Program Collaborative and Community-Based Exploration and Planning Process

**Name of Person Submitting Success Story**

Agency - Maternal, Infant and Early Childhood Home Visiting (MIECHV), Child Health Unit

Contact Person – Cynthia Zagar, [ZagarC@michigan.gov](mailto:ZagarC@michigan.gov), 517-335-3965

**Description of Process**

The Maternal, Infant and Early Childhood Home Visiting (MIECHV) program, a provision of the Affordable Care Act, is designed to improve the health of vulnerable families with children ages 0-5, through Health Resources and Services Administration identified evidence-based home visiting models. In 2010, the program embarked on an innovative collaborative and planning process in an effort to steer services to families with the greatest needs.

Based on data and recommendations from a state-level Home Visiting Work Group (convened by the Child Health Unit), the MIECHV program notified 10 communities, primarily local health departments (LHDs), that funding opportunities were available to implement home visiting programs. These 10 communities were approached as a result of having significantly high county rates of the following: prenatal, maternal, newborn or child health concerns; crime; domestic violence, high school dropouts, substance abuse and unemployment.

Each LHD in the identified counties were then asked to assemble a local work group requiring representatives from public health, Head Start, Department of Human Services/Child Abuse and Neglect Council, and substance abuse organizations. They were encouraged to also include representation from education, mental health, the Great Start Collaborative and parents who have participated in home visiting programs.

To initiate the process, MIECHV staff and members of the state-level Home Visiting Work Group met face-to-face with local work groups in each community to discuss the conditions of funding. MIECHV staff explained that specific communities were already designated to receive home visiting services based on local economic, health and social data. As a pre-requisite of funding, the 11 local work groups were charged with reviewing their local data, completing a needs assessment, and identifying gaps in services for their designated communities.

Following this process, each work group was charged with the task of determining and recommending which agency(ies) had the capacity to address the identified gaps in services and would be most suited to receive funding for home visiting services. This was especially challenging because the representatives could not simply advocate that his/her organization get the funding.

Rather, the collective group had to assess and agree on which local organization(s) could most effectively begin to close the gaps in services for vulnerable families by offering the most culturally appropriate evidence-based home visiting program for their target population. The home visiting model could not be pre-determined, but had to be decided on as a result of the needs of the identified target population and the model that had proven outcomes with those specific needs.

### **Results/Success**

Because the MIECHV grants have only recently been awarded, there is no data regarding the overall health impact that this planning process has had on families receiving home visiting services. Nevertheless, the process yielded the following positive outcomes related to “community exploration” and “engaging local partners in a decision-making process.” This process:

- Challenged lead agencies to conduct local assessments of current services, gaps in services, and needs of vulnerable families before implementing new programs.
- Challenged agencies’ preconceived ideas regarding which programs to implement, who to serve (i.e.; easily accessible families vs. those more difficult to reach), etc.
- Challenged local agencies to conduct targeted and purposeful outreach to the most vulnerable families.
- Challenged local agencies to consider and implement the most culturally and needs appropriate program models for the communities and population identified for services.
- Shifts resources to the most vulnerable communities and families.

### **Next Steps**

Based on the initial effort, an exploration and planning tool was created utilizing the concepts described above along with the research on Implementation Science. The tool was piloted in one community, has been edited as a result of that pilot experience and will now be used to help communities re-evaluate their needs, assets and the needs of vulnerable families with young children as well as identify the “best-fit” home visiting model for those needs.

To ensure that the overall process is and continues to be effective, the MIECHV program will engage the local work groups in a Continuous Quality Improvement (CQI) analysis of the process. The findings will build on the collaborative process’ strengths and inform opportunities for improvement.

## Health Equity Steering Committee Ambassador Project Success Story 9

**Overall Strategy** – Incorporating culturally and linguistically appropriate standards

**Name of Initiative/Project-** Implementation of Culturally and Linguistically Appropriate Standards for HIV/AIDS Care and Treatment Service Agencies

### **Name of Person Submitting Success Story**

Agency --HIV/AIDS Prevention and Intervention Section (HAPIS) – August 2013  
Contact Person –Jane DuFrane, [DuFraneJ@michigan.gov](mailto:DuFraneJ@michigan.gov), 517-241-5904

### **Description of Process**

In 2000, the Office of Minority Health (OMH), U.S. Department of Health and Human Services published National Culturally and Linguistically Appropriate Standards (CLAS) aimed at providing the most appropriate services for diverse populations. These standards were revised and enhanced by HHS in 2013. CLAS Standards provide a framework to health and health care organizations for the delivery of “culturally respectful and linguistically responsive” care and services. In 2007, the Michigan Department of Community Health’s (MDCH) HAPIS adopted the CLAS framework and required all MDCH, HAPIS Continuum of Care sub-recipients to adhere to these standards, measures and incorporated CLAS Standards into sub-recipient monitoring practices.

Since the initial requirement was implemented, these standards were “Michiganized,” or made specific to HIV/AIDS support services, in order to better meet the needs of racial, ethnic and sexual minorities living with HIV. CLAS measures, a sub-recipient monitoring tool and training material were developed to assure that agencies were providing services appropriate to the target populations within their geographic areas. Training was provided to sub-recipients and HAPIS staff.

There are 21 sub-recipients/service providers throughout the state serving over 7,000 individuals with HIV/AIDS, inclusive of some local health departments, federally qualified health centers, medical clinics, hospitals and community-based service organizations. The goal of the CLAS standards training was to ensure that HAPIS staff and sub-recipients were trained, prepared and able to appropriately meet the service needs of all individuals living with HIV/AIDS regardless of geographic location, race, ethnicity, sexual orientation, gender identity, language, spirituality, or disability.

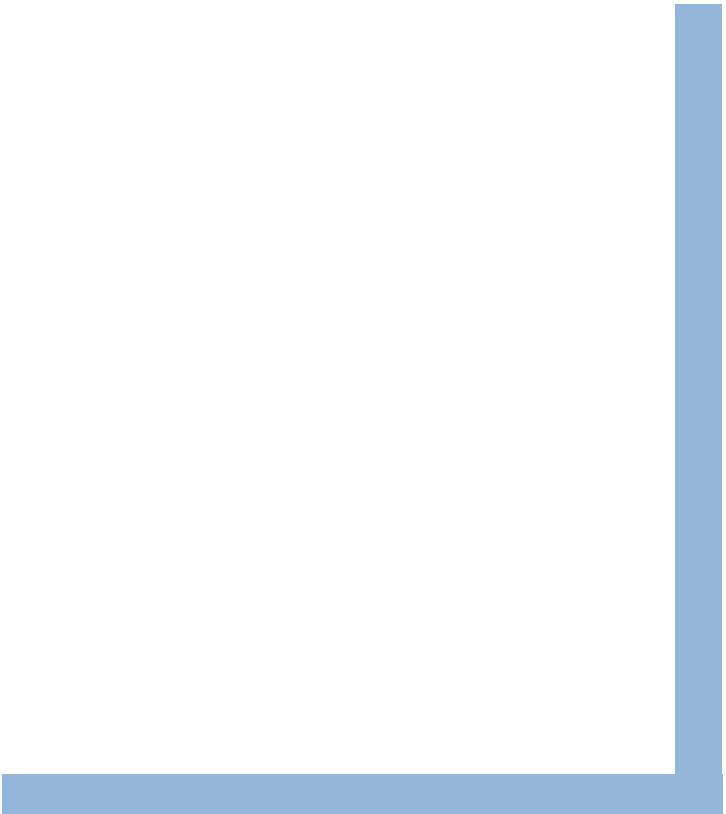
CLAS are also incorporated into the Strategic Plan and Continuum of Care Request for Proposals. The anticipated outcomes are: 1) reduced health disparities among racial, ethnic and sexual minorities living with HIV/AIDS, and 2) a decrease in the number of new infections. These goals are aligned with the National HIV/AIDS Strategy, and a strategic plan shared by three MDCH Sections—Sexually Transmitted Diseases (STD), Health Disparity Reduction and Minority Health (HDRMH) and HAPIS.



## **Results/Success**

While it may take years to assess or measure the impact that implementation of CLAS Standards have on reducing HIV-related disparities in Michigan, there are tangible successes that have resulted from this process. They include the development of monitoring tools and training materials, the requirement that sub-recipients adopt and adhere to CLAS Standards, and the training of HAPIS staff and sub-recipients. As a result, culturally and linguistically appropriate and equitable services are being provided to individuals living with HIV/AIDS in Michigan.

In an effort to build on this momentum, the HAPIS, STD, and HDRMH Sections are collaboratively developing a Train-the-Trainer CLAS curricula for internal and external partners.



# Health Equity Steering Committee Ambassador Project **Success Story 10**

**Overall Strategy** – Incorporating Health Equity Questions into the Interview process

**Name of Product/Project** – Health Equity Interview Questions

**Name of Person Submitting Success Story**

- Sheryl Weir – Manager, Health Disparities Reduction and Minority Health Section, [WeirS@michigan.gov](mailto:WeirS@michigan.gov), 313-456-4314;
- Brenda Fink - Director, Division of Family and Community Health, [FinkB@michigan.gov](mailto:FinkB@michigan.gov), 517-335-8863
- Janet Kiley – Unit Manager, Tobacco Section, [KileyJ@michigan.gov](mailto:KileyJ@michigan.gov), 517-335-9407
- Gwen Imes – Unit Manager, Cardiovascular Health, Nutrition & Physical Activity Section, [ImesG@michigan.gov](mailto:ImesG@michigan.gov), 517-335-9492
- Jane DuFrane, Manager, HIV/AIDS Prevention and Intervention Section, [DufraneJ@michigan.gov](mailto:DufraneJ@michigan.gov), 517-241-5904

**Objective of the Product/Project**

To become familiar with an applicant’s understanding and experiences regarding healthy equity, health disparities and social determinants of health\* during the interview process.

**Description of the Product/Project**

Interview questions were developed for positions to be filled at the Michigan Department of Community Health and its affiliates to assess an applicant’s understanding of the concepts of health equity, health disparities and social determinants of health.

**How was product used and by whom**

Healthy equity, health disparities and social determinants of health questions were developed and added to posting/supplemental questions or interview questions by the listed MDCH programs.

**Results/Success/How being used**

The questions provide programs with information regarding an applicant’s knowledge and experience related to healthy equity that will help with determining the best candidate for the position. Additionally, the movement towards integrating the concepts of health equity, health disparities and social determinants of health into public health programming is enhanced with the additions of these types of questions.

*\* Definitions used by Health Disparities Reduction and Minority Health Section*

*(Health Equity – Fair and just opportunity for health for all; absence of systematic disparities in health between groups of people at different levels of social advantage.  
Health disparities – Difference in health status or health outcomes between populations (ex.; Blacks and Whites) often described as unfair and unjust.*

*Social determinants of health - Social, economic, and environmental factors that contribute to the overall health of individuals and communities. (Includes racial and ethnic discrimination, political influence, income, education, employment, wealth, living and working conditions, transportation, air and water quality, etc.).*

### **Sample Interview Questions**

The following questions may be adapted for your specific program.

#### **I. Sheryl Weir – Manager, Health Disparities Reduction and Minority Health Section**

- Our program is working to direct more policy and programmatic attention to the importance of health equity both within MDCH and with our external partners. What is your understanding of the concepts of health equity, health disparities and social determinants of health\*? Examples?
- Please give some examples of health disparities related to refugee populations.
- How do you define social determinants of health? Can you provide some refugee specific examples?
- In what ways do race, ethnicity and language impact health?
- What can health department programs, i.e. refugee health services, do (or do differently) to address health disparities?
- How can local communities be empowered to address health inequities for refugee populations?
- What is the role of policy and environmental change in the effort to achieve health equity?

#### **II. Brenda Fink - Director, Division of Family and Community Health**

- Have you had opportunities to address the impacts of the social determinants of health in your current or past work/experiences? How did you measure the results?
- What strategies do you find important to incorporate as part of improving social justice and equity in program development, management and evaluation?
- What role/opportunities do communities have in mitigating the negative impacts of social determinants of health? What opportunities/role/obligation does the state have?

#### **III. Janet Kiley – Unit Manager, Tobacco Section**

##### Posting questions:

- Describe your recent experience working with a health project or program targeting diverse populations\*.



- Describe your recent experiences facilitating or leading a multi-cultural, community coalition and working with local health agencies representing diverse populations.
- Describe the significant social and economic determinants that hamper equal access to care.

*\* Diverse populations include ethnic, racial, LGBT or other groups challenged by social, cultural and economic factors.*

Interview questions:

- Describe a situation in which you worked with someone whose beliefs or approach to an issue differed from yours. How was the issue resolved?
- Please describe your understanding of the health effects of commercial tobacco use and of secondhand smoke. We use the terms ‘commercial tobacco’ to distinguish it from the ritual or sacred use by Native Americans.

**IV. Gwen Imes – Unit Manager, Cardiovascular Health, Nutrition and Physical Activity Section**

- How have urban sprawl affected obesity and physical activity and what could be done to address its effect on obesity rates.
- What is your philosophy concerning obesity prevention, its contributing factors and strategies to address these factors.

**V. Jane DuFrane – Manager, HIV/AIDS Prevention and Intervention Section**

- What is your understanding of the concepts of health equity, health disparities and social determinants of health? Please describe how they might impact “disease/condition” prevention and care.
- Describe your understanding of how “disease/condition” health disparities affect minority populations.
- Federal and state funding is being reduced. How will you effectively manage a program with these reductions and still focus on reducing health disparities and health inequity?

## Health Equity Steering Committee Ambassador Project Success Story II

**Overall Strategy** – Using data collection to plan, implement and improve programming

**Name of Product/Project** – *Special Cancer Behavioral Risk Factor Survey, 2008*. Published April 2010

**Name of Person Submitting Success Story**

Agency – Cancer Prevention and Control Section

Contact Person – May Yassine, Michigan Public Health Institute, [myassine@mphi.org](mailto:myassine@mphi.org), 517-324-7308

**Objective of the Product/Project**

To collect systematic population-based data that is generalizable for the population of interest for program planning, implementation and improvement.

**Description of the Product/Project**

The Special Cancer Behavioral Risk Factor Survey (SCBRFS) was an ongoing surveillance designed to measure progress towards achieving several priorities of the Michigan Cancer Consortium (MCC). The first baseline SCBRFS was conducted in 2001-2002. The SCBRFS was repeated in 2004, 2006, and 2008. Results from subsequent surveys can be compared against baseline data in order to evaluate the progress in cancer-related behaviors and knowledge within the Michigan adult population.

The 2008 SCBRFS was conducted in a representative sample of the general population which included an over-sampling of African American, American Indian, Hispanic, Arab American and Asian American residents. Only the 2004 and 2008 surveys over-sampled Asian American residents of the state. The 2004, 2006 and 2008 surveys targeted individuals 40 years of age or older while the 2001-02 survey included only those 50 years of age or older. For the 2008 survey, a total of 5,631 interviews were completed.

The data was collected using telephone surveillance methodology. This methodology closely followed protocols used in the Michigan Behavioral Risk Factor Surveillance System (BRFSS) and all data collection was performed by the Office for Survey Research.

The survey gathered measures for screening and risk behaviors as well as end of life care including pain management. The project was a partnership among the Michigan Public Health Institute, Michigan State University, and numerous member organizations of the Michigan Cancer Coalition including ACCESS, a community based service provider for the Arab/Chaldean community.

### **How was product used and by whom**

Data has been used by the Department, as well as community partners. For instance, ACCESS (spell out) developed a media campaign focused on screening for colorectal cancer based on disparate findings in their target community. The MDCH Tobacco Control Section also used study data to identify associations between risk and behavior and developed targeted cessation programming. Community partners have utilized data in grant writing and have received cancer related grants from local and federal sources.

Data in the pain management area led to the establishment of the Pain Management Unit, under the Bureau of Health Professions. This body has been active since 2004 in areas of regulation and education regarding patient rights and pain management. They have also partnered to influence pain education in medical school curricula focusing on the disparate experiences across racial and ethnic lines.

### **Results/Success/How being used**

The published data continue to be accessed by stakeholders via the Department website. Excerpts of the data are used in papers and presentations for meetings, committees, and conferences. Additionally, many Masters level students have conducted secondary analysis of the data set, published papers of significance, and received their degrees.

#### **Item available:**

Attached

Electronically at <http://www.michigancancer.org/PDFs/MCCReports/>

[SCBRFS\\_2008-042910.pdf](#)

## Health Equity Steering Committee Ambassador Project Success Story 12

**Overall Strategy** – Increase awareness of health disparities with race and ethnicity data

**Name of Product/Project** – Obesity Burden Report (2009) and Surveillance Annual Updates

### **Name of Person Submitting Success Story**

Agency – Cardiovascular Health, Nutrition and Physical Activity Section

Contact Person – Gwen Imes (Program), [ImesG@michigan.gov](mailto:ImesG@michigan.gov), 517-335-9492; Michelle Byrd (Epidemiology), [ByrdM2@michigan.gov](mailto:ByrdM2@michigan.gov), 517-241-4639

### **Objectives of the Product/Project**

- To share surveillance data with program partners across the state,
- To demonstrate progress in decreasing the prevalence in obesity and overweight, and
- To identify the behavioral risk factors associated with these conditions.

### **Description of the Product/Project**

**Overweight and Obesity in Michigan: Surveillance Report 2009** – a fifty-two page document which includes an executive summary, as well as key findings and recommendations for multiple data points related to obesity. The document is well organized and includes a narrative next to each graph to simplify the data for the reader.

**Overweight and Obesity in Michigan: Surveillance Report, Annual Update** – A ten to fifteen page annual update of data presented in the larger 2009 document. Updated data is presented in graphic and narrative format and data is interpreted by epidemiologists in a manner that is understandable to the general public.

### **How was product used and by whom**

The product was used by the state and local partners to identify disproportionately impacted sub-populations and to guide programming efforts and resource allocations.

### **Results/Success/How being used**

Since publishing the original document in 2009, it has prompted additional data requests, and has served as an important tool for building the capacity of stakeholders to read and understand data. The documents increase awareness of health disparities through the presentation of data which is stratified by race and ethnicity. The Program also found it important to provide data to stakeholders for use in writing grants, and comparison at the local, and state levels.

### **Item available:**

- Attached
- Electronically at [www.michigan.gov/preventobesity](http://www.michigan.gov/preventobesity) (scroll to bottom)

**Health Equity Steering Committee**  
Ambassador Project  
**Success Story 13**

**Overall Strategy** – Improve data collection related to race and ethnicity

**Name of Product/Project** – Why We Ask Data Improvement Campaign

**Name of Person Submitting Success Story**

Agency – Division on Health, Wellness and Disease Control, STD Section

Contact Person – Amy Peterson, [PetersonA7@michigan.gov](mailto:PetersonA7@michigan.gov), 313-456-4425

**Objective of the Product/Project**

Accurate and complete data are fundamental to quality service provision, valid epidemiology, and the development of targeted interventions. The objective of the Why We Ask campaign is to improve the completeness and quality of race and ethnicity data in Michigan's STD reporting systems.

**Description of the Product/Project**

The *You Decide* Campaign materials have been developed as one tool to improve the completeness of these data. Materials developed for distribution include: posters, folders, and privacy flaps.

**How was product used and by whom**

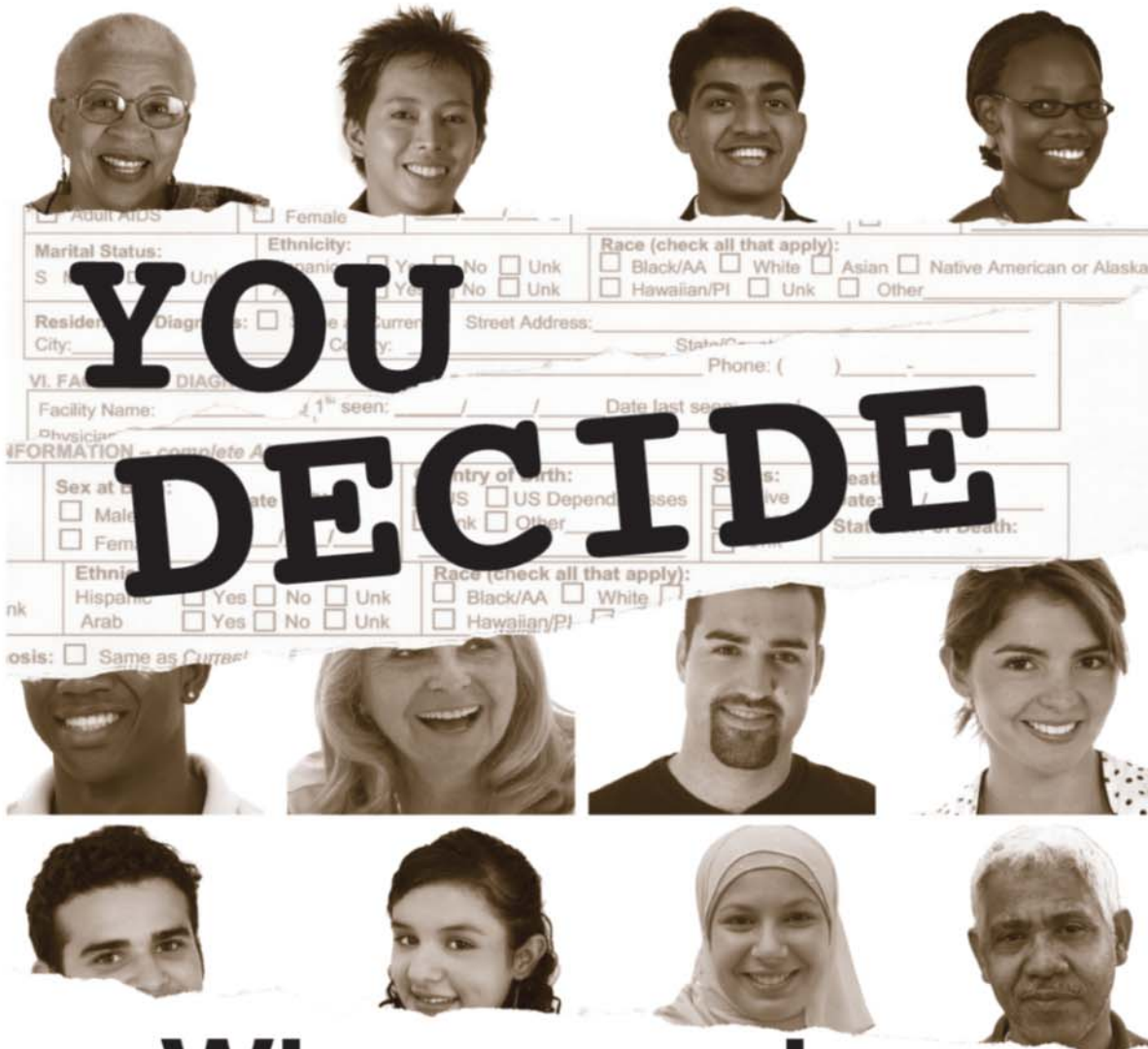
Items were placed in waiting rooms, exam rooms, and made present at patient registration in ????. The items and accompanying educational materials were also distributed to staff as training tools to increase their attention to race and ethnicity data as well.

**Results/Success/How being used**

Each year between 60,000 and 65,000 cases of chlamydia and gonorrhea are diagnosed and reported into the Michigan Disease Surveillance System (MDSS). From 2006 to 2010, the completeness of race data on these cases increased from 55% to 61%. Why We Ask was implemented in 2008.

Campaign materials continue to be distributed at conferences and trainings. They are on display in public STD screening venues.

**Item available:**      Attached (contact Amy Peterson as noted above)  
                               Electronically at



## Why we ask...

**RACE and ETHNICITY are separate concepts describing a person's identity.**

**Complete RACE and ETHNICITY information helps us to improve our services for diverse communities.**

When completing forms...

- Answer all RACE and ETHNICITY questions when you see them.
- If you identify your ETHNICITY as Hispanic or of Arab descent, also select the RACE that best describes you.
- If you are not Hispanic or of Arab descent, mark Hispanic "No" Arab "No", as well as your race.

