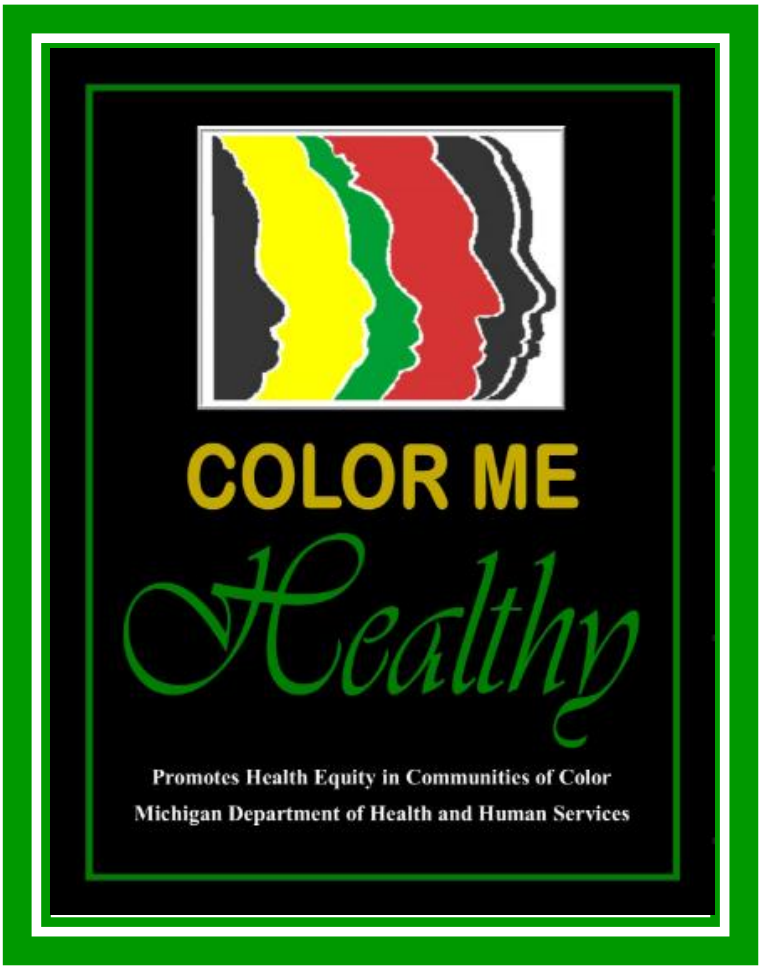
Michigan Department of Health and Human Services

2021 Health Equity Report

Moving Health Equity Forward



Released May 2022

MDHHS
Michigan Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

May 2022

Dear Legislator:

On behalf of the Michigan Department of Health and Human Services (MDHHS), I am pleased to present the 2021 MDHHS Health Equity Report, "Moving Health Equity Forward." In accordance with Public Act (PA) 653, also known as Michigan's Minority Health Law, this report documents many of the department's efforts to address racial and ethnic health disparities in Michigan.

As discussed in last year's report, the COVID-19 pandemic has illuminated long-standing inequities experienced by racial and ethnic populations and other marginalized communities. As we continue to address COVID-19 and these inequities, it is important to look at the structure and capacity of our public health and human services systems and ensure there is a strong foundation supporting our efforts now and in the future. Therefore, the 2021 Health Equity Report focuses on the public health and human services infrastructure and key components necessary to promote racial and ethnic equity in accordance with PA 653 provisions.

Included in the report is an overview of the department's current infrastructure along with existing gaps and recommendations for strengthening the department's capacity to advance health and social equity. A supplemental data brief that looks at leading health and social disparities by race and ethnicity is included as well.

While Michigan's public health and human services infrastructure has both strengths and weaknesses, MDHHS remains committed to maintaining, supporting and improving existing structures to eliminate disparities, address gaps and challenges, and strengthen its infrastructure to assure equity for all racial and ethnic populations. However, this will require long-term and sustained investments in organizational and system capacity, as well as a focus on addressing the underlying and structural inequities that contribute to racial and ethnic disparities.

With federal relief funds provided in response to the pandemic, we have a unique and historic opportunity to strategically invest in a public health and human services infrastructure that is poised to address existing and emerging challenges and rebuild communities with an eye towards equity. This will only be possible by working collaboratively with communities, state and local governments and other sectors. Together, we can set a course for health and well-being in Michigan that advances equity and provides opportunities for each Michigander to attain their full potential. We hope this report will be informative and useful to our collective efforts.

Sincerely,

Brenda J. Jegede, MPH, MSW
Leader, Office of Equity and Minority Health
Office of Race Equity, Diversity & Inclusion
Michigan Department of Health and Human Services

Table of Contents

2021 Health Equity Report
Moving Health Equity Forward
Executive Summary

The Michigan Department of Health and Human Services (MDHHS) 2021 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. This legislation was passed by Michigan's 93rd Legislature in 2006 and became effective in January 2007. It amends the Michigan Public Health Code (1978 PA 368; MCL Section 333.2227). (See Attachment A.)

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

Over the past two years, the COVID-19 pandemic has not only illuminated pervasive inequities among racial and ethnic minority populations, but also exposed weaknesses in the public health and human services infrastructure. Having a strong, multidimensional and integrated infrastructure is essential to Michigan's health, safety and economic prosperity, as well as to achieving health and social equity.[1,2] The increased awareness of racial and ethnic inequities, along with the recent influx of federal COVID-19 relief dollars, presents a unique opportunity to strategically invest in and strengthen the state's public health and human service infrastructure with a particular eye towards equity.[1,3] Therefore, the 2021 Health Equity Report focuses on MDHHS's infrastructure and key components necessary to promote racial and ethnic equity in accordance with PA 653 provisions.

For the purpose of this report, infrastructure is defined as the underlying foundation that supports the planning, delivery and evaluation of public health and social service activities and practices.[4] Core components include: workforce capacity and competency, robust and up-to-date data and information systems, and organizational capacity to address public health and social needs.[5] Additional domains include financing, policy/law, technology, cross-sector partnerships, and community engagement.[1]

Included in the 2021 Report is an overview of what is currently in place with regard to each of the above-named elements of infrastructure along with existing gaps and recommendations for strengthening the department's capacity to advance health and social equity. In addition, the report includes a data brief highlighting leading health and social disparities for Michigan's racial and ethnic populations (Attachment B).

Information for this report was obtained through a department-wide survey completed by MDHHS organizational areas. Overarching findings showed that among survey respondents:

- Over 88 percent (88.9%) implemented practices to promote workforce diversity, retention and advancement.
- Over 98 percent (98.4%) reported that personnel participated in training or professional development to enhance cultural competency and capacity to address health and social equity.
- Nearly two-thirds (65.1%) had data and information systems to collect, analyze and/or report race and ethnicity data.
- Over three-quarters (77.8%) had structures in place to support health and social equity work.
- A quarter (25.4%) received funding for efforts to advance health/social equity.
- Two-thirds (66.7%) established/followed equity-promoting policies and/or laws.
- About 44 percent (44.4%) used new or existing technology to advance health/social equity among racial and ethnic groups.
- Nearly 62 percent (61.9%) engaged in cross-sector partnerships to address social determinants of health and advance equity for racial and ethnic populations.
- Over half (55.6%) engaged communities to improve health and social conditions for racial and ethnic populations.

Moving forward, the State of Michigan should invest resources in sustainable, long-term solutions that continue to build a robust and equitable public health and human services infrastructure. Doing so will help to provide a firm foundation on which to rebuild the economic security, health and well-being of Michigan citizens post-pandemic as well as prepare the state to address future challenges and crises. The department invites policymakers as well as partners across the state to seize this opportunity and come together to take action.

Acknowledgements
The Office of Equity and Minority Health (OEMH) would like to thank all MDHHS administration, bureau and division directors as well as other managers and personnel that completed the 2021 Health Equity Survey. The time and assistance of survey participants is much appreciated.

2021 Health Equity Report
Moving Health Equity Forward

Introduction

The 2021 Health Equity Report, "Moving Health Equity Forward," serves as the Michigan Department of Health and Human Services (MDHHS) annual report documenting efforts to address racial and ethnic disparities as required by Public Act 653. Also known as Michigan's Minority Health Law, Public Act 653 was passed in 2006 and enacted in January 2007. It amends the Public Health Code (1978 PA 368; MCL Section 333.2227) and includes provisions for addressing racial and ethnic health disparities as well as advancing equity throughout the state (see Attachment A). Public Act (PA) 653 focuses on five racial, ethnic and tribal populations in Michigan: African American, Hispanic/Latino, Native American, Asian American/Pacific Islander, and Arab/Chaldean American.

Over the past two years, the novel coronavirus disease 2019 (COVID-19) pandemic has illuminated deep-rooted and pervasive inequities among racial and ethnic residents and other marginalized populations. This includes groups and communities that experience discrimination and exclusion because of unequal power relationships across economic, political, social and cultural dimensions (such as people living in poverty, individuals of differing sexual orientation and/or gender identity, people with disabilities, migrant workers, etc.).[6] At the same time, the pandemic has exposed weaknesses and fractures in the public health and human services infrastructure.[1]

Having a strong, multidimensional and integrated public health and human services infrastructure is necessary to carry out the provisions of PA 653 as well as essential to ensuring Michigan's health, safety and economic prosperity.[1,2] However, the chronic underinvestment in public health and human services since before the pandemic has eroded both the nation's and Michigan's ability to address emergent and ongoing threat's to the public's health and well-being.[7] To truly transform the public health and human services system into a comprehensive, high-performing, reliable entity there needs to be a broad-scale, long-term and sustainable commitment to strengthening this infrastructure.[3] The increased awareness of racial and ethnic inequities, along with the influx of federal relief dollars in response to the pandemic, presents a unique opportunity to strategically invest in and bolster the state's public health and human service infrastructure with a particular eye towards equity.[1,3]

Therefore, the MDHHS 2021 Health Equity Report focuses on Michigan's public health and human services infrastructure and key components necessary to promote racial and ethnic equity. Specifically, this report provides an overview of MDHHS structures currently in place to address racial and ethnic inequities along with existing gaps and recommendations for strengthening the department's capacity to advance health and social equity. In addition, the report includes a data brief highlighting leading health and social disparities for Michigan's racial and ethnic populations (Attachment B).

Infrastructure Overview and Importance

A strong infrastructure and the underlying structures of which it is comprised are essential to the seamless operation of a country, region or society at large. Likewise, a robust public health and human services infrastructure is vital to ensuring a well-functioning public health and human services system. Simply put, public health and human services infrastructure provides the foundation that supports the planning, delivery and evaluation of activities, practices, policies and services necessary to protect and improve the public's health and promote well-being.[4,8]

Infrastructure has been described as "the nerve center"[9] of the public health and human services system, providing a foundation for front-line defenses against emerging and existing public health threats and essential support for social service programs.[9] This infrastructure consists of three core components:

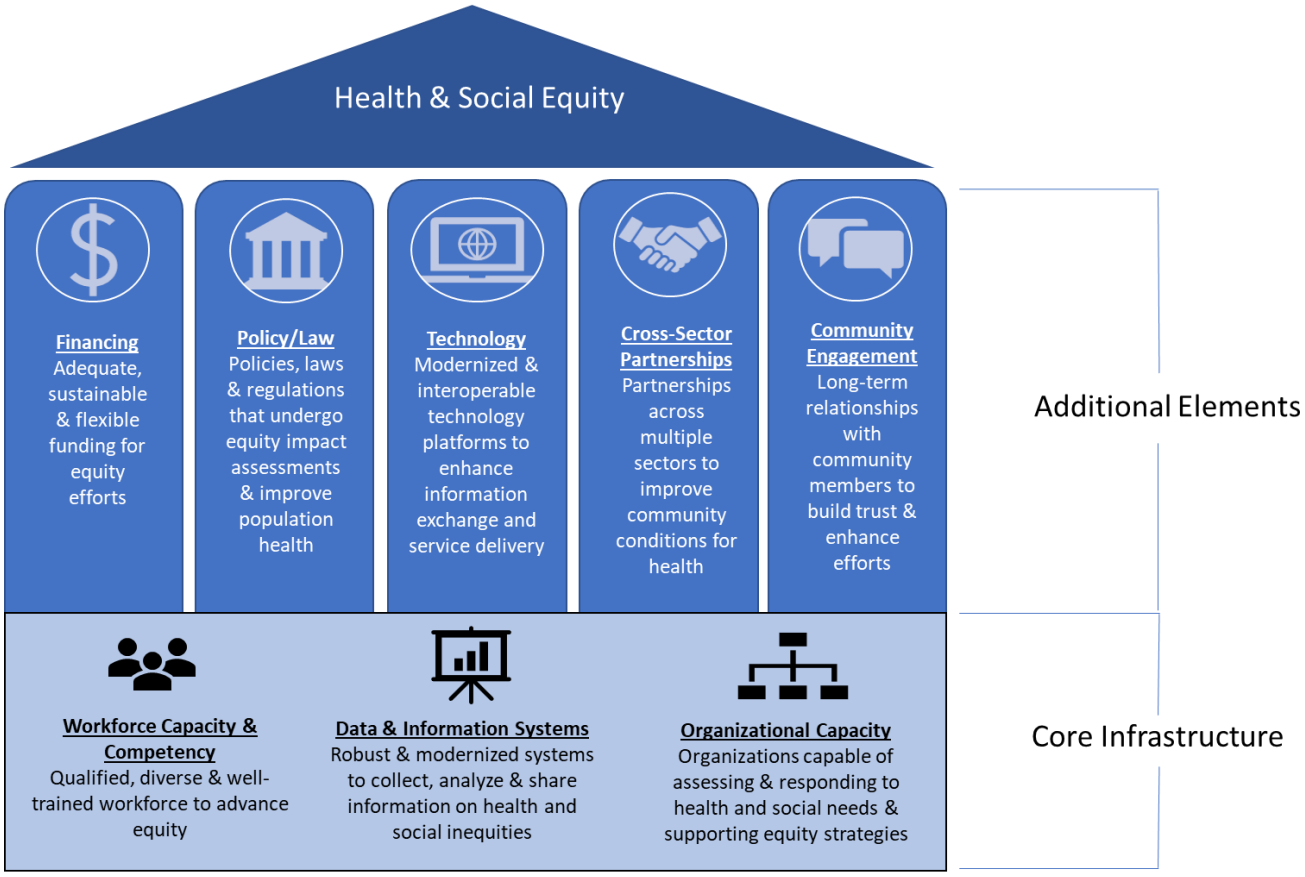
- **Workforce capacity and competency** – A capable, skilled, diverse and qualified workforce.
- **Data and information systems** – Robust, modernized, up-to-date data and information systems that collect, analyze and share data.
- **Organizational capacity** – Competent and coordinated organizations, agencies and laboratories capable of identifying, assessing and responding to public health and social needs.[5,8,9]

These three areas provide the essential underpinning for a strong infrastructure that allow core functions and essential services to be carried out. However, achieving health and social equity further requires a multidimensional and well-integrated public health and human services infrastructure[2] that encompasses additional domains (Figure 1). These include:

- **Financing** – Adequate, sustainable and flexible funding.
- **Policy/law** – Equitable policies, laws and regulations that are fair and unbiased and improve health and well-being for all.

- **Technology** – Modernized and interoperable platforms that enhance communication, information exchange and service delivery.
- **Cross-sector partnerships** – Collaboration with multiple sectors (e.g., housing, education, transportation, etc.) to improve community conditions for health.
- **Community engagement** – Long-term relationships with communities to build trust and enhance efforts.[1]

Figure 1
Infrastructure Framework for Health and Social Equity



Adapted from Bipartisan Policy Center. Public Health Forward: Modernizing the U.S. Public Health System, p.7. Washington, D.C. December 2021. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/12/BPC_Public-Health-Forward_R01_WEB.pdf. Accessed 12/23/21.

The various components of infrastructure are all interrelated. Deficiencies in one area affect other areas and have an impact on the entire system.[9] Therefore, a strong public health and human services infrastructure capable of advancing health and social equity—and ensuring Michigan's health, safety and economic prosperity—depends on optimizing all of these elements.[2]

Understanding Health and Social Equity

Health equity refers to the "fair, just and equitable distribution of and access to public services, social resources and implementation of public policy necessary to achieve well-being and thrive."[6] In other words, it is the opportunity for every person to "attain his or her full health potential" without experiencing "disadvantage from achieving this potential because of social position or other socially determined circumstances."[10] Similarly, social equity is defined as "the full and equal access to opportunities, power and resources necessary for all people to achieve their full potential and thrive."[6]

Inequities—the unfair and avoidable differences in health and social well-being seen within and between different racial/ethnic groups, socioeconomic classes and geographical areas—are rooted in population-level factors, such as the physical, built, social, economic, and policy environments, also known as the social determinants of health (SDOH).[11,12] Specifically, SDOH are defined as "the conditions and systems in which people are born, grow, live, work, and age that influence the health and well-being of individuals and communities."[6] Social determinants conducive to health include quality education, safe and affordable housing, financial security through stable employment and living wages, occupational safety, accessible quality health care, access to healthy foods and green spaces, and freedom from racism, classism, sexism and other forms of exclusion, marginalization and discrimination.[11] These conditions are shaped by historical and contemporary policies, law, governance, investments, culture, and norms.[13]

Inequities are perpetuated when policies, practices and structures of organizations or systems advantage some populations while disadvantaging others.[14] To achieve health and social equity there must be fair, just and equitable availability of public services, social resources and public policy conducive to all people attaining health and well-being. This requires removing economic and social obstacles and putting structures in place to promote better health and social outcomes for racial and ethnic populations and other marginalized groups.[6] Therefore, strategic investments are needed in the public health and human services infrastructure that support sustainable, multidimensional structures and functions necessary to improve health and social equity.

MDHHS Infrastructure for Racial and Ethnic Equity

As noted, addressing racial and ethnic health and social inequities requires having a multidimensional and robust public health and human services infrastructure that

provides a strong foundation for developing, implementing and evaluating initiatives to counter inequities and advance equity. Following is an overview of MDHHS's current infrastructure along with existing gaps or limitations and recommendations for improving each of the core components and key elements of an infrastructure promoting health and social equity.

Information was obtained through the MDHHS 2021 Health Equity Survey completed by MDHHS administrators, managers and staff. A total of 75 organizational areas are represented in the survey responses out of 83 organizational areas to which the survey was sent, for a 90 percent response rate. Information from the survey was used to develop this report as well as inform the ongoing assessment of health and social equity initiatives within the department.

Core Infrastructure Components

Workforce Capacity and Competency

A qualified, diverse and well-trained workforce is an essential component of an infrastructure that supports health and social equity.[2] Workforce diversity is important to equity on several fronts. First, a workforce that is representative of various lived experience—whether due to race, ethnicity, gender, sexual orientation, national origin, socioeconomic status, disability, place of residence (e.g., rural or urban), etc.—provides unique and varied insights into how to address challenges and best achieve health and well-being.[1] Additionally, a diverse workforce can foster trust among racial and ethnic groups and other marginalized populations by reflecting the diversity of communities served.[1]

Achieving workforce diversity relies on effectively recruiting and retaining personnel from a wide range of cultural and professional backgrounds.[2] This requires having equitable pathways to employment and advancement, competitive salary and benefit packages, and cultivating inclusive and supportive working environments that foster retention.[1] There should also be opportunities for training and professional development that arm the workforce with the skills needed to address ongoing and emerging issues and further enhance workforce competency to advance equity. This includes fostering a public health and human services workforce comprised of culturally and linguistically competent professionals who are adept at tailoring health and social programs, information and communications to meet the specific needs of various communities.[2] Thus, a key component of building a long-term, sustainable infrastructure for public health and human services that advances equity depends on having a diverse, highly-qualified and well-trained workforce with a variety of expertise that is able to deliver

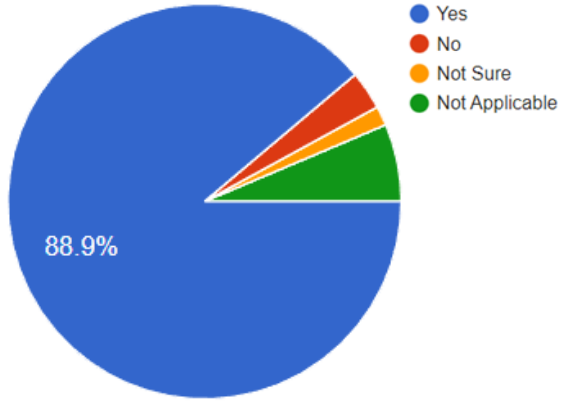
essential services while also being able to respond swiftly and adeptly to emerging threats.[1]

Current Infrastructure

In 2021, MDHHS continued to make strides in promoting workforce diversity through recruitment, retention and advancement efforts, along with providing equity-related professional development and training. Of those responding to the 2021 Health Equity Survey, ***nearly 89 percent (88.9%) reported implementing practices to promote workforce diversity, retention and advancement***, ***while nearly all responding areas (98.4%) reported that personnel participate in training or professional development opportunities*** to enhance cultural competency and capacity to address health and social equity (Figures 2 and 3).

Figure 2

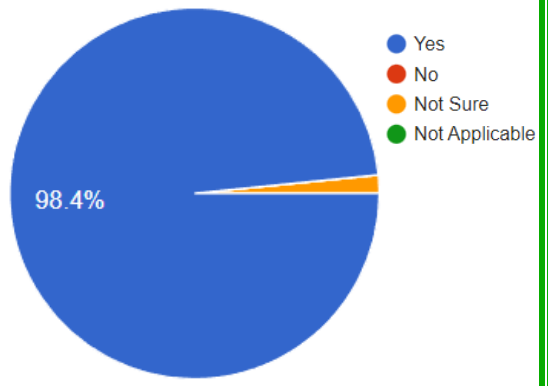
2021 MDHHS Health Equity Survey
Workforce Diversity Recruitment/Retention
In 2021, did your organizational area implement any practices to promote workforce diversity, retention and advancement?



Among efforts to promote workforce diversity, retention and advancement, the most commonly reported practices included:
1) Providing training for hiring managers and interview panels on inclusive recruitment, interviewing and hiring, along with countering bias in the interview and hiring process.
2) Convening diverse interview panels.
3) Implementing measures to broaden the candidate pool, such as expanding job postings to venues that reach a more diverse group of candidates, increasing the number of applicants interviewed, and revising screening and selection criteria to be more inclusive of various professional and educational backgrounds.

Figure 3

2021 MDHHS Health Equity Survey
Training/Professional Development
In 2021, did staff, management and/or leadership in your organizational area participate in any training or professional development opportunities to enhance cultural competency and workforce capacity to address health/social equity?



Additionally, areas reported:

- Adding questions to the application and interview process pertaining to diversity, equity and inclusion (DEI).
- Using the department's DEI manager's hiring toolkit to guide their recruitment and hiring efforts.
- Convening a workgroup, advisory committee or diversity hiring team to review hiring practices, offer feedback and make recommendations to improve equity in the hiring process.

Several areas also noted that ***offering full-time remote work options*** on an ongoing (post-pandemic) basis has been effective at increasing the diversity of candidate pools, in part by widening the geographic area from which programs can recruit. In terms of ***retention and advancement***, areas reported being intentional about ***cultivating a culture of conversation, learning, inclusion and acceptance, as well as developing a mentoring process*** aimed at preparing diverse individuals for future opportunities.

Box 1: Eliminating Racism and Claiming/Celebrating Equity (ERACCE)
Understanding and Analyzing Systemic Racism Workshop

This two-and-a-half-day training is offered through ERACCE—an anti-racism organizing and training resource center based in Kalamazoo, Michigan. The purpose of the workshop is to provide an opportunity for participants to develop a shared language around systemic racism, explore an introductory analysis of systemic racism, and examine basic strategies for dismantling racism within their organization. The workshop includes discussion of the socio-historic development of institutional racism; how racism and racist institutional values have been legally codified and institutionally perpetuated throughout U.S. history; how racism manifests on individual, cultural and institutional levels; and how long-term organizing informed by antiracist values can lay the path toward institutional antiracist transformation.
Source: https://www.eracce.org/training

With regard to ***training and professional development***, MDHHS continued to offer and promote a variety of opportunities to enhance cultural competency and workforce capacity to address health and social equity. This included ***required trainings on health equity, systemic racism, implicit bias, and working with tribal governments.*** Additional training opportunities encompassed DEI seminars and presentations, a cultural intelligence certification program, lunch and learn sessions on equity-related topics, addressing social determinants of health, and specialized training programs such as Eliminating Racism and Claiming/Celebrating Equity (ERACCE) (see Box 1). Additionally, many areas included discussions of social justice, health equity and related topics as part of regular workgroup and/or staff meetings.

Collectively, trainings and professional development opportunities have expanded knowledge of different cultures, racial issues and lived experiences as well as brought people together who may not typically work together to hear different perspectives. Trainings and discussions have also helped to promote an inclusive workplace culture and assisted with employee engagement and retention by fostering relationship building, communication and empathy.

Gaps/Limitations

Despite continued efforts to recruit and retain racially and ethnically diverse staff as well as provide ongoing equity-related training and professional development opportunities, several gaps and limitations exist. One of the most frequently mentioned issues was ***restrictive civil service requirements***, including rigid qualification criteria, laborious hiring processes and non-competitive pay structures. These factors preclude some qualified applicants from applying for positions. For example, education requirements for some positions limit who is eligible to apply. However, some areas noted that having personnel with a broader array of educational backgrounds would be beneficial, particularly to better match the cross-cutting nature of public health and human services work. Providing flexibility and variety in educational background could also facilitate the recruitment of individuals from more diverse racial, ethnic, social and economic backgrounds to fill these positions.

Another gap cited by survey respondents was ***limited recruiting options***. Despite efforts to advertise job openings in more diverse outlets, there is still a need to expand the publication of job opportunities to better reach diverse populations and job seekers. Promoting job postings on various platforms could be improved to attract a more diverse applicant pool. In addition, highlighting jobs that can be performed remotely could help increase the diversity of candidate pools by drawing from a larger geographic area.

Another issue pertaining to workforce capacity is dealing with ***hiring freezes and FTE caps***, which has resulted in a lack of opportunities to hire or promote staff. This can be further complicated by frequent turnover of staff, which compromises workforce stability, retention and advancement.

Finally, survey respondents noted the ***limited opportunities for leadership development and advancement for diverse staff*** as a gap within the department's workforce infrastructure. In particular, respondents noted the need for more initiatives like the emerging leaders program within the department. They also cited a lack of mentorship opportunities, job shadowing and succession planning for employees. Such efforts could help prepare diverse "up-and-coming" employees for higher-level positions

as well as potentially increase staff retention if these opportunities were available.

With regard to training and professional development, the most frequently cited challenges included ***lack of time, scheduling conflicts, limited resources to host or attend trainings, and competing priorities.*** Several organizational areas expressed how difficult it was to balance training with day-to-day work responsibilities. Particularly over the past two years with the increased demands of the COVID-19 pandemic, staff have been overextended, which has limited participation in equity-related training and professional development opportunities.

> *"Our division is struggling with many priorities and projects, as well as staffing turnover and new team members. This makes it difficult to find time to attend training as well as develop internal processes, procedures and program-specific training to support DEI both with our staff as well as in the program to support the people we serve."*

In terms of the training curriculum, a primary challenge noted was ***bridging the gap between knowledge and the practical application of information*** to participants' daily work. This includes offering trainings that delve beyond definitions and examples of health and social equity, and include more examples of personal experiences and tangible actions that can be taken that are pertinent to the participants' scope of work. Survey respondents also noted the ***need for more guidance regarding the most logical progression of training courses*** (e.g., which trainings to take first, second, third, etc.), along with the need to have training that is suitable to staff at different levels of equity understanding and competency (e.g., beginner, intermediate, advanced). Finally, there is a ***gap in the department's capacity to develop and deliver ongoing and advanced training*** due to an insufficient number of dedicated training staff. This has resulted in in the Office of Equity and Minority Health (OEMH) and the Office of Race Equity, Diversity and Inclusion (REDI) teams not being able to fulfill training requests.

Recommendations

In order to mitigate gaps and challenges with the department's workforce diversity and training efforts, organizational areas offered several recommendations. One of the most frequently mentioned recommendations was to ***make civil service accommodations to allow for more flexibility in the hiring process***. Specific suggestions include:

- Expand recruiting options.
- Update position descriptions to permit broader educational backgrounds and work experience.
- Allow candidates to substitute years of experience for educational requirements.
- Modify candidate screening criteria.

- Allow hiring managers more leeway in the interview process.
- Increase starting pay and pay grades.
- Streamline the process of advancing personnel up a classification category.

In addition, areas recommended ***continuing to distribute and post job announcements in a wide range of outlets to better reach diverse populations***. To aid in this effort, survey respondents suggested developing a comprehensive list of places, websites and resources for job postings, updating this list regularly (e.g., every week or month), and housing the list in a central location where it is accessible to all managers. Another suggestion was to work with schools, training programs, community colleges, and academic institutions to more effectively leverage fellowships and internships. This could help attract diverse talent into the field and offer insights into career opportunities within MDHHS.

In terms of employee retention and advancement, the most frequently mentioned recommendation was to ***provide more formal opportunities for mentorship, leadership training, professional development, network building, and relationship building***. This includes:

- Fostering opportunities for staff to interact with others performing similar functions in different areas of the department as well as those in manager/leadership roles.
- Building a network of individuals that can bolster job satisfaction, feelings of belonging and identification of opportunities for growth and advancement.
- Providing opportunities for individuals with different work, life and educational experiences to grow and develop within the organization.

Such initiatives could bolster retention of diverse individuals that bring unique and critical perspectives along with varying experience and knowledge to the department. It could also drive equity by fostering an inclusive environment that values a broader range of skills, knowledge, experience, educational backgrounds, and interest.

With regard to training and professional development, some organizational areas suggested ***making more trainings mandatory***. Although staff time and availability present challenges, respondents felt that making training mandatory provides a motivating factor for ensuring training is prioritized and attended. Other suggestions include:

- Offering training sessions at various times to better accommodate schedules.
- Building dedicated time and space for training into work schedules and allowing staff to adjust workloads and responsibilities as needed to attend trainings.

- Increasing training frequency in order to reinforce learning and maintain momentum.

Survey respondents also had the following ***recommendations to improve the training curriculum***:

- Develop new trainings on a continuous basis so personnel are not repeating the same training each year.
- Offer basic and advanced trainings to accommodate participants' progression and different levels of understanding.
- Provide more tailored trainings that are specific to various roles in the department and address special topics (e.g., trauma-informed care/services, understanding poverty, intersectionality experienced by marginalized groups).
- Incorporate post-training debriefing sessions, follow-up conversations and action planning that build capacity to move from knowledge to action by applying what is learned and assessing impact and outcomes.

Given the already limited training resources and personnel within the department, such improvements would require a dedicated investment in expanding training staff, expertise and programming. In addition, the department's training infrastructure could be strengthened by ***developing a central repository—such as a website or portal—to house training resources***. Suggested items include training/professional development opportunities, a speaker's list, skill-building and implementation tools, and a curated list of recommended resources such as readings, books, documentaries, websites, podcasts, and other relevant media.

Data and Information Systems

Data and information systems are another core component of the public health and human services infrastructure. Data serve as the building blocks for identifying, describing and understanding the health and well-being of populations, formulating solutions to problems, and evaluating the impact of intervention efforts.[15] Data also drive much of the decision-making process, ensuring that actions are appropriately tailored and resources allocated to those who need it most.[1,15] Therefore, it is crucial to have robust, modern and interoperable data and information systems that provide complete, accurate, real-time, and actionable data.[1]

Current Infrastructure

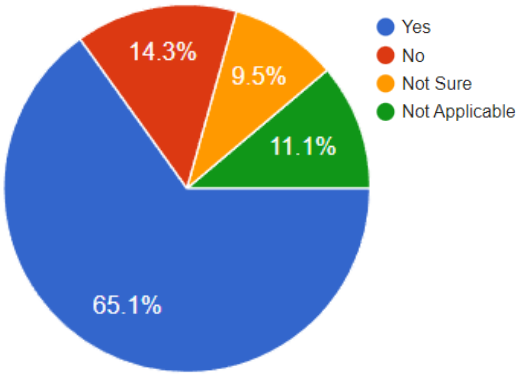
MDHHS has numerous data and information systems in place that include the collection of race and ethnicity data in order to identify and address health and social inequities. According to the 2021 Health Equity Survey, ***nearly two-thirds (65.1%) of***

organizational areas reported having these systems in place (Figure 4). ***Data was collected through various sources and mechanisms*** including state databases and surveys, disease registries, program-based data, provider/contractor and grantee data, laboratory and healthcare systems databases, population assessments/surveys, and national data sources. Systems were used to collect data on populations served, workforce demographics, health conditions, vital statistics (i.e., birth and mortality), social determinants of health, behavioral risk factors, healthcare and emergency services utilization, and specific population groups.

Figure 4

2021 MDHHS Health Equity Survey
Data and Information Systems

In 2021, did your organizational area have practices or systems in place to collect, analyze, and/or report race and ethnicity data?



For example, the Children's Services Agency (CSA), collects data on the race and ethnicity of children and families who come to the attention of the child welfare system through the Michigan Statewide Automated Child Welfare Information System (MiSACWIS). This data is assessed to determine disproportionality of specific populations within the welfare system. Likewise, the Child and Adolescent Health Center Program collects demographic data—including race and ethnicity—for all users and looks at trends. Additionally, they have a risk assessment system that generates reports showing risk stratified by varying health equity measures. The Health and Aging Services Administration also uses data to identify disparities in Michigan's Medicaid population through its Medicaid Health Equity Project (see Box 2).

Box 2: Health and Aging Services Administration Medicaid Health Equity Project

One of the most well established and robust health equity data efforts within MDHHS is the Medicaid Health Equity Project. As a means of measuring quality consistently across Managed Health Plans (MHPs), and to facilitate comparison across states, MHPs submit audited HEDIS data to MDHHS for each measure that pertains to Medicaid covered benefits. MHPs also submit select HEDIS measures broken down by race/ethnicity to MDHHS. These measures are further stratified by racial population and assessed for disparities. A report from this project is published yearly and is used to direct efforts and develop pilot projects within the MHP contract for care and services.

Population-based data and information systems utilized by organizational areas included: the Behavioral Risk Factor Surveillance System (BRFSS), Vital Statistics, Youth Risk Behavior Survey, Michigan Profiles for Healthy Youth, Michigan Violent Death Reporting System, the Michigan Disease Surveillance System (MDSS), State-level census data, and the Michigan Care Improvement Registry (MCIR)

(see Box 3). Data from these systems are disaggregated by race and ethnicity whenever possible to identify and address health disparities and inequities across the state.

Box 3: Michigan Care Improvement Registry (MCIR)

The Michigan Care Improvement Registry (MCIR) houses immunization information for Michigan residents. The MCIR system was recently upgraded to better capture race and ethnicity information. Providers that submit information into the system were given education on the needs for collecting race and ethnicity data, means to collect this information and guidance for recording and reporting the data to MCIR. The positive impacts this information has on public health decision making and goal setting for health and social equity was also communicated to help improve the collection and analysis of race and ethnicity data. This data has also been increasingly analyzed to assure equitable and fair distribution and access to COVID-19 vaccines.

Finally, a few organizational areas ***conduct special surveys and assessments focused on specific populations***. For example, the MDHHS Tobacco Section periodically conducts a survey about tobacco use and quitting behavior among specific racial and ethnic groups. Data are used to study and understand better the behavior of specific populations around tobacco use. The section has also performed a comprehensive survey among Michigan's African American population, which helped to inform an educational campaign geared towards statewide stakeholders. The MDHHS Office of Equity and Minority Health also periodically conducts specialized Behavioral Risk Factor Surveys on specific racial and ethnic populations, which provides a more in-depth look at health behaviors and risk factors in these populations and helps to identify programming that can address any inequities.

Gaps/Limitations

A number of gaps and limitations in the state's data and information infrastructure have come to light, particularly since the onset of the COVID-19 pandemic. Among the most cited challenges is a ***lack of standardization in racial and ethnic classifications and definitions***. As survey respondents noted, racial and ethnic groupings and definitions are not standardized across different tools and systems used within MDHHS as well as among partners. Although several programs follow federal guidelines and classifications for race and ethnicity, federal categories are generally too limiting and do not include all populations in Michigan, such as Arab and Chaldean. This makes it difficult to capture accurate data on race and ethnicity as well as link, compare and share data across information systems.

Another gap is the ***lack of consistency in reporting as well as the completeness of racial/ethnic data collected***. This has especially been a problem with the Michigan Disease Surveillance System during the pandemic. Healthcare entities and providers

may not collect racial and ethnic data, and even if collected, they may not enter it into laboratory requisitions that report this data to MDHHS. This missing data increases the number of cases for which race/ethnicity is unknown, further limiting the ability to identify and address potential trends and inequities.

In other instances, ***data on race and ethnicity may be collected, but reported inaccurately***. This could be due to inadequate race/ethnicity classifications that are not fully inclusive and representative of racial and ethnic groups (as noted above), or due to service providers entering race and ethnicity data for clients without guidance or discussion with families and individuals with whom they are engaging. Inaccurate reporting can lead to questionable data and undermine efforts to respond effectively to community needs and health events.

Additional gaps and challenges in the data and information infrastructure include:

- Data being unavailable for certain geographical areas.
- Lack of program capacity to capture race and ethnicity data.
- Small sample sizes for some racial/ethnic groups that make it difficult to report accurate findings.
- Siloed data systems that inhibit coordination and sharing between data sources.
- Insufficient resources (e.g., funding, tools, expertise, and software) to pull/collect and analyze data.

Recommendations

Addressing the gaps and limitations of Michigan's data and information systems will require a continued investment in improving and updating the department's infrastructure and capacity to collect, store, analyze, and share data across systems. This includes ensuring the accurate and complete collection of data on race and ethnicity, as well as other social metrics that are important to understanding inequities. (See Box 4: Children's Service Agency Race Data Project.)

Box 4: Children's Service Agency Race Data Project

The MDHHS Children's Service Agency (CSA) is leading a Race Data Project consisting of a statewide assessment of how the agency collects race and ethnicity data. The goal is to increase the accuracy, reliability and completeness of the race and ethnicity data the CSA collects. The agency is working with both internal and external partners in this effort.

One primary recommendation to accomplish this is to ***expand and standardize the collection of race, ethnicity and other demographic characteristics*** that are important to assessing and addressing inequities. This includes:

- Identifying and standardizing race and ethnicity categories that are more representative of and relatable to Michigan's population (including

subclassifications and mixed race/ethnicities categories), along with updating data and information systems to include these fields.
- Providing more training and tools for both departmental staff and partners to build capacity around the accurate collection, analysis and interpretation of race, ethnicity and social metrics data.
- Providing guidance for personnel who routinely interact with clients and families on how to accurate capture race/ethnicity information.

Another recommended action is to ***invest in building and improving integrated and interconnected information technology systems*** to reduce siloed data systems and improve consistency in data collection and reporting. This could help ensure the completeness of data collected and facilitate access to information across data systems. Additional training on software applications used for data collection and reporting, along with routine technical assistance and support, could further strengthen internal data collection and analysis capacity.

In order to gather more information on specific racial/ethnic groups, including those with smaller populations for which sufficient data is difficult to collect, areas recommended funding and ***conducting specialized surveys more routinely***. A related recommendation was to have the statewide BRFSS maximally sample for a particular racial/ethnic group annually and rotate which group is over sampled each year.

Finally, several areas recommended ***providing easier access to data systems across the department***. Specific suggestions include:

- Having universal data sharing agreements for organizational areas.
- Establishing a centralized location for data storage in the department.
- Developing a platform or dashboard to display data that includes search filters. data visualization tools, mapping, etc.

Organizational Structures and Capacity

A third core component of the public health and human services infrastructure is organizational capacity. This broadly refers to the ability of public health and human services agencies to identify, assess and respond to community health and social needs, including emerging issues.[16] In terms of health and social equity, organizational capacity encompasses having institutional structures and functions in place that facilitate, support and advance equity efforts. These include:

- Organizational areas focused on equity issues
- Senior leadership positions overseeing equity efforts
- Staff that work specifically on equity issues

- Department-wide or program-specific equity work groups, committees, task forces, advisory groups, or other equity-related entities
- Strategic plans and priorities that incorporate equity into goals and strategies[2]

Current Infrastructure

The Office of Equity and Minority Health (OEMH) serves as the primary structure and coordinating body within MDHHS to address racial and ethnic health disparities. Its mission is "to provide a persistent and continuing focus on assuring health equity and eliminating health disparities"[17] among Michigan's racial and ethnic populations. Overarching OEMH activities include:

- Supporting and initiating programs, policies and applied research to address social determinants of health that contribute to health inequities for racial and ethnic minority populations in Michigan.
- Collaborating in the development of MDHHS prevention, health service delivery and research strategies in an effort to improve health outcomes for racial and ethnic minority populations in Michigan.
- Facilitating implementation of culturally and linguistically appropriate health services throughout MDHHS.[17]

OEMH is housed within the Office of Race Equity, Diversity and Inclusion (REDI), which is responsible for setting the strategic direction for the department to identify and address issues of inequities due to systemic marginalization, and to create a culture of diversity, equity and inclusion in both its practices and policies by addressing racial, health, social, and wealth disparities that impact both internal and external partners. The REDI office was established in 2020 and is part of the MDHHS senior leadership team.

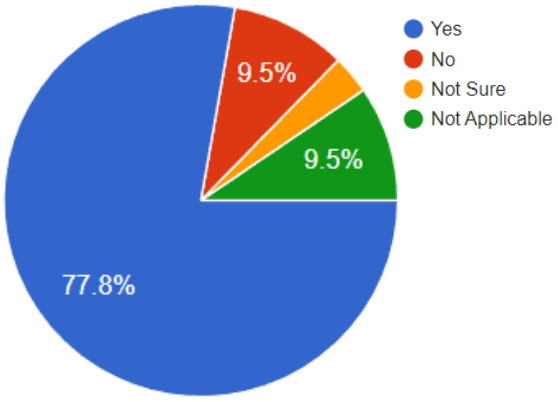
In addition to OEMH, the REDI office includes ***the Equity Development Division***—whose mission is to build a MDHHS workforce that is informed, equipped and engaged with race equity, diversity and inclusion principles—and ***the Leadership Development Division***, which provides leadership development, training and resources that promote a diverse, equitable and inclusive organization. The department also has a Diversity, Equity and Inclusion (DEI) Plan and ***DEI Council***, which serves as a structure to further promote diversity, equity and inclusion within the department and thereby advance health and social equity.

Additionally, many organizational areas within MDHHS have structures to advance equity as well. ***Over three-quarters (77.8%) of areas that completed the 2021 Health Equity Survey reported having structures in place to support health and social equity work*** (Figure 5). Many of these structures are extensions of the larger

Figure 5

2021 MDHHS Health Equity Survey
Organizational Structures

In 2021, did your organizational area have any structures in place to support health/social equity work?



departmental DEI effort, such as the establishment of a DEI committee within their organizational area, development of a DEI plan for their area, and/or staff members that serve on the MDHHS DEI Council or Action Teams.

Organizational areas also reported having ***workgroups, tasks forces or teams centered around health and social equity***. These groups meet regularly to discuss equity and social justice issues, may organize lunch and learn sessions, as well as work on projects that promote equity within their programs and among contractors and staff. In addition, several organizational areas reported ***having staff and FTE positions devoted to equity work***. Duties include leading equity efforts, coordinating equity-related trainings, providing technical assistance, and working with specific racial/ethnic groups (see Box 5). Finally, a number of areas also have ***incorporated equity goals and strategies into their strategic plans and program priorities***.

Box 5: Examples of Staff/FTE Positions Devoted to Equity Work

- The Division of Chronic Disease and Injury Control has one FTE funded through their Preventive Block Grant that leads collective health equity efforts across the six sections within the division. The staff member also serves as the lead for the division's Michigan Real Adaptive Changes to Equity (MiRACE) Leadership Team. This group works to advance racial equity and improve health outcomes through authentic community engagement and by challenging internal and external policies and practices that continue to perpetuate structural racism.
- The Office of Policy and Planning hired a racial equity consultant to assist with state's strategic plan on reducing overdose deaths.
- Legislative Affairs and Constituent Services employs a tribal liaison that works with Michigan's 12 federally recognized tribes and Indian organizations.
- The Children's Services Agency (CSA) has an analyst focused on race equity as well as a manager over Native American Affairs and Race Equity.

Gaps/Limitations

The structures and efforts highlighted above represent a solid organizational infrastructure to support and promote health and social equity. However, gaps and challenges still remain.

One gap frequently noted by organizational areas is the ***limited availability of staff*** to participate in health and social equity committees, tasks

forces and other groups. Many areas expressed that their current staff is at capacity with their routine roles and work responsibilities, making it difficult to invest additional time to actively participate in equity initiatives. The ***lack of dedicated positions focused explicitly on equity*** presents another challenge. Although several areas reported having staff to coordinate and lead equity efforts, other areas identified the need for staff positions or a dedicated team member who could serve as the lead on equity efforts and take on primary responsibility for coordinating initiatives within their area.

> *"[Our] bureau has a limited number of staff to complete routine actions. All are interested in working to address health/social equity in programs, but would benefit from a dedicated team member with primary responsibility across the bureau."*

Staff capacity is also a challenge in departmental areas that lead health and social equity work. For example, OEMH needs increased staff in order to develop and provide necessary training and technical assistance related to racial and ethnic population health as well as foster relationships within MDHHS and across state government. Legislative Affairs and Constituent Services, which houses a tribal liaison, also noted that they have limited staff capacity to specialize in equity and inadequate staff support to handle an increasing volume of tribal work.

A related gap is the ***lack of sufficient time for health and social equity work that is necessary for meaningful change***. Achieving equity requires a long-term commitment and investment. Many strategies involve policy, system and environmental changes that take time and resources to implement. However, competing priorities and other mandated job duties limit the time that existing staff can devote to this work.

Another challenge is ***finding ways to integrate health and social equity into existing job responsibilities***. In some ways, this work is still viewed as an extra task to be done instead of something infused into daily work. Therefore, there is a need to further identify practical strategies that staff can use within their sphere of influence to advance this work. There is also a lack of metrics and measures to track and report the impact of health equity work, which could help areas find ways to build this work into existing goals and priorities.

> *"Generally speaking, one limitation is looking at health/social equity as a specific task to be done instead of something infused in all the work we do. That may be, in part, because of the way we interpret and speak about health/social equity."*

Finally, ***inadequate funding for organizational structures*** that support health and social equity work constitutes a significant gap. Many areas noted that there is a lack of funding and resources to support equity-related projects internally as well as to execute

work at the local level. Often the funding that does exist has restrictions and limitations that does not allow for the implementation of strategies needed to effectively impact health and social equity. For example, many funding sources require quantitative outcomes within a short period of time, or outcomes that are specific to certain programs versus upstream factors—such as changes in the social determinants of health. Although some funding has come through from the federal government's COVID-19 relief package, this funding is still restricted and does not allow for addressing infrastructure needs to address systemic inequities that are necessary for meaningful change.

Recommendations

Recommendations to improve the department's organizational infrastructure for health and social equity including recommendations to support existing efforts as well as suggestions to address the gaps and limitation identified above. ***Recommendations regarding ongoing efforts include:***

- Continue to support efforts already in place, both department-wide as well as within individual organizational areas.
- Maintain a focus on and commitment to equity, particularly at the leadership level to enhance consistent messaging and further uplift the importance of this work.
- Continue to educate, raise awareness and share information across the department about equity efforts, strategies and best practices.

Recommendations to address gaps and limitations include:

- Promote and allocate more time for staff to participate in equity-related organizational structures and efforts.
- Facilitate the establishment of FTE positions within MDHHS organizational areas to specifically support equity efforts and enable equity work to be prioritized.
- Designate health/social equity liaisons and/or dedicated team members with expertise in this area to serve as champions within administrations or bureaus.
- Provide more time for personnel to increase their knowledge about equity and participate in equity-related workgroups, committees, task forces, and related groups.
- Allocate more funding and resources to support structures and initiatives promoting equity. This includes funding for staff, internal and external equity projects and equity-related training.

"Adequate staffing will allow staff to spend more time analyzing impacts of legislation on health equity and discussing findings of program staff with the Executive Office and Legislature, as well as provide additional support to tribes and tribal health, public health and human services programs as well as staff in all MDHHS divisions across the department that need assistance in working with tribes and Indian organizations."

- Increase funding and staffing for the REDI office to enhance their capacity to meet the needs of the department.

Additional recommendations to bolster organizational capacity and infrastructure include:

- Encourage areas to include equity as a standing priority/objective that is integrated into strategic plans.
- Make involvement in equity efforts more of an expectation throughout the department—including a commitment to implementing DEI area action plans and establishing DEI committees.
- Facilitate more discussions and information sharing across the department about successful strategies and best practices to advance health and social equity for racial and ethnic populations.
- Create a central repository of information about existing equity efforts and opportunities.

Lastly, several areas expressed that they would like to have a closer working relationship with the REDI office and recommended providing ***more tailored training, technical assistance and small group coaching sessions*** for specific work areas and teams (e.g., policy teams, data analyst, etc.) that could benefit from guidance specific to their work.

Additional Elements of Infrastructure

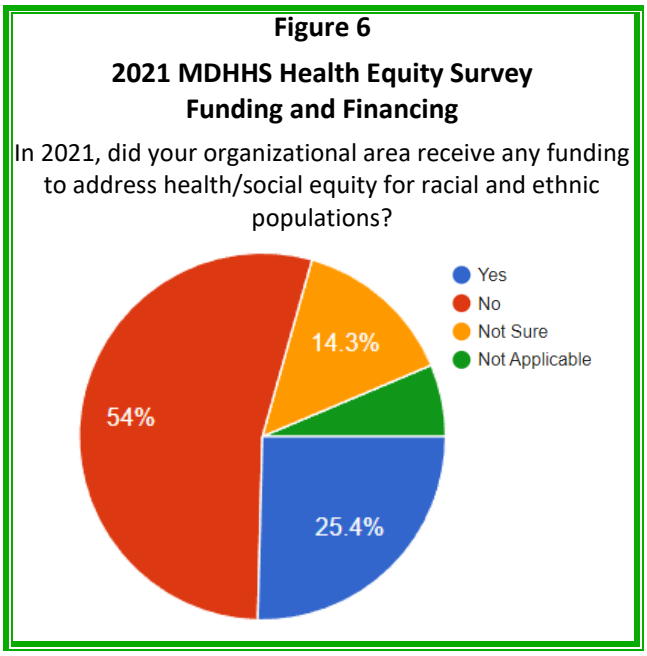
Financing

A solid infrastructure depends on consistent and sustained investments at the federal, state and local levels.[9] Unfortunately, public health has historically been underfunded, which has eroded its infrastructure over time. The funding that does exist usually consists of limited and inconsistent funding—often in the form of federal, state or foundation grants or budget line-item allocations that are restricted to addressing specific diseases or health and social issues. This funding structure hinders public health's and human services' ability to be nimble in responding to emerging issues, as well as limits their capacity to address cross-cutting challenges and inequities experienced by racial and ethnic populations and other marginalized groups.[1]

Current Infrastructure

As noted previously, funding to address health and social equity efforts for racial and ethnic populations in Michigan is lacking. Of those responding to the 2021 Health Equity Survey, ***a quarter (25.4%) reported that they received funding for equity work***

(Figure 6). Funding sources consisted primarily of federal dollars, followed by state and foundation funding.



Most of the ***federal funding*** received supports existing programs that provide services to populations in which racial and ethnic groups are disproportionately represented. A few organizational areas reported receiving ***federal funding specifically for efforts to reduce health disparities and advance equity*** (see Box 6, page 22). Although some federal funding for equity efforts is part of ongoing funding sources, much of this funding is time-limited or consists of one-time grants.

Fewer programs receive state funding for equity initiatives. Of those areas that responded to the survey, only two noted that they received dollars from the State of Michigan's General Fund and/or Healthy Michigan Fund for this purpose. This includes the Workforce/Access and Grants Management Section within the Policy and Planning Office, which receives state funding to support 10 multicultural agencies that provide primary care services to the uninsured, underinsured and people on Medicaid, including immigrants and refugees. OEMH also receives state funding, which supports staff positions in their area.

Gaps/Limitations

The most cited gap with regard to funding for health and social equity efforts is the ***general lack of funds and funding opportunities***. Several areas reported that they do not receive dedicated funding to address health and social equity—either from federal or state sources. They further noted that funding opportunities for these efforts do not currently exist for their specific work area or if it does exist, is not widely known. Others expressed that the grant opportunities that do exist are limited, specifically those for which they are eligible to apply, making the acquisition of grant dollars more competitive.

Even when funding does exist, it may be ***inadequate to fully support equity efforts***. For example, the Cardiovascular Health, Nutrition and Physical Activity Section shared that they have used CDC funding to start to address health disparities and equity issues, but that they need a higher level of funding to do this work in an impactful

way. Other funding sources have ***limitations and restrictions on how the funding can be used***, which limits innovation and implementation of promising practices. As described above, funding sources that are prescriptive in nature tend to value quantitative data and short-term results over qualitative data and upstream outcomes. Yet, sustainable health and social equity work involves policy, system and environmental changes that require a longer-term investment and takes time to show an impact.

Box 6: Examples of MDHHS Equity Work Supported by Federal Funding

Funding that includes underserved/marginalized populations:

- The Division of HIV and STD programs receives ongoing federal funding through the Ryan White Program, which provides HIV-related health services to people living with HIV/AIDS that lack health care coverage or financial resources.
- The Division of Victim Services receives federal funding to provide services for victims of domestic violence, sexual assault, child abuse and related crimes, which includes funding elements for underserved and marginalized communities.
- Other organizational areas (e.g., Division for Chronic Disease and Injury Control, Local Health Services, OEMH) use federal funding, such as Preventive Health and Health Services Block Grants, to support existing health and social equity initiatives in their area that fall within grant requirements.

Funding that specifically addresses health disparities/equity:

- The Policy and Planning Division received grant funding from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) that was dedicated to services and engagement in minority communities.
- Michigan's Disability Determination Services (DDS) was awarded funds from the Social Security Administration to provide racial equity and cultural intelligence training for their action teams to increase capacity to address health and social inequities.
- OEMH has received funding from the Centers for Disease Control and Prevention (CDC) to address COVID-19 health disparities and advance health equity among high risk and underserved populations, including racial and ethnic minority groups and people living in rural areas.

Funding may also be ***difficult to secure for specific purposes and tools*** that could aid equity efforts. Examples include information technology (IT) funding for data collection systems that incorporate additional fields and data points related to health and social equity, as well as dollars for data visualization tools and software specialists within the department. These could help programs better identify and communicate disease and risk burdens among racial and ethnic populations. Additional ***funding is also needed to support capacity building and culturally specific community-based organizations*** that are important to extending the department's reach and ensuring meaningful change at the local level. Finally, the lack of sufficient and consistent funding undermines the departments infrastructure for health and social equity by making it difficult to engage in long-term planning and achieve sustainable change.

Recommendations

In order to build and sustain robust public health and human services systems, long-term funding mechanisms are needed that provide sufficient, predictable and flexible funds. This includes looking for innovative ways to bring funding streams together to create multisource, braided and disease- or issue-agnostic funding sources that provides leeway in how dollars are used, particularly in meeting the needs of racial and ethnic populations and marginalized groups.[1]

Recommendations to improve financing of public health and human services include:

- Provide dedicated funding to support health and social equity work in Michigan. This includes appropriating more funds through state allocations—not just sourced from federal grants.
- Allow flexibility in how funds are used in order to best meet the needs of affected populations, facilitate integration across the department, and allow for the purchase of tools and resources to increase capacity and infrastructure to address equity issues.
- Increase funding to enhanced training and technical assistance to support health and social equity efforts.
- Require a diversity and equity component for programs that currently receive state funding and include an additional dollar allocation to cover costs associated with such a component.

In light of fiscal constraints, it was recommended that the department ***look for innovative ways to incorporate funding for equity-related efforts into existing priorities and funding streams***. Specific suggestions include:

- Earmark funding from existing sources for DEI personnel to consult with and provide technical assistance to organizational areas on their equity efforts and initiatives.
- Identify options for supporting health and social equity efforts within existing programs and services.
- Explore the potential to include support for DEI and equity team members as part of the department's overall indirect funding formula.

Additional recommendations pertaining to funding include:

- Provide more information on grants and funding opportunities available for equity work—including funding opportunities for community-driven equity efforts.
- Create a dashboard to track and monitor the percent of funds that support equity-related programs and services to ensure funding is adequate and appropriately allocated to meet the needs of affected populations.

Policy/Law

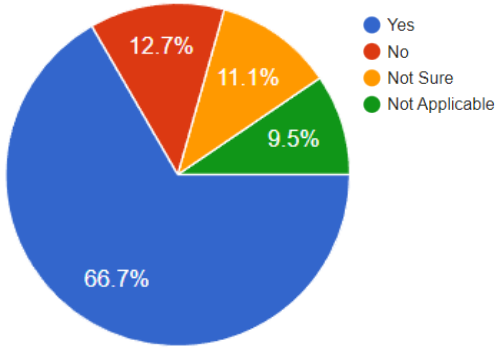
Having equitable policies and laws is another essential component of a public health and human services infrastructure that supports health and social equity. These policies and laws create an important framework for equity-related work by formalizing and codifying a commitment to health and social equity, facilitating the integration of equity into state and local efforts, and ensuring best practices are supported and consistently applied.[18,19]

In addition to enacting legislation and policies to address racial and ethnic minority health and advance equity, it is also important to ensure that laws and policies—whether health-related or not—do not inadvertently disadvantage a particular group or population. This can be done by conducting an Equity Impact Assessment (EIA). An EIA provides a systematic, data-driven approach to identifying the potential consequences (either positive or negative) or potential inequities resulting from a proposed or existing policy or program. Completing an EIA helps to maximize the health and social benefits while minimizing adverse effects of policies on racial and ethnic populations and other marginalized communities.[20]

Current Infrastructure

Over the years, MDHHS as well as individual organizational areas have established and implemented various policies related to advancing health and social equity. These include formal policies—such as written and codified regulations or requirements, as well as informal policies—including best practices and common operations. Of those organizational areas responding to the 2021 Health Equity Survey, ***two-thirds (66.7%) reported that they implemented or adhered to equity-promoting policies and/or laws*** (Figure 7).

Figure 7
2021 MDHHS Health Equity Survey
Policy/Law
In 2021, did your organizational area implement or adhere to any policies (either formal–e.g., written/codified regulations or requirements, or informal–e.g., unwritten best practices or common operations) and/or laws to address racial and ethnic disparities and/or promote equity?



Among these policies is ***a department-wide requirement for Diversity, Equity and Inclusion Training***. This policy mandates that all MDHHS employees and state affiliates complete two online trainings each year: 1) Introduction to Health Equity and 2) Systemic Racism. Executive Directive 2020-09 also requires Implicit Bias Training be made available to MDHHS employees and state contractors. An additional training on tribal relations was developed in 2021, in

accordance with Executive Directive 2019-17, and was mandated for all MDHHS personnel as well. In addition to these department-wide training requirements, several organizational areas require their staff and grantees or contractors to complete additional training on equity-related issues.

Other policies reported by organizational areas include:

- Policies to ensure equity in the hiring and promotion process.
- Requirements regarding the collection, reporting and analysis of race/ethnicity data.
- Policies and guidelines to improve the diverse make up of advisory groups and committees.
- Required review of documents to ensure the use of correct language and make sure materials are written through an equity lens.

Several organizational areas also have policies regarding the inclusion of equity language in requests for proposals, incorporating equity considerations into program and funding decisions, and including health and social equity requirements in contracts (see Box 7).

Efforts are also underway to implement an Equity Impact Assessment (EIA) process within the department. As described above, this tool will help to inform decisions and create more equitable solutions by identifying potential unintended impacts of a policy, program or initiative on marginalized populations. OEMH is currently leading a pilot of the EIA process in three administrations. The pilot began in May 2021 and is scheduled to end in October 2022. The goal is to replicate the process across MDHHS and other state departments.

Box 7: Examples of Policies Promoting Health/Social Equity

- The Injury and Violence Prevention Section has language in all requests for proposals that require applicants to address racial/ethnic disparities and health equity in their proposed program.
- The Division of Child and Adolescent Health's School Health Unit has incorporated policies related to funding decisions for agencies serving marginalized populations.
- The Health and Aging Services Administration's Medicaid Health Plan contracts have a variety of provisions regarding health equity. This includes requirements that the plans offer evidence-based interventions to address SDOH and reduce health disparities, as well as measure and report annually on the effectiveness of its evidence-based interventions to reduce health disparities.

Gaps/Limitations

With regard to gaps and limitations in the department's infrastructure for equity-related policies and laws, several areas noted the ***lack of an accountability and reporting structure*** to ensure policies are followed. Inconsistent emphasis across the department

on following policies and the potential for push back also present challenges, although this can be overcome with strong leadership commitment and departmental support for such policies.

Another limitation of policies and laws addressing diversity and equity is a ***lack of awareness, understanding and buy-in***—including the general public's lack of knowledge of such policies and/or laws as well as awareness among staff and state personnel. This may be due, in part, to insufficient community and staff input and involvement in developing laws and policies—particularly those that impact them.

Organizational areas also cited a ***lack of time and staff capacity*** to research and develop new policies as well as evaluate the impact of existing policies. Bureaucratic processes, system inefficiencies and resource limitations can also hinder policy development and slow down the pace with which policy and procedure changes move forward. In addition, ***politics can serve as a barrier*** to the creation and implementation of policies to promote equity. This includes lack of political will and support and lack of urgency when trying to create or improve policies to better promote equity.

Additional overarching gaps include not looking at policies through an equity lens, not always recognizing the unintended negative consequences of existing policies, and challenges with addressing the legacy of structural racism and other systemic issues that have been perpetuated by past policies and laws (such as redlining).

Finally, as with many other elements of infrastructure, a ***lack of funding*** presents a gap when it comes to implementing equity-promoting policies and laws. Often policies and laws include unfunded mandates and requirements that take resources to fully implement. This lack of additional funding serves as a barrier to carrying out provisions of the law or policy and undermines its effectiveness.

Recommendations

Organizational areas responding to the survey offered ***several recommendations to improve policies and laws to advance racial and ethnic health/social equity*** and strengthen the department's capacity and infrastructure in this arena. These include:

- Offer ongoing training for managers and staff focused on policy development and effective strategies/best practices for equity-promoting policies.
- Provide open and frequent communication to increase visibility of equity-related policies and laws, explain and increase understanding of these policies and regulations, and inform personnel about changes in these policies and laws when they occur.

- Facilitate sharing of information and best practices across the department regarding equity-promoting policies; provide consistent guidance and facilitated discussions around improving policies and practices to advance equity and highlight areas that have successfully implemented equity-related policies.
- Expand the use of Equity Impact Assessments to guide the creation of new policies and the review of existing policies to ensure they are unbiased and equitable; make changes to policies when necessary.
- Implement more department-wide policies that advance racial and ethnic health/social equity, which could help strengthen the implementation of such policies across the board.
- Ensure policies—both department-wide and within specific organizational areas—include metrics to measure adherence and effectiveness and create a reporting structure to improve accountability.

Several organizational areas also recommended that the department should ***solicit more community input***, particularly from those disproportionately impacted by health disparities and inequities, to create more equitable and community-driven policies that better meet identified needs. This approach recognizes the expertise communities have in identifying their own needs and determining how best to address those needs. This could not only help increase the effectiveness of such policies, but also shift the power dynamic by lifting up community voices and partnering with them on policy solutions rather than issuing top-down directives.

Finally, it was recommended that the department and its partners work to ***garner more political will and support***. Specifically, this could be done by educating law and policymakers about health equity, why diversity is important and how to integrate diversity and equity-promoting values into policies and laws. It follows that when such policies and laws are instituted, there should be funding to support their implementation.

Technology

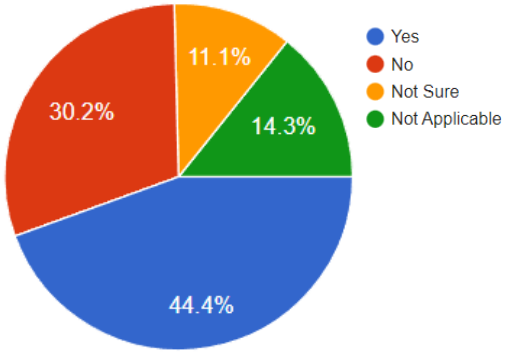
In today's increasingly digital age, technology is becoming another crucial component of a strong health and human services infrastructure. Unfortunately, as was illuminated by the COVID-19 pandemic, there is a lack of access to full-scale technology capabilities and connectivity within public health, human services and partnering communities. This not only includes limitations with data and surveillance systems described previously, but also with the availability and application of innovative technology platforms and broadband internet. A solid technology infrastructure requires modern, efficient and interoperable platforms that build a foundation for creating and applying innovative public health and human services technology solutions to improve community health

and well-being.[1,21]

Current Infrastructure

While the COVID-19 pandemic exposed weaknesses in the department's technology infrastructure, it also propelled it forward. Of those responding to the 2021 Health Equity Survey, ***about 44 percent (44.4%) reported using technology in their health and social equity efforts*** (Figure 8). Many organizational areas expanded the use of technology in interacting with clients, program participants, services providers, and beyond.

Figure 8
2021 MDHHS Health Equity Survey
Technology
In 2021, did your organizational area utilize new or existing technology–including virtual platforms, software, and hardware tools–to better reach populations, provide services, disseminate information, conduct surveillance, and/or support efforts to advance health/social equity among racial/ethnic groups?



Technology platforms were also used throughout the department and among partners, contractors and grantees for communication, reporting, information sharing, meetings, trainings, etc. In addition, some areas used social media on a greater scale to disseminate and share information and messaging. In many ways, the use of virtual platforms enhanced services by extending reach, increasing the number of training participants and facilitating access for individuals with disabilities (such as people with hearing impairments) by providing closed caption and interpreters.

Box 8: Examples of Technology Platforms for Data Collection, Visualization and Information Sharing

- The Power BI Dashboard, MDHHS Data Warehouse and Master Person Index were used to access and disseminate data more effectively across various systems.
- GIS mapping and data from the CDC Social Vulnerability Index (SVI) were used in the COVID-19 response to identify areas of high need and distribute vaccinations and therapeutics.
- Data visualization tools, such as Tableau, have been used with census data, SVI and other measures of inequity—including health and environmental data—to better understand the challenges experienced by marginalized populations in certain geographic areas.

The department also continued to ***use technology in its grant and funding award process*** through the State of Michigan's Electronic Grants Administration and Management System (EGrAMS). The EGrAMS portal is a password protected site through which registered users can access information on grants and funding opportunities and submit grant applications. In addition, the department has made ***use of technology platforms for data collection, disease registries, data visualization/Geographic Information Systems (GIS), and data/information sharing*** (see Box 8).

Gaps/Limitations

Despite the increasing use of technology platforms across MDHHS, the department's technology infrastructure still has gaps and challenges. Foremost is ***lack of access***. Many communities across the state still lack access to broadband internet, particularly racial and ethnic populations, rural areas and low-income households.[22] Consequently, the inconsistency of connectivity across Michigan limits the scope and quality of services that are able to be delivered by health and human services agencies.[18]

Fortunately, the state has begun to address these issues by funding projects to increase broadband internet access and narrow the digital divide.[23] However, there is still a need to invest in modern, efficient and interoperable technology platforms to further strengthen this infrastructure. This includes the ongoing ***need for funding to purchase specific software tools***—as it is expensive to purchase various types of technology to reach different populations—and assistance with obtaining the appropriate approvals need to purchase such software. This need also extends to providing financial assistance to community organizations and partners—as technology can be expensive and places a financial burden on small organizations.

A related limitation pertains to ***state requirements and restrictions*** regarding which technology platforms can be used. These restrictions have created obstacles within MDHHS in terms of its ability to connect and work effectively with partners through technology systems. Essentially, community-based organizations, partners and service providers may not have access to the same products MDHHS organizational areas are required to use. Likewise, MDHHS areas may not be allowed to use technology platforms used by partners and others in communities served. This has further impeded access and ability to advance equity in marginalized communities, particularly during the pandemic.

Another gap is the ***lack of training resources*** for individuals regarding how to use available technology. This applies not only to staff within MDHHS, but also to community agencies, services providers and grantees with whom the department partners. Many social service organizations and non-profits not only lack resources for robust technology, but also the time and capacity to train staff on these technology systems and platforms.

As more program and services shift to technology platforms, there is also the ***need for increased access to communication experts*** who can assist with tailoring information and materials for digital formats. This includes assistance with making materials compliant with the American Disabilities Act (ADA), translating digital materials into various languages, and ensuring visuals are well suited for digital devices.

There are also ***challenges with specific technology systems*** used by the

department, such as the EGrAMS grant management system. As noted by several survey respondents, many community-based organizations—particularly smaller organizations, including those serving racial and ethnic minority populations—are overwhelmed by the EGrAMS granting process and do not apply for funding due to difficulties they experience working with the system.

> *"An additional observation department-wide is the challenge that tribes and Indian organizations face in using the EGrAMs grant management system, to the point that several tribes have declined funding earmarked to support Covid response and other tribal health programs. I consider that a barrier if they cannot access the funds earmarked for them because they don't have enough staff to do the administrative work that we require in that system."*

Finally, there are limitations posed by a ***lack of system integration and interoperability*** among different technology platforms. With various technology systems being utilized across the department and among partners, it can be difficult for people to enter data into multiple platforms. Improving the integration, compatibility and interoperability of these systems could increase efficiencies along with the accuracy of data across systems. For those systems that are already integrated, ensuring that the software is routinely updated can be a challenge.

Recommendations

As noted above, a strong technology infrastructure for health and social equity requires an investment in modern, efficient and interoperable platforms that build a foundation for creating and applying innovative public health and human services technology solutions.[1,21] This relies on fostering a culture of innovation that enables new public-private partnerships to be formed with health care providers, technology companies and other entities, along with the infrastructure necessary to create and implement new tools that empower communities and consumers.[24] The State of Michigan has started to make progress in this area. In order to continue this momentum and further improve the state's and MDHHS's technology infrastructure, ***organizational areas proposed several recommendations. These include:***

- Continue to remove barriers to technology and its application by further investing in technology infrastructure and expanding broadband to ensure all areas of the state have access to high-speed internet.
- Minimize financial barriers by providing low or no cost internet services/wi-fi and digital devices to those in need.
- Allocate more funding for technology improvements and remote training platforms, including funding for grantees that is earmarked for technology upgrades.
- Expand the use of mobile technology platforms—including texting and messaging applications along with other apps—that are easily accessible through smartphones and other mobile devices, which could help to further

increase access to programs, services and messaging among racial and ethnic populations.

- Offer more training to staff, partner organizations and service providers on the use of technology platforms and how to effectively engage with diverse populations through technology.
- Provide education and information on available technology tools and how they can be used to advance equity.
- Convene a team of individuals from across the department to identify ways to improve coordination and integration of technology systems and platforms. This includes best practices for combining data across major MDHHS information systems and strategies to improve the accuracy of individual data sets as well as the ability to combine information in an easy, effective and timely manner.
- Improve data share agreements among state departments (e.g., Department of Education, Michigan State Police, etc.) in order to increase access to and application of data collected by different systems, which can be used to inform practices promoting health and social equity across state government.

Finally, to address specific challenges with the state's EGrAMS system, survey respondents recommended that the department ***provide alternative ways for small community-based organization to access and apply for grants*** and respond to requests for proposals. In addition, MDHHS should conduct an assessment of how the granting system and contractual process affect equity and explore ways to remove barriers to advancing equity imposed by these systems. This could help open doors for community organizations to better access funding through grants and contracts—particularly for smaller community-based organizations that work with racial and ethnic populations and are best suited to do equity work.

Cross-Sector Partnerships

Cultivating communities in which everyone has fair and just opportunities to reach their full health potential and achieve optimal well-being requires the work of many sectors. From housing, food, transportation, and education to faith-based institutions, businesses, health care, public health, and social services—all have a vital part in creating a strong and stable foundation that allows a community and its members to thrive. No one sector can do it alone. Therefore, cross-sector partnerships are essential to addressing community challenges and advancing health and social equity.[1] Through partnerships with multiple sectors, public health and human services can better assess a community's needs and assets, monitor health and social impacts, identify shared goals and priorities, and formulate collaborative efforts to achieve better outcomes.[1]

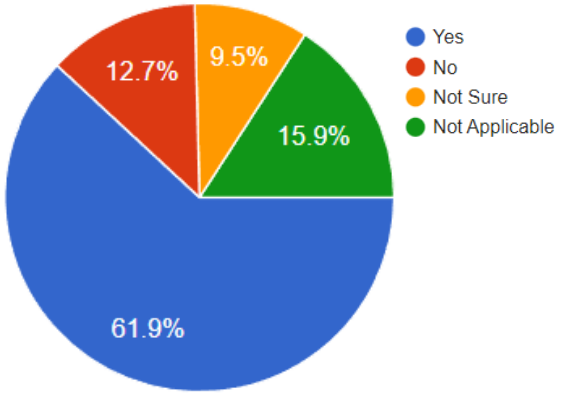
Current Infrastructure

Nearly 62 percent (61.9%) of MDHHS organizational areas reported engaging in cross-sector partnerships to enhance community conditions, address social determinants of health and/or advance equity for racial and ethnic populations (Figure 9). Partners included representatives from faith-based organizations, health care systems, schools, public safety, criminal justice, housing, local government, academic institutions, community-based organizations, professional societies, and corporate organizations, among others (see Box 9, page 33).

Figure 9

2021 MDHHS Health Equity Survey
Cross-Sector Partnerships

In 2021, did your organizational area engage in cross-sector partnerships to enhance community conditions, address social determinants of health, and/or advance equity for racial and ethnic populations?



Cross-sector partnerships have also been part of the department's work with tribal communities. For example, the MDHHS Tribal Liaison worked with outside agencies and organizations in support of various Michigan tribes to help facilitate COVID-19 response efforts, including testing and vaccination clinics and events. Partners included the Indian Health Service, tribal governments, local health departments, the Michigan National Guard, and a private event promotion company.

Collaborative work and partnerships also exist across sectors within MDHHS, including collaboration on equity-related projects, policies and capacity building across the department. For instance, the Office of Workforce Development and Training co-funds and partners with the Children's Services Agency on their Antiracism Transformation Team, whose goal is to reduce the disproportionality of children of color in the Michigan Child Welfare System. They also partner with the MDHHS DEI Council and the REDI Office (including OEMH) on training and technical assistance related to DEI and race equity.

Cross-sector partnerships also include efforts across state government. Specifically, the Division of Child and Adolescent Health worked with colleagues from the Michigan Department of Education and Michigan State Police to provide mental health services and support to school-aged youth in Michigan. Similarly, the Injury and Violence Prevention Section's suicide prevention programs have worked with several state departments—including the Department of Education, Department of Corrections,

Department of Military and Veterans Affairs, Office of the State Employer, Child Welfare, and Behavioral Health—to address social determinants of health and reduce suicide and suicide behavior statewide.

Gaps/Limitations

Although cross-sector partnerships are a key component of many MDHHS programs, there are a number of gaps and limitations that hinder these partnership efforts. As with other elements of infrastructure, one of the main limitations is ***staff time and availability***. Establishing, maintaining and advancing successful cross-sector partnerships takes a significant amount of time, skill and funding. As previously described, staff within many areas of the department are at maximum work capacity with existing workloads and federal grant requirements, thus limiting their ability to invest additional time and resources in cultivating these partnerships.

A related gap is funding. Often funding is prescriptive—particularly those tied to grant awards—and may not support cross-sector partnerships. Siloed budgets within the department can also make sharing funding across sectors complicated and labor intensive. Funding can also serve as a challenge for partnering organizations in terms of their ability to collaborate given their own existing workloads. This is particularly the case if there is no financial compensation for this partnership work.

Box 9: Examples of Cross-Sector Partnerships

- The Office of Community and Faith Engagement partners with houses of faith and faith leaders to address mental health issues and disparities in infant mortality among racial and ethnic communities and other marginalized populations.
- Legislative Affairs and Constituent Services works with both the public and private sector to develop legislation, related strategies and policy on various issues. This includes representatives from human services, public health, public safety/EMS, children's services, and various health care providers and associations.
- Several MDHHS areas and partners—including OEMH; the Division of Maternal and Infant Health; Women, Infants and Children (WIC); Office of Strategic Partnerships and Medicaid; Substance Abuse Prevention Section; the Department of Education; and a local community-based organization—are participants in an initiative entitled, "Calling All Sectors: State Agencies Joined Together for Health." Together, they are working to address maternal and child health issues through initiatives that encourage development of public policies across sectors that consider and improve health equity. The guiding principle of this work is that disparities in health outcomes caused by factors such as race, income or geography should be addressed and prevented. (https://www.pewtrusts.org/en/research-and-analysis/articles/2021/01/08/state-initiatives-pivot-to-address-public-health-challenges-during-pandemic)

Another limitation is ***identifying organizations and groups that are willing to participate*** in cross-sector partnerships and have the capacity to do so. This could be due, in part, to organizational areas knowing which agencies and contacts to reach out to, as well as the capacity of partners to engage in health and equity work. Trust may also be a factor in finding community organizations and agencies with which to partner.

Unfortunately, many communities have histories of negative working relationships with different organizations and government entities, which could be hard to overcome.

Even when agencies are willing and able to participate in cross-sector partnerships, there may be ***challenges with communication and coordination of efforts***. This is especially true if partners come to the table with a different knowledge base and understanding of and language around health and social equity, as well as varying viewpoints on goals, benefits and approaches or ways of working to achieve equity. Additionally, cross-sector communication and partnerships can be hindered by agencies having competing goals and priorities. All of these factors can undermine trust and the sustainability of partnerships.

Finally, organizational areas noted that there is a ***need for enhanced training and technical assistance on cross-sector partnerships***. Specifically, more training and consultation is needed on: 1) how to approach potential partners, 2) facilitating conversations across sectors and 3) best practices for forming partnerships and cultivating relationships.

Recommendations

Organizational areas shared several recommendations for strengthening capacity and infrastructure for cross-sector partnerships. Primary among these is for MDHHS to ***elevate cross-sector partnerships as a strategic priority and provide more leadership and guidance in this area***. This includes:

- Raising awareness of the importance and value of cross-sector partnerships, particularly in advancing health and social equity.
- Outlining expected work, outcomes and best practices for engaging in cross-sector partnerships.
- Identifying ways to integrate partnerships into organizational and departmental structures.
- Forming a task force to conduct a statewide review of existing efforts and opportunities for cross-sector partnerships, facilitate department-wide discussions on these efforts and opportunities, and coordinate information sharing across the department of successful strategies and examples.

Additional recommendations to improve cross-sector partnerships include:

- Work with leadership across state government to identify programs, services and policies that influence each other and establish mechanisms for collaboration.
- Reduce restrictions, mitigate logistical challenges and modify policies that serve

as barriers to interdepartmental work as well as work with non-government sectors.

- Allocate additional funding and staffing to conduct cross-sector partnership work.
    - Allow more leeway in how funds can be used and distributed.
    - Streamline the process for establishing cost pools, appropriations and budgets across different work areas.
    - Hire dedicated staff to foster and nurture cross-sector partnerships.
- Provide more opportunities for organizational areas to learn about and network with various organizations, agencies, institutions, and groups across different sectors that could serve as partners.
    - Convene networking events and "meet and greets" that allow potential partners to learn about each other and explore mutually beneficial partnerships.
    - Host gatherings that showcase existing successful partnerships.
- Offer more training, professional development and technical assistance on partnering across sectors, including the "how-tos" on fostering these partnerships; offer training to partners and other state departments as well.

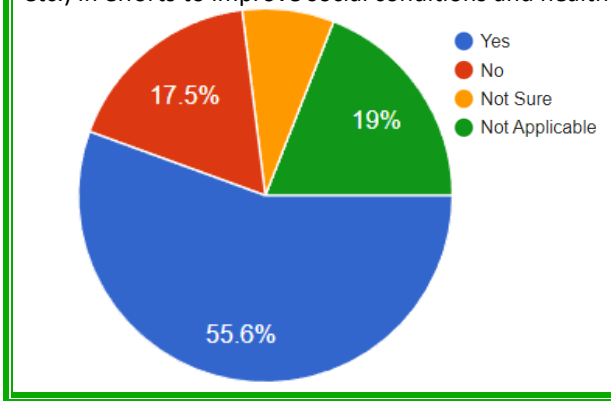
Community Engagement

In addition to partnerships, community engagement is another essential component of a solid public health and human services infrastructure to advance racial and ethnic equity. Effective community engagement requires investing in long-terms relationships with community residents and trusted community leaders and organizations—particularly those experiencing health and social inequities—and centering their voices in identifying priorities and shaping culturally relevant interventions and strategies.[1] This allows community health and social priorities to be addressed with community-driven approaches. It also directs public health and human services to prioritize the right interventions, policies and practices to best meet community needs.[1] Working alongside community members and sharing decision-making with them enhances public health and human services practice and outcomes.[1] However, for community partnerships to be successful, trust must be established. Therefore, public health and human services professionals must devote

Figure 10

2021 MDHHS Health Equity Survey
Community Engagement

In 2021, did your organizational area engage communities (i.e., build relationships and trust with community leaders, members, local agencies, groups, etc.) in efforts to improve social conditions and health?



time and effort to identifying ways to meaningfully engage community members and build authentic relationships.[25]

Current Infrastructure

Just ***over half (55.6%) of organizational areas responding to the 2021 Health Equity Survey reported that they engage communities in efforts to improve social conditions and health*** (Figure 10). Overall, communities were engaged in three main ways: 1) through community representation on committees, task forces or advisory groups; 2) by soliciting input directly from community members, program participants and people served via focus groups, listening sessions, surveys, or community gatherings/meetings; and 3) by engaging with community leaders, stakeholders and advocates (see Box 10). In addition, several areas ***engage communities through their grantees and contractors***. For example, the Injury and Violence Prevention Section funded contractors to conduct work in selected communities, which included focus groups and community engagement efforts. OEMH administers grants for Capacity

Box 10: Examples of Community Engagement

Community Representation on Advisory Councils:

- The Diabetes and Other Chronic Diseases Section has community members on their advisory councils, which concentrate on areas of high need, as does the Michigan Office of Child Support.
- The Division of Maternal and Infant Health requires that people in the community make up at least 10 percent of members in their Regional Perinatal Quality Collaboratives.

Community Input Through Focus Groups, Listening Sessions, Surveys:

- Programs within the Cancer Prevention and Control Section have held numerous focus groups with program and community participants to solicit feedback on programs and services.
- The Division of Victim Services has administered surveys and held focus groups, talking circles, group meetings and programmatic site visits to engage underserved populations across Michigan.

Engage With Community Leaders, Stakeholders and Advocates:

- The Policy and Planning Division surveyed stakeholders on priorities for opioid settlement dollars. They intentionally reached out to organizations that work with minority communities to ensure their voices were heard.
- A MDHHS Business Service Center met with community leaders in various areas to discuss disparities and disproportionality, and to obtain input regarding next steps and potential interventions.
- Areas within the Policy, Planning and Operational Support Administration have engaged health, social services, consumer advocates and others in developing a state Health Information Technology Roadmap, which addresses ways to leverage data sharing and technology to reduce disparities and use evidence-based approaches to better care for residents.
- The Testing and Coordination Team and OEMH continued to engage local health departments, faith-based organizations and local officials in maintaining 22 neighborhood COVID-19 testing and vaccination sites.

Building Projects to support culturally and linguistically appropriate community-level projects and engagement efforts that build capacity to identify and implement programs, policies and practices to address social determinants of health that impact health inequities for racial and ethnic minority populations in Michigan.

Gaps/Limitations

Many of the gaps and limitations with cross-sector partnerships also extend to community engagement. First among these is a ***lack of staff, time and organizational or programmatic capacity***—both within MDHHS as well as within communities. Meaningful community engagement requires a long-term investment since it takes time to build trust and have a beneficial impact. As has been described, many MDHHS organizational areas and programs lack the staff capacity to devote the time and effort necessary to actively engage communities, particularly in ways that foster authentic relationships. Likewise, many community leaders, stakeholders, organizations, and members are often overburden with their own responsibilities and competing priorities which impede participation.

> *"It can be challenging to identify community leaders in some regions that have interest in our work."*

Identifying interested and willing community members, leaders and organizations to take part in community engagement efforts can also be a challenge. Historical and current mistrust of working with government entities continues to pervade many communities—particularly racial and ethnic populations and other marginalized groups. Cultivating relationships with various partners and communities is essential to increasing trust. However, the initial lack of trust can make it difficult to establish these relationships in the first place. It can also be challenging to identify community leaders in some regions, particularly in communities where partnerships are not already present.

> *"We need to continue to cultivate relationships with various partners and communities to help increase trust."*

Another gap with community engagement work is funding. This not only includes having sufficient funding to support the necessary staff and resources to effectively conduct engagement efforts, but also flexibility in how funding can be used. This includes limitations and complexities with providing direct funding to the community, inability to compensate community members for their time

> *"The [in]ability to pay people for their time is a significant barrier. Not all projects have the flexibility in their funding to support paying communities for their expertise and participation in information gathering opportunities."*

and expertise, and restrictions on providing food, transportation and child care for participants.

Finally, ***lack of knowledge and information*** serve as additional gaps. This includes knowledge of which organizations to work with at the local level, opportunities and methods for community engagement and insights into community dynamics.

Recommendations

Organizational areas proposed several recommendations to address the gaps, limitations and challenges of community engagement identified above. ***Primary recommendations include***:

- Provide additional staffing, time and resources for community engagement work.
    - Allow dedicated staff time to develop and nurture relationships with communities.
    - Streamline funding processes to provide funds more easily to community-based organizations; make changes in the grant and contracting process to remove barriers faced by smaller community-based organizations (e.g., allow flexibility in reporting, provide more timely payments, etc.).
    - Compensate community members for their time and expertise.
    - Seek funds that can be used to provide food, transportation and child care to for those participating in community engagement events.
- Foster community engagement work that is more community-driven.
    - Value community voices—actively listen to community needs and concerns and take time to create authentic relationships.
    - Work alongside communities to build local, community leadership to better sustain efforts, rather than initiating a state-level top-down directed community effort.
    - Recognize that communities are best served if members from that community are guiding the community engagement efforts in a collaborative manner.
    - Place precedence on community-identified needs and solutions rather than departmental or programmatic priorities and strategies.
- Ensure community engagement is a two-way process; share information, data and findings from community engagement efforts with community members.
- Involve communities earlier in the process—particularly in strategic planning, priority setting and decision-making that directly impacts them.

> *"MDHHS has a unique opportunity to do more community engagement as we talk about how to rebuild public health. The first thing we should do is listen. Listening sessions with different sectors at a very local level would be helpful…The concept behind this model is that we do not come to the community with a solution to a problem we have identified, but we come to a community to hear what their concerns are."*

- Match funding with community-identified needs and priorities.
- Ensure community-driven versus department-driven equity strategies and approaches are implemented.

> *"Communities want to be involved earlier in the process – to help us identify priorities and programs, not just after the state has come up with a program and released an RFP [Request for Proposal]."*

Additional recommendations to strengthen community engagement included:

- Build relationships with community-based organizations that serve racial and ethnic communities and have a direct connection to communities served; these organizations are often best suited—and more trusted—to conduct community engagement work.
- Support implementation and evaluation of innovative community-driven strategies aimed to improve social and health outcomes for racial and ethnic populations.
- Work with partners and community leaders to ensure sustainability of successful community-driven initiatives.
- Provide more training and expert consultation for staff, partners and grantees on effective community engagement practices.

Infrastructure Alignment with Public Act 653

Many elements of the department's infrastructure to advance health and social equity align with PA 653 provisions. These are highlighted in the following chart.

PA 653 Provision	MDHHS Program/Initiative and Activities
(a) Develop and implement a structure to address racial and ethnic health disparities in this state.	The Office of Equity and Minority Health (OEMH) serves as the primary coordinating body within MDHHS to address racial and ethnic health disparities. OEMH provides a persistent and continuous focus on reducing health disparities and achieving health equity. OEMH is housed within the Office of Race Equity, Diversity and Inclusion (REDI), which was established in 2020. The REDI Office is part of the MDHHS senior leadership team and is responsible for setting the strategic direction for the department to identify and address issues of inequities due to systemic marginalization, and to create a culture of Diversity, Equity and Inclusion in both its practices and policies. The REDI office also includes the Equity Development Division and Leadership Development Division.

PA 653 Provision	MDHHS Program/Initiative and Activities
	The department also has a Diversity, Equity and Inclusion (DEI) Council, which serves as a structure to promote diversity, equity and inclusion within the department, and thereby advance health and social equity. In addition, 77.8 percent of organizational areas responding to the 2021 Health Equity Survey reported having structures in place to support health/social equity work. This included having a sub-unit within their area focused on equity; staff devoted to equity work; and equity-focused workgroups, committees, task forces and teams.
(b) Monitor minority health progress.	According to the 2021 Health Equity Survey, nearly two-thirds (65.1%) of MDHHS organizational areas have practices or systems in place to collect, analyze and/or report race and ethnicity data. For example: • The Child and Adolescent Health Center program collects demographic data—including race and ethnicity—for all users and looks at trends. Additionally, they generate reports from a risk assessment system that shows risk stratified by varying health equity measures. • The Division of Chronic Disease and Injury Control works with the Bureau of Epidemiology to gather, analyze and report chronic disease and injury data, including race and ethnicity. • OEMH conducts special Behavioral Risk Factor Surveys on racial and ethnic populations.
(c) Establish minority health policy.	MDHHS has a training policy that requires employees to complete two equity-related trainings each year (Introduction to Health Equity and Systemic Racism). In addition, several organizational areas require staff to complete additional training pertaining to health and social equity. Other policies implemented by organizational areas to promote racial and ethnic minority health include: • Incorporating equity language and requirements into grants and contracts.

PA 653 Provision	MDHHS Program/Initiative and Activities
	• Building an equity component into requests for proposals (RFPs). • Policies to ensure the recruitment of diverse candidate pools and promote workforce diversity. • Requirements pertaining to the collection of race/ethnicity data. • Policies regarding the use of disparity data to inform decisions. • Requirements concerning document review to ensure cultural and linguistic appropriateness. • Implementation of an Equity Impact Assessment process to ensure policies, practices and procedures are equitable.
(d) Develop and implement an effective statewide strategic plan for the reduction of racial and ethnic health disparities.	OEMH has a Michigan Health Equity Roadmap that serves as the statewide strategic plan for eliminating health disparities in the state. Additionally, MDHHS continues to implement its Diversity, Equity and Inclusion (DEI) plan. Other strategic plans also incorporate equity. For example: • The Diabetes Improvement Plan 2021-2025 has a focus on race equity and evaluation indicators tied to measuring these disparities. • The Asthma Strategic Plan has a health equity focus and includes health equity-related definitions, identified disparities among populations with asthma and their causes, and steps to address these disparities. • Race equity is also included in the Office of Workforce Development and Training's strategic plan.

PA 653 Provision	MDHHS Program/Initiative and Activities
(e) Utilize federal, state and private resources, as available and within the limits of appropriations, to fund minority health programs, research and other initiatives.	A number of MDHHS organizational areas utilize funding from federal, state and other sources to support minority health programs and initiatives. Select examples include: • The Policy and Planning Division received SAMHSA grant funding that was dedicated to services and engagement in minority communities. They also used CDC Health Equity funding to maintain the CHIR program, which funds community partner agencies to address minority health issues and disparities. • The Division of Victim Services administers a variety of grant programs specific to underserved and marginalized communities. They have contracts across several funding sources that fund 20 projects serving underserved victims of domestic violence and or sexual assault. • OEMH funds Capacity Building Projects to support culturally and linguistically appropriate community-level projects that build capacity to identify and implement programs, policies and practices to address social determinants of health that impact health inequities for racial and ethnic minority populations in Michigan. They have also received federal funding to address COVID-19 health disparities among racial and ethnic populations and rural communities.
(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	Many MDHHS organizational areas provide data and technical assistance to grantees, communities and local entities to inform efforts to reduce racial and ethnic disparities. For example: • The Early Childhood Health Section's Home Visiting Unit uses data disaggregated by race/ethnicity to put together health equity spotlights for their grantees. They also provide training to grantees on how to utilize statistical analysis to understand local disaggregated data.

PA 653 Provision	MDHHS Program/Initiative and Activities
interventions that address the elimination of racial and ethnic health disparities.	• The Tobacco Section works with BRFSS and Vital Statistics within MDHHS to annually update data on racial and ethnic disparities related to tobacco use and impact; this data is shared with stakeholders. • The Medicaid Health Equity Project uses HEDIS measures broken down by race/ethnicity to assess health disparities. Findings are shared in an annual report and used to set measurable objectives for specific efforts and pilot projects implemented through health plans to reduce these disparities.
(g) Establish a web page on the department's website, in coordination with the state health disparities reduction and minority health section.	The Office of Equity and Minority Health continues to maintain its web page, which provides access to minority health information, reports, documents, training, data, grant/funding opportunities, tools, resources and research.
(h) Develop and implement recruitment and retention strategies to increase the number of minorities in the health and social services professions.	Over 88 percent of organizational areas responding to the 2021 Health Equity Survey reported implementing practices to promote workforce diversity, retention and advancement. Strategies included: • Implementing measures to broaden the candidate pool—e.g., posting job announcements in diverse venues, revising position descriptions to be more inclusive, revising screening and selection criteria. • Providing training for hiring managers and interview panels to counter bias in the interview/selection process. • Convening diverse interview panels. • Including equity-related questions in the interview.
(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.	Over 98 percent of MDHHS organizational areas reported providing training or professional development opportunities to increase awareness and enhance cultural competency and workforce capacity to address health and social equity. Many programs also provide equity-related training for external partners, grantees, contractors and service providers.

PA 653 Provision	MDHHS Program/Initiative and Activities
(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.	Departmental efforts to promote the implementation of culturally and linguistically appropriate programs and services continued in 2021. These included: • Culturally appropriate information and messaging about COVID-19 testing, vaccination and treatment. • Translation and interpretation services at testing, vaccination and health care delivery sites. • Translation of health/social program information and educational materials into various languages. • Cultural and linguistic competence training for staff, service providers and community partners. • Working with community groups to ensure the cultural appropriateness of programs and services.
(k) Promote the development and networking of minority health coalitions.	Many organizational areas work with local entities and coalition groups as part of their equity-promoting efforts. Over half (55.6%) of organizational areas reported engaging with communities; 61.9 percent reported engaging in cross-sector partnerships to address social determinants of health, improve social conditions, and advance equity for racial and ethnic populations. Community engagement and partnerships are also requirements of several grantee efforts.
(l) Appoint a department liaison to: (i) Assist in the development of local prevention and intervention plans; (ii & iii) Relay the concerns of local minority health coalitions and assist in coordinating minority input; and (iv) Serve as the link between the department and local efforts to	Many organizational areas have staff that work on equity-related issues. Examples include: • Policy and Planning hired a racial equity consultant to assist with state's strategic plan on reducing overdose deaths. • CSA has an analyst focused on race equity and also hired a manager over Native American Affairs and Race Equity. • Legislative Affairs and Constituent Services has a tribal liaison that works with Michigan's federally

PA 653 Provision	MDHHS Program/Initiative and Activities
eliminate racial and ethnic health.	recognized tribes and Indian organizations and engages with tribal government staff. Additionally, several areas work with community groups and solicit participation, input and feedback from racial and ethnic minority populations served.
(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.	In 2021, MDHHS organizational areas continued to provided funding to support evidence-based preventative health, education and treatment programs in minority communities. For instance: • CDC funding continued to be used to provide grants to support Mobile Health Units for COVID-19 testing and connection to care in under-resourced and marginalized communities. New funding has also been awarded to address COVID-19 health disparities among racial/ethnic populations and rural communities and reduce disparities in vaccination. • The Tobacco Section awarded funds from its CDC Disparity Grant to community organization for ongoing efforts to address tobacco use and impact, including within racial and ethnic communities. • The Policy and Planning Office's Workforce/Access and Grants Management Section has ongoing state funding to support 10 multicultural agencies that provide primary care services/clinics in the state. Care is provided to the uninsured, underinsured and people on Medicaid. Immigrants and refugees also use these services.
(n) Provide TA 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.	Many programs within MDHHS partner with and fund local communities to address needs, gaps and barriers related to health care access and delivery along with receipt of social services. This includes facilitating clinical-community linkages to improve access to care. Departmental programs also provide informational webinars and technical assistance to potential grantee applicants as part of their RFP and funding announcement process.

Conclusion

As described, achieving equity requires a robust public health and human services infrastructure that is multidimensional and integrated.[2] Components include workforce diversity and competency, modernized data and information systems, organizational coordination and capacity, equitable policies, appropriate funding, innovative technology, cross-sector partnerships, and meaningful community engagement. Collectively, these elements create a strong foundation that is fundamental to promoting public health and well-being and achieving health and social equity.

Establishing and maintaining this infrastructure requires clear directives, ongoing prioritization and strategic investments in cross-cutting elements of infrastructure that have the potential to transform public health and human services and yield a long-term positive return on the investment.[3,26] With the increased attention on health and social equity arising from the COVID-19 pandemic and availability of funds from the federal government, it is vital that Michigan invest resources now to strengthen the public health and human services infrastructure that will continue into the future. This includes structures to not only provide core functions and essential services, but also advance efforts to counter racial/ethnic disparities and promote health and social equity.

Additionally, a comprehensive and robust public health and human services infrastructure will enable the state to effectively address ongoing issues while preparing for and responding to emerging and future challenges.[9] Therefore, it is important for elected representatives, policymakers and public health and human services officials to capitalize on this moment and invest today in an equitable, effective and sustainable public health and human services infrastructure that has the capacity to provide enhanced health, safety and economic security for Michigan residents now and for generations to come.[1,9]

References

1. Bipartisan Policy Center. Public Health Forward: Modernizing the U.S. Public Health System. Washington, D.C. December 2021. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/12/BPC_Public-Health-Forward_R01_WEB.pdf Accessed 12/23/21.

2. Dean HD, Roberts GW, Bouye KE, Green Y, McDonald M. Sustaining a Focus on Health Equity at the Centers for Disease Control and Prevention Through Organizational Structures and Functions. Journal of Public Health Management and Practice. 2016 Jan-Feb;22 Suppl 1:S60-7. doi: 10.1097/PHH.0000000000000305. PMID: 26599031.

3. Association of State and Territorial Health Officials (ASTHO). Public Health Review Podcast - Financing the Future of Public Health, aired December 1, 2021. https://www.astho.org/communications/podcast/financing-the-future-of-public-health/ Accessed 3/30/22.

4. Preventing Emerging Infectious Diseases: A Strategy for the 21st Century. Overview of the Updated CDC plan. MMWR Recommendations and Reports. 1998; Sep 11;47(RR-15):1-14. PMID: 9751113.

5. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2030. Public Health Infrastructure. Healthy People 2030 Website. https://health.gov/healthypeople/objectives-and-data/browse-objectives/public-health-infrastructure Accessed 1/3/22.

6. Michigan Department of Health and Human Services, DEI Training and Professional Development Action Team, Office of Equity and Minority Health. “Diversity, Equity, and Inclusion Glossary.” 2020.

7. National Conference of State Legislatures (NCSL). Sustaining and Increasing the Benefits of Public Health. October 2014. https://www.ncsl.org/research/health/public-health-infrastructure-webpage.aspx Accessed 1/18/22.

8. Public Health Infrastructure: Overview & Importance. Study.com. October 21, 2017. https://study.com/academy/lesson/public-health-infrastructure-overview-importance.html Accessed 1/3/22.

9. Centers for Disease Control and Prevention (CDC). Public Health’s Infrastructure: A Status Report. Prepared for The Appropriations Committee of the United States Senate. March 2001. https://stacks.cdc.gov/view/cdc/11337 Accessed 12/23/21.

10. Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Health Equity Webpage. March 11, 2020. https://www.cdc.gov/chronicdisease/healthequity/index.htm Accessed 1/4/22.

11. Centers for Disease Control and Prevention (CDC), National Expert Panel on Social Determinants of Health Equity. Report of the National Expert Panel on Social Determinants of Health Equity: Recommendations for Advancing Efforts to Achieve Health Equity. Atlanta: Georgia. September 2009. https://stacks.cdc.gov/view/cdc/44748 Accessed 12/23/21.

12. Centers for Disease Control and Prevention (CDC). Paving the Road to Health Equity website: https://www.cdc.gov/minorityhealth/publications/health_equity/index.html Page last reviewed: November 30, 2020. Accessed 12/23/21.

13. National Academies of Sciences, Engineering, and Medicine 2017. Communities in Action: Pathways to Health Equity. Washington, DC: The National Academies Press. https://doi.org/10.17226/24624.

14. National Institute for Health Care Management (NIHCM) Foundation. Systemic Racism, Disparities & COVID-19: Impacts on Latino Health. 2020. https://nihcm.org/publications/systemic-racism-disparities-covid-19-impacts-on-latino-health Accessed 1/14/22.

15. Robert Wood Johnson Foundation (RWJF). Charting a Course for an Equity-Centered Data System. Recommendations from the National Commission to Transform Public Health Data Systems. October 19, 2021 Publisher: Robert Wood Johnson Foundation Author(s): National Commission to Transform Public Health Data Systems Editor(s): Christopher GC, Zimmerman EB, Chandra A, and Martin LT. https://www.rwjf.org/en/library/research/2021/10/charting-a-course-for-an-equity-centered-data-system.html Accessed 1/9/22.

16. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2030. Public Health Infrastructure Workgroup webage: https://health.gov/healthypeople/about/workgroups/public-health-infrastructure-workgroup#about Accessed 1/11/22.

17. Michigan Department of Health and Human Services, Office of Equity and Minority Health webpage: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2985---,00.html Accessed 3/25/22.

18. National Network of Public Health Institutes (NNPHI). Challenges and Opportunities for Strengthening the US Public Health Infrastructure: Findings from the Scan of the Literature. May 2021. https://nnphi.org/wp-content/uploads/2021/06/NNPHI-E2A-Kresge-Report-Web.pdf Accessed 1/10/22.

19. Michigan Department of Health and Human Services. 2015 Health Equity Report: Moving Health Equity Forward. April 2016. https://www.michigan.gov/documents/mdhhs/2015_Health_Equity_Base_Report_526910_7.pdf Accessed 1/11/22.

20. Knight, E. Promising Practices for Achieving Health Equity Through Public Health Practice. Health Equity Strategy Alignment. March 26, 2012. Available at: http://dhss.delaware.gov/dhss/dph/mh/files/promisingpracticesforachievinghealthequity.pdf Accessed 1/11/22.

21. Keck School of Medicine of University of Southern California. Your Public Health Blog article. 5 Public Health Technologies to Revolutionize Health Care Delivery. July 15, 2021. https://mphdegree.usc.edu/blog/public-health-technology/ Accessed 1/10/22.

22. Slootmaker E. Lack of broadband access is a barrier to health care – and Michigan is aiming to eliminate it. Second Wave Michigan. November 4, 2021. https://www.secondwavemedia.com/features/broadbandhealth11042021.aspx Accessed 1/10/22.

23. State of Michigan, Office of Governor Gretchen Whitmer. Press Release. Gov. Whitmer announces initiatives to increase high-speed internet across Michigan. October 8, 2020. https://www.michigan.gov/whitmer/0,9309,7-387-90499_90640-542115--,00.html Accessed 1/10/22.

24. Lane JT, Smith K, Allen M, Surio P, Ruebush E. COVID-19 Highlights Critical Need for Public Health Data Modernization to Remain a Priority. Journal of Public Health Management and Practice. 2020 Nov/Dec;26(6):634-636. doi: 10.1097/PHH.0000000000001268. PMID: 32969954.

25. Cooper R and Rosenthal J. National Academy for State Health Policy - States Build Infrastructure to Advance Equity in their COVID-19 Responses and Beyond. November 30, 2020. https://www.nashp.org/states-build-infrastructure-to-advance-equity-in-their-covid-19-responses-and-beyond/ Accessed 4/8/22.

26. Plescia M. Association of State and Territorial Health Officials (ASTHO) Experts Blog: The Historic Opportunity COVID-19 Presents to Address Health Equity. November 24, 2021. https://astho.org/StatePublicHealth/The-Historic-Opportunity-COVID-19-Presents-to-Address-Health-Equity/11-24-21/?utm_source=informz&utm_medium=email&utm_campaign=asthophw&utm_content=CMOHISTORIC&utm_term=CMOHISTORIC Accessed 1/25/22.

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

Attachment B

Supplemental Data Brief
Leading Health and Social Disparities
in Michigan by Race and Ethnicity

SUMMARY DATA BRIEF OF THE CHANGES IN HEALTH DISPARITIES BETWEEN 2018-2020

INTRODUCTION

The focus of this summary data brief is to offer a broad overview of the health disparities within the various population of the State of Michigan. This summary data brief presents group-level data for five racial and ethnic groups in Michigan across the time period of (2018-2020) compared to Michigan's total population for this same period. The data brief describes how populations compare to one another in terms of population rates for several social determinants of health and health outcomes. These comparisons describe populations relative to each other while highlighting some of the largest disparities within each population. The purpose of these data tables is to allow for routine monitoring of health disparities in Michigan and to evaluate their progress over time.

HEALTH INDICATORS

Each of the tables contains four sets of indicators with data for each racial and ethnic population. The first set of indicators include social determinants of health related to economic determinants and healthcare access. The second set of indicators focus on housing and environmental determinants of health. The third and fourth set of indicators include health outcomes respectively represented by morbidity and mortality rates for several diseases.

SOCIAL DETERMINANTS OF HEALTH PROFILE:
AFRICAN AMERICAN COMMUNITY AND STATE

Within the African American community some of the largest disparities exist around housing, economic factors, and chronic health disease. When compared to the state's population a disproportionate number of African Americans lived in rental properties (48.4% African Americans vs 17.0% state population).

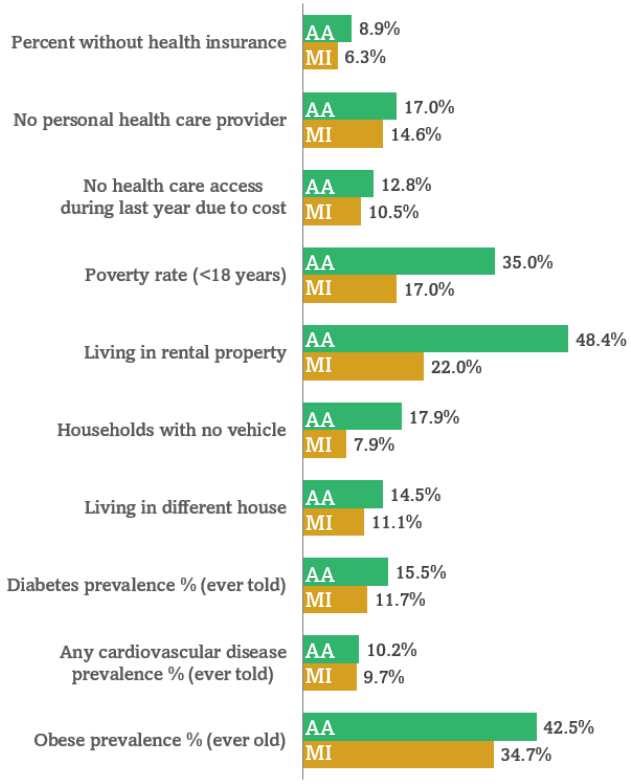
Lack of homeownership is one of the largest economic disparities facing the country. Within the African American community 48.4% of individuals live in rental properties compared to 22.0% of the state's population who live in rental properties.

In terms of economic disparities as of 2020 35.0% of African Americans in the state were in poverty (at 100% of the federal poverty level or below) compared to the 17.0% of the state's population in poverty. Additionally, 17.9% of African Americans in the state live in a household with no vehicle while only 7.9% of the state's population live in households without a vehicle.

Lastly two of the major health disparities in chronic disease facing the African American community are diabetes and obesity with 15.5% of the community having diabetes and 42.5% having obesity. This is compared to 11.7% of the state's population having diabetes and 34.7% having obesity.

SELECTED HEALTH DISAPRITIES 2018-2020

AFRICAN AMERICAN POPULATION OF MICHIGAN COMPARED TO OVERALL STATE POPULATION

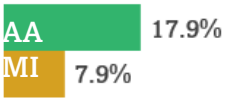


42.5%

of African American adults in Michigan are **obese**

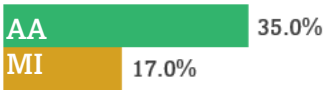
17.9%

of African American adults in Michigan **have no vehicle in their household.**



35.0%

of African American adults in Michigan are in **poverty**



SOCIAL DETERMINANTS OF HEALTH, MORTALITY, AND MORBIDITY PROFILE:
AFRICAN AMERICAN COMMUNITY AND STATE

SOCIAL DETERMINANT	AFRICAN AMERICAN	STATE
High school dropout rate, %[a]	12.7%	7.8%
Less than HS diploma persons ≥25 years, %[a]	13.6%	8.1%
Bachelor's degree persons ≥25 years, %[a]	31.0%	27.8%
Median annual household income, $[a]	36561	59234
Poverty rate (population), %[a]	24.7%	12.3%
Female-headed households, %[a]	31.8%	11.9%
Unemployment rate, %[a]	8.1%	4.6%
Percent without health insurance, %[b]	8.9%	6.3%
Poor physical health on at least 14 days in the past month %[b]	14.2%	13.4%
No personal health care provider %[b]	17.0%	14.6%
No health care access during past 12 months due to cost %[b]	12.8%	10.5%
No routine checkup in past year %[b]	17.0%	21.2%
Poverty rate (<18 years) %[a]	35.0%	17.0%
Population 3 years and older enrolled in nursery/preschool[a]	6.4%	7.4%

MORBIDITY INDICATORS	AFRICAN AMERICAN	STATE
Diabetes prevalence % (ever told)[b]	15.5%	11.7%
Asthma prevalence % (ever told)[b]	19.7%	15.9%
COPD prevalence % (ever told)[b]	8.0%	8.4%
Arthritis prevalence % (ever told)[b]	29.9%	31.0%
Any cardiovascular disease prevalence % (ever told)[b]	10.2%	9.7%
Cancer prevalence % (ever told)[b]	6.8%	12.9%
Kidney disease prevalence % (ever told)[b]	3.9%	3.4%
Depression prevalence % (ever told)[b]	18.2%	21.4%
Disability prevalence % (ever told)[b]	29.1%	27.7%
Obese prevalence % (ever told)[b]	42.5%	34.7%

HOUSING FACTORS	AFRICAN AMERICAN	STATE
Living in owner-occupied housing %[a]	46.7%	75.3%
Living in renter-occupied housing %[a]	48.4%	22.0%
Households with no vehicle available %[a]	17.9%	7.9%
Living in different house than last year %[a]	14.5%	11.1%
Household with broadband internet access %[a]	79.2%	85.9%

MORTALITY INDICATORS	AFRICAN AMERICAN	STATE
All cause mortality per 100,000[c]	1252.8	1175.1
Cardiovascular disease mortality per 100,000[c]	369.6	342.3
Heart disease mortality per 100,000[c]	281.8	260.4
Heart failure mortality per 100,000[c]	27.5	31.3
Hypertension mortality per 100,000[c]	73.4	47.5
Hypertensive heart disease mortality per 100,000[c]	54.8	35.2
Stroke mortality per 100,000[c]	56.3	57.1
Diabetes mortality per 100,000[c]	41.9	34.0
All malignant neoplasms (all cancer) mortality per 100,000[c]	188.7	210.8
Liver mortality per 100,000[c]	18.7	22.7
Kidney mortality per 100,000[c]	27.9	19.3
Alzheimer's mortality per 100,000[c]	22.1	41.9
Respiratory disease mortality per 100,000[c]	267.4	262.1
Chronic lower respiratory disease mortality per 100,000[c]	33.6	51.7
Chronic obstructive pulmonary disease mortality per 100,000[c]	29.3	48.2
Asthma mortality per 100,000[c]	2.3	0.8
Pneumonia and flu mortality per 100,000[c]	16.8	12.9
Septicemia mortality per 100,000[c]	19.5	12.4
Covid-19 mortality per 100,000[c]	144.3	135.1

a. Data Source: American Community Survey, population profile 3 year estimate 2018-2020; 1 year estimate 2020. For these indicators Asian estimate does not include Pacific Islanders and all races are non-Hispanic. For Indicators of Hispanic estimates, Hispanics include combination with one or more races.
b. Data Source: Michigan Behavioral Risk Factor Survey, 3 year estimates 2018-2020. For these indicators all race and ethnicities are non-Hispanic.
c. Data Source: Division for Vital Records and Health Statistics. Michigan Department of Health and Human Services 1 year estimate 2020.
d. Mortality data was suppressed for having a cell count below 5 deaths and the cell list **** of a percentage.
e. Morbidity data was not available for this year and is represented by -----.

SOCIAL DETERMINANTS OF HEALTH PROFILE:
NATIVE AMERICAN COMMUNITY AND STATE

Within the Native American community some of the largest disparities exist around access to health care and health insurance, economic factors, and chronic health disease. When compared to the state's population many Native Americans have not had access to health care in the last year due to cost (15.4% Native Americans vs 10.5% state).

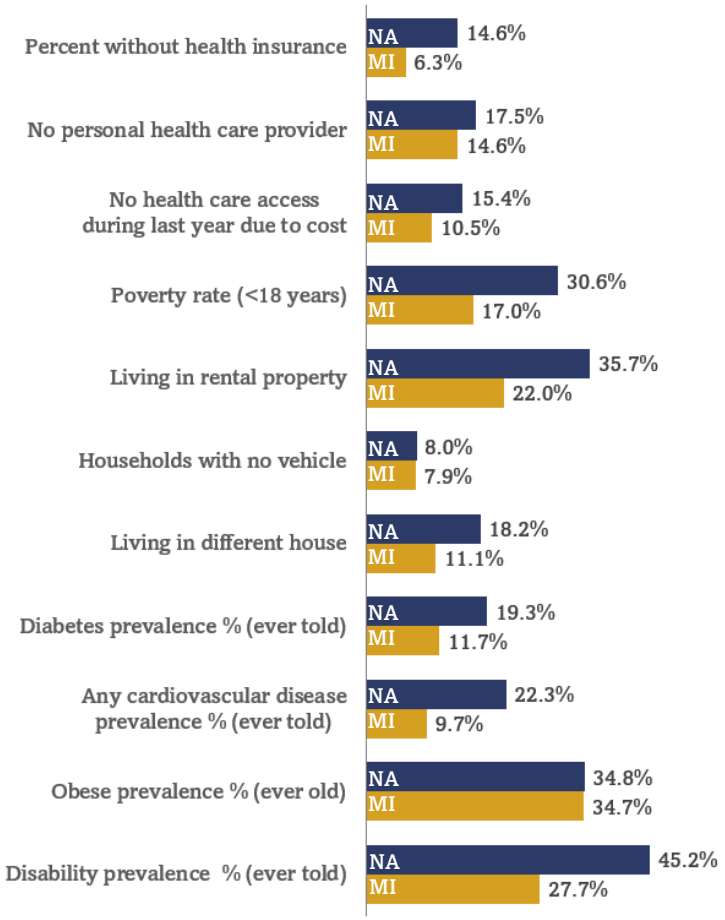
Health insurance is a major social determinant of health and there is a large disparity between the Native American community and the state's population in terms of access to health care. In Michigan, 14.6% of Native Americans do not have access to health insurance compared to the 6.3% of the state's population which does not have health insurance.

In terms of economic disparities as of 2020, 30.6% of Native Americans in the state are in poverty compared to the 17.0% of the state's population in poverty.

Lastly there are multiple health disparities in chronic disease facing the Native American community. First is the disparity in cardiovascular disease prevalence with 22.3% of Native Americans having cardiovascular disease compared to 9.7% state's population having the disease. Second and third are diabetes and disability with 19.3% of the community having diabetes and 45.2% having a disability compared to 11.7% of the state's population having diabetes and 27.7% having a disability.

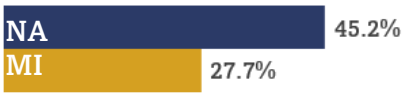
SELECTED HEALTH DISAPRITIES 2018-2020

NATIVE AMERICAN POPULATION OF MICHIGAN COMPARED TO OVERALL STATE POPULATION



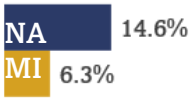
45.2%

of American Indian adults in Michigan have **disabilities**



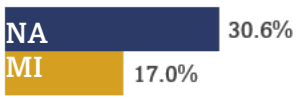
14.6%

of American Indian adults in Michigan **have no health insurance.**



30.6%

of American Indian adults in Michigan are in **poverty**



SOCIAL DETERMINANTS OF HEALTH, MORTALITY, AND MORBIDITY PROFILE:
NATIVE AMERICAN COMMUNITY AND STATE

SOCIAL DETERMINANT	AMERICAN INDIAN	STATE
High school dropout rate, %[a]	11.8%	7.8%
Less than HS diploma persons ≥25 years, %[a]	13.5%	8.1%
Bachelor's degree persons ≥25 years, %[a]	32.1%	27.8%
Median annual household income, $[a]	45530	59234
Poverty rate (population), %[a]	21.9%	12.3%
Female-headed households, %[a]	15.6%	11.9%
Unemployment rate, %[a]	4.6%	4.6%
Percent without health insurance, %[b]	14.6%	6.3%
Poor physical health on at least 14 days in the past month %[b]	32.0%	13.4%
No personal health care provider %[b]	17.5%	14.6%
No health care access during past 12 months due to cost %[b]	15.4%	10.5%
No routine checkup in past year %[b]	16.5%	21.2%
Poverty rate (<18 years) %[a]	30.6%	17.0%
Population 3 years and older enrolled in nursery/preschool[a]	9.0%	7.4%

MORBIDITY INDICATORS	AMERICAN INDIAN	STATE
Diabetes prevalence % (ever told)[b]	19.3%	11.7%
Asthma prevalence % (ever told)[b]	27.1%	15.9%
COPD prevalence % (ever told)[b]	20.5%	8.4%
Arthritis prevalence % (ever told)[b]	48.6%	31.0%
Any cardiovascular disease prevalence % (ever told)[b]	22.3%	9.7%
Cancer prevalence % (ever told)[b]	11.5%	12.9%
Kidney disease prevalence % (ever told)[b]	-----	3.4%
Depression prevalence % (ever told)[b]	30.8%	21.4%
Disability prevalence % (ever told)[b]	45.2%	27.7%
Obese prevalence % (ever told)[b]	34.8%	34.7%

HOUSING FACTORS	AMERICAN INDIAN	STATE
Living in owner-occupied housing %[a]	61.4%	75.3%
Living in renter-occupied housing %[a]	35.7%	22.0%
Households with no vehicle available %[a]	8.0%	7.9%
Living in different house than last year %[a]	18.2%	11.1%
Household with broadband internet access %[a]	81.7%	85.9%

MORTALITY INDICATORS	AMERICAN INDIAN	STATE
All cause mortality per 100,000[c]	1123.1	1175.1
Cardiovascular disease mortality per 100,000[c]	275.2	342.3
Heart disease mortality per 100,000[c]	212.9	260.4
Heart failure mortality per 100,000[c]	20.8	31.3
Hypertension mortality per 100,000[c]	36.3	47.5
Hypertensive heart disease mortality per 100,000[c]	29.4	35.2
Stroke mortality per 100,000[c]	45.0	57.1
Diabetes mortality per 100,000[c]	50.2	34.0
All malignant neoplasms (all cancer) mortality per 100,000[c]	188.6	210.8
Liver mortality per 100,000[c]	55.4	22.7
Kidney mortality per 100,000[c]	15.6	19.3
Alzheimer's mortality per 100,000[c]	22.5	41.9
Respiratory disease mortality per 100,000[c]	332.3	262.1
Chronic lower respiratory disease mortality per 100,000[c]	38.1	51.7
Chronic obstructive pulmonary disease mortality per 100,000[c]	36.3	48.2
Asthma mortality per 100,000[c]	****	0.8
Pneumonia and flu mortality per 100,000[c]	15.6	12.9
Septicemia mortality per 100,000[c]	****	12.4
Covid-19 mortality per 100,000[c]	181.7	135.1

a. Data Source: American Community Survey, population profile 3 year estimate 2018-2020; 1 year estimate 2020. For these indicators Asian estimate does not include Pacific Islanders and all races are non-Hispanic. For Indicators of Hispanic estimates, Hispanics include combination with one or more races.
b. Data Source: Michigan Behavioral Risk Factor Survey, 3 year estimates 2018-2020. For these indicators all race and ethnicities are non-Hispanic.
c. Data Source: Division for Vital Records and Health Statistics. Michigan Department of Health and Human Services 1 year estimate 2020.
d. Mortality data was suppressed for having a cell count below 5 deaths and the cell list **** of a percentage.
e. Morbidity data was not available for this year and is represented by -----.

SOCIAL DETERMINANTS OF HEALTH PROFILE:
ASIAN AMERICAN COMMUNITY AND STATE

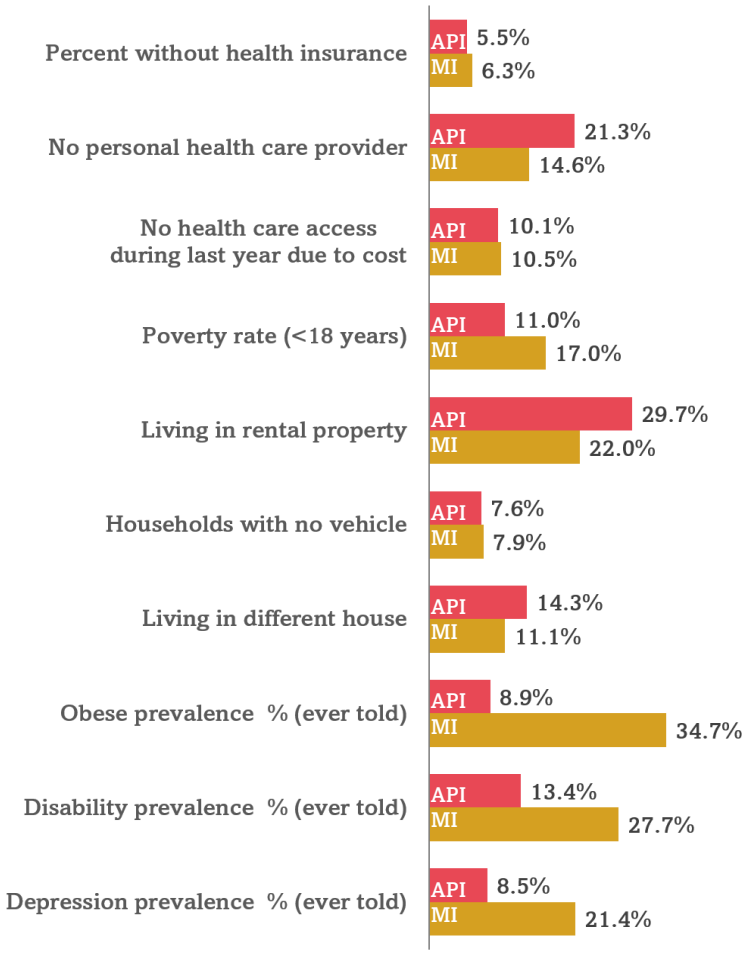
The Asian American community compared to the state's population does not have many health disparities. They have much lower rates of chronic disease and a better economic condition compared to the state's population. However, some disparities do exist especially in the realm of access to healthcare.

Within the Asian American access to primary care providers is issue for the community with 21.3% of Asian Americans not having access to a primary care provider compared to the 14.6% of the state's population.

While not many disparities exist within the larger Asian American community, this does not mean there are no areas of concern within the community. The Asian American population is a very diverse group with multiple nationalities represented of different socio-economic statuses. Due to limitations in being able to disaggregate this population into the more respective nationalities and cultural identities that make up the population, disparities are often masked by larger and wealthier populations that compose the aggregate population.

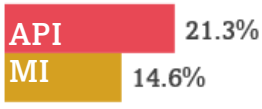
SELECTED HEALTH DISAPRITIES 2018-2020

ASIAN AMERICAN POPULATION OF MICHIGAN COMPARED TO OVERALL STATE POPULATION



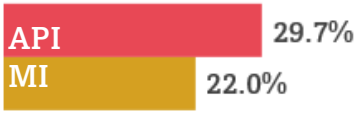
21.3%

of Asian American adults in Michigan **have no personal healthcare provider**



29.7%

of Asian American adults in Michigan **live in rental properties**



SOCIAL DETERMINANTS OF HEALTH, MORTALITY, AND MORBIDITY PROFILE:
ASIAN AMERICAN COMMUNITY AND STATE

SOCIAL DETERMINANT	ASIAN AMERICAN	STATE
High school dropout rate, %[a]	2.7%	7.8%
Less than HS diploma persons ≥25 years, %[a]	11.4%	8.1%
Bachelor's degree persons ≥25 years, %[a]	14.4%	27.8%
Median annual household income, $[a]	88990	59234
Poverty rate (population), %[a]	11.8%	12.3%
Female-headed households, %[a]	5.8%	11.9%
Unemployment rate, %[a]	3.2%	4.6%
Percent without health insurance, %[b]	5.5%	6.3%
Poor physical health on at least 14 days in the past month %[b]	7.3%	13.4%
No personal health care provider %[b]	21.3%	14.6%
No health care access during past 12 months due to cost %[b]	10.1%	10.5%
No routine checkup in past year %[b]	26.7%	21.2%
Poverty rate (<18 years) %[a]	11.0%	17.0%
Population 3 years and older enrolled in nursery/preschool[a]	5.0%	7.4%

MORBIDITY INDICATORS	ASIAN AMERICAN	STATE
Diabetes prevalence % (ever told)[b]	5.3%	11.7%
Asthma prevalence % (ever told)[b]	8.9%	15.9%
COPD prevalence % (ever told)[b]	-----	8.4%
Arthritis prevalence % (ever told)[b]	8.5%	31.0%
Any cardiovascular disease prevalence % (ever told)[b]	-----	9.7%
Cancer prevalence % (ever told)[b]	-----	12.9%
Kidney disease prevalence % (ever told)[b]	-----	3.4%
Depression prevalence % (ever told)[b]	8.5%	21.4%
Disability prevalence % (ever told)[b]	13.4%	27.7%
Obese prevalence % (ever told)[b]	8.9%	34.7%

HOUSING FACTORS	ASIAN AMERICAN	STATE
Living in owner-occupied housing %[a]	67.1%	75.3%
Living in renter-occupied housing %[a]	29.7%	22.0%
Households with no vehicle available %[a]	7.6%	7.9%
Living in different house than last year %[a]	14.3%	11.1%
Household with broadband internet access %[a]	93.4%	85.9%

MORTALITY INDICATORS	ASIAN AMERICAN	STATE
All cause mortality per 100,000[c]	340.4	1175.1
Cardiovascular disease mortality per 100,000[c]	95.3	342.3
Heart disease mortality per 100,000[c]	63.3	260.4
Heart failure mortality per 100,000[c]	5.5	31.3
Hypertension mortality per 100,000[c]	10.4	47.5
Hypertensive heart disease mortality per 100,000[c]	5.5	35.2
Stroke mortality per 100,000[c]	24.8	57.1
Diabetes mortality per 100,000[c]	11.6	34.0
All malignant neoplasms (all cancer) mortality per 100,000[c]	71.8	210.8
Liver mortality per 100,000[c]	5.5	22.7
Kidney mortality per 100,000[c]	4.9	19.3
Alzheimer's mortality per 100,000[c]	6.7	41.9
Respiratory disease mortality per 100,000[c]	78.2	262.1
Chronic lower respiratory disease mortality per 100,000[c]	3.7	51.7
Chronic obstructive pulmonary disease mortality per 100,000[c]	2.8	48.2
Asthma mortality per 100,000[c]	****	0.8
Pneumonia and flu mortality per 100,000[c]	4.9	12.9
Septicemia mortality per 100,000[c]	****	12.4
Covid-19 mortality per 100,000[c]	50.4	135.1

a. Data Source: American Community Survey, population profile 3 year estimate 2018-2020; 1 year estimate 2020. For these indicators Asian estimate does not include Pacific Islanders and all races are non-Hispanic. For Indicators of Hispanic estimates, Hispanics include combination with one or more races.
b. Data Source: Michigan Behavioral Risk Factor Survey, 3 year estimates 2018-2020. For these indicators all race and ethnicities are non-Hispanic.
c. Data Source: Division for Vital Records and Health Statistics. Michigan Department of Health and Human Services 1 year estimate 2020.
d. Mortality data was suppressed for having a cell count below 5 deaths and the cell list **** of a percentage.
e. Morbidity data was not available for this year and is represented by -----.

SOCIAL DETERMINANTS OF HEALTH PROFILE:
HISPANIC AMERICAN COMMUNITY AND STATE

Within the Hispanic American community some of the largest disparities exist around access to health care, economic factors, and chronic health disease. When compared to the state's population a disproportionate number of Hispanic Americans do not have health insurance (13.2% Hispanic Americans vs 6.3% state population).

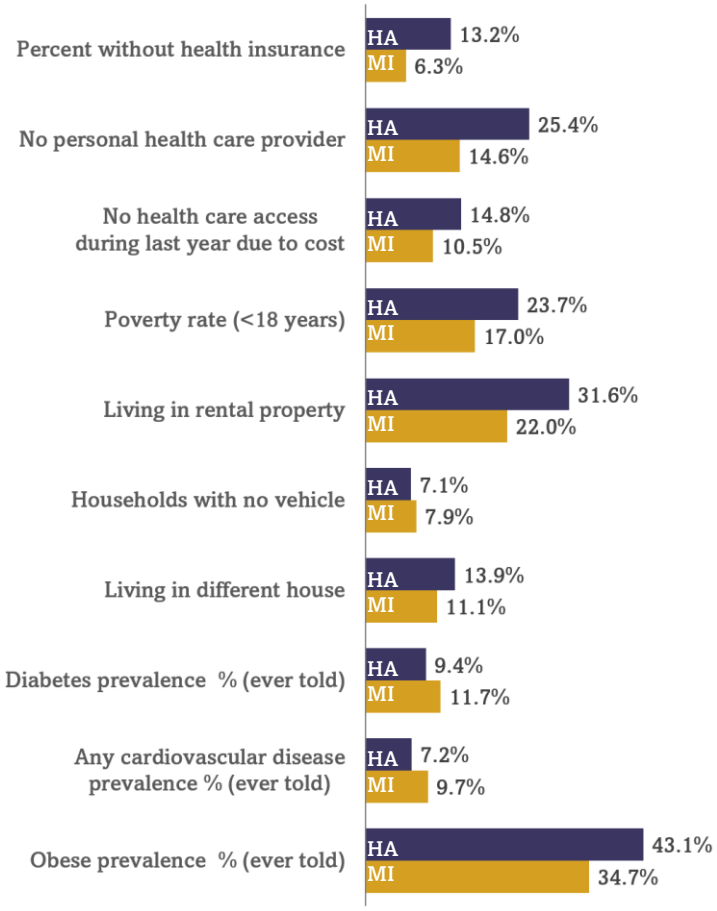
Access to healthcare is a large health disparity facing the Hispanic American community and exists in multiple facets. The first is affordability, 14.8% of Hispanic Americans could not afford healthcare in the past year compared to the 10.5% of the state's population who can afford healthcare. Second is lack of access to primary care providers, 25.4% of Hispanic Americans did not have a primary care provider.

In terms of economic disparities, in 2020 23.7% of Hispanic Americans in the state were in poverty compared to 17.0% of the state's population. Additionally, 31.6% of the Hispanic Americans lived in rental properties compared to the 22.0% of the state's population who lived in rental properties.

Lastly one of the major health disparities in chronic disease facing the Hispanic American community is obesity. Some 43.1% of Hispanic Americans are obese compared to the state's population 34.7% of Michigan citizens being obese.

SELECTED HEALTH DISAPRITIES 2018-2020

HISPANIC AMERICAN POPULATION OF MICHIGAN COMPARED TO OVERALL STATE POPULATION

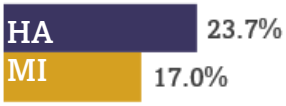


43.1%

of Hispanic American adults in Michigan are **obese.**

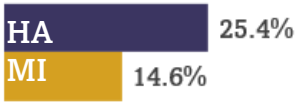
23.7%

of Hispanic American adults in Michigan are in **poverty.**



25.4%

of Hispanic American adults in Michigan **have no health care provider.**



SOCIAL DETERMINANTS OF HEALTH, MORTALITY, AND MORBIDITY PROFILE:
HISPANIC AMERICAN COMMUNITY AND STATE

SOCIAL DETERMINANT	HISPANIC AMERICAN	STATE
High school dropout rate, %[a]	12.3%	7.8%
Less than HS diploma persons ≥25 years, %[a]	19.9%	8.1%
Bachelor's degree persons ≥25 years, %[a]	29.0%	27.8%
Median annual household income, $[a]	50802	59234
Poverty rate (population), %[a]	18.2%	12.3%
Female-headed households, %[a]	13.0%	11.9%
Unemployment rate, %[a]	6.7%	4.6%
Percent without health insurance, %[b]	13.2%	6.3%
Poor physical health on at least 14 days in the past month %[b]	11.8%	13.4%
No personal health care provider %[b]	25.4%	14.6%
No health care access during past 12 months due to cost %[b]	14.8%	10.5%
No routine checkup in past year %[b]	26.4%	21.2%
Poverty rate (<18 years) %[a]	23.7%	17.0%
Population 3 years and older enrolled in nursery/preschool[a]	6.4%	7.4%

MORBIDITY INDICATORS	HISPANIC AMERICAN	STATE
Diabetes prevalence % (ever told)[b]	9.4%	11.7%
Asthma prevalence % (ever told)[b]	16.3%	15.9%
COPD prevalence % (ever told)[b]	7.0%	8.4%
Arthritis prevalence % (ever told)[b]	19.8%	31.0%
Any cardiovascular disease prevalence % (ever told)[b]	7.2%	9.7%
Cancer prevalence % (ever told)[b]	5.6%	12.9%
Kidney disease prevalence % (ever told)[b]	-----	3.4%
Depression prevalence % (ever told)[b]	25.4%	21.4%
Disability prevalence % (ever told)[b]	27.3%	27.7%
Obese prevalence % (ever told)[b]	43.1%	34.7%

HOUSING FACTORS	HISPANIC AMERICAN	STATE
Living in owner-occupied housing %[a]	65.8%	75.3%
Living in renter-occupied housing %[a]	31.6%	22.0%
Households with no vehicle available %[a]	7.1%	7.9%
Living in different house than last year %[a]	13.9%	11.1%
Household with broadband internet access %[a]	84.8%	85.9%

MORTALITY INDICATORS	HISPANIC AMERICAN	STATE
All cause mortality per 100,000[c]	497.6	1175.1
Cardiovascular disease mortality per 100,000[c]	96.7	342.3
Heart disease mortality per 100,000[c]	77.0	260.4
Heart failure mortality per 100,000[c]	7.2	31.3
Hypertension mortality per 100,000[c]	12.5	47.5
Hypertensive heart disease mortality per 100,000[c]	10.6	35.2
Stroke mortality per 100,000[c]	14.1	57.1
Diabetes mortality per 100,000[c]	16.2	34.0
All malignant neoplasms (all cancer) mortality per 100,000[c]	76.2	210.8
Liver mortality per 100,000[c]	20.7	22.7
Kidney mortality per 100,000[c]	7.4	19.3
Alzheimer's mortality per 100,000[c]	8.9	41.9
Respiratory disease mortality per 100,000[c]	135.3	262.1
Chronic lower respiratory disease mortality per 100,000[c]	9.7	51.7
Chronic obstructive pulmonary disease mortality per 100,000[c]	8.9	48.2
Asthma mortality per 100,000[c]	****	0.8
Pneumonia and flu mortality per 100,000[c]	4.4	12.9
Septicemia mortality per 100,000[c]	****	12.4
Covid-19 mortality per 100,000[c]	104.3	135.1

a. Data Source: American Community Survey, population profile 3 year estimate 2018-2020; 1 year estimate 2020. For these indicators Asian estimate does not include Pacific Islanders and all races are non-Hispanic. For Indicators of Hispanic estimates, Hispanics include combination with one or more races.
b. Data Source: Michigan Behavioral Risk Factor Survey, 3 year estimates 2018-2020. For these indicators all race and ethnicities are non-Hispanic.
c. Data Source: Division for Vital Records and Health Statistics. Michigan Department of Health and Human Services 1 year estimate 2020.
d. Mortality data was suppressed for having a cell count below 5 deaths and the cell list **** of a percentage.
e. Morbidity data was not available for this year and is represented by -----.

SOCIAL DETERMINANTS OF HEALTH PROFILE:
ARAB AMERICAN COMMUNITY AND STATE

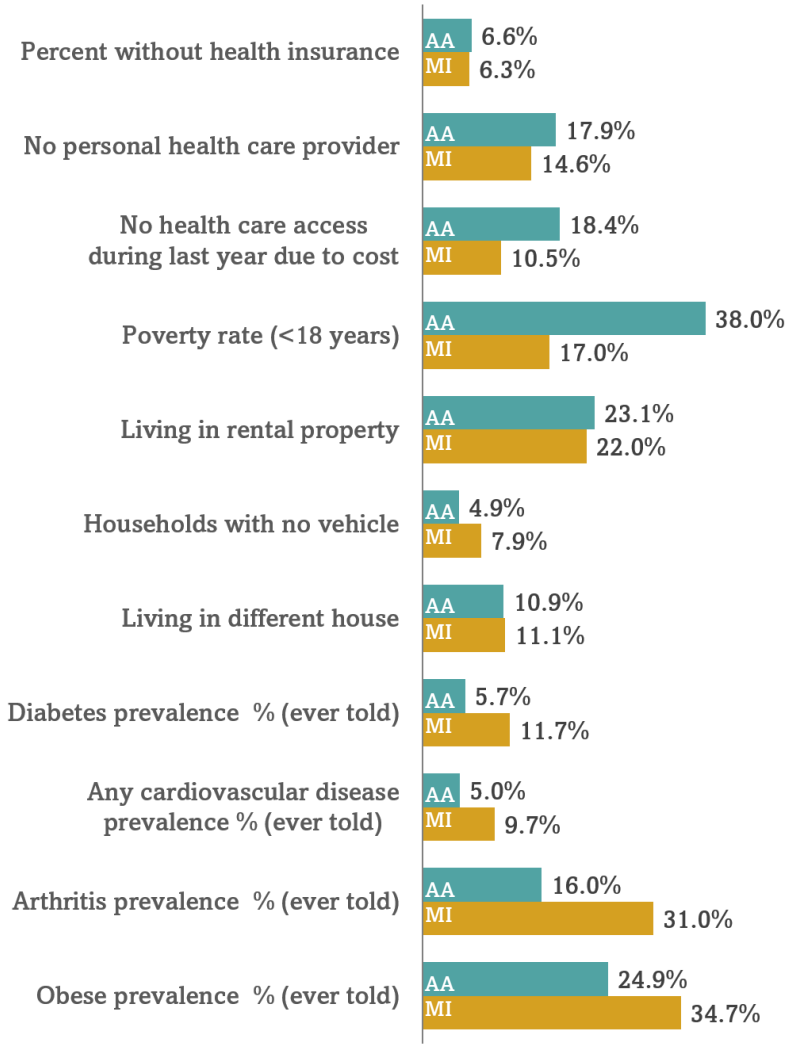
Within the Arab American community, access to health care and poverty are two of the largest health disparities facing the community. While only 6.6% of Arab Americans do not have health insurance, which is similar to the State of Michigan's population (6.3%), access to primary care providers and affordability of health care are still issues.

Some 18.4% of Arab Americans did not have access to healthcare in the last year due to cost. This is compared to only 10.5% of the state's population not having access to health care in the past year due to cost.

Poverty is one of the largest economic disparities in the Arab American community. As of 2020 over 38.0% of Arab Americans were in poverty within the State of Michigan. This is compared to 17.0% of the state's population being in poverty. Poverty can affect individuals' ability to afford healthcare, housing, and other essential services in the long-term leading to a worsening of health disparities over time. While many chronic disease measures for the Arab American community are currently lower than the state's population, these indicators have risen over the past 10 years.

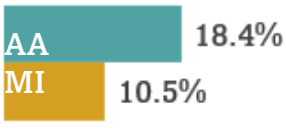
SELECTED HEALTH DISAPRITIES 2018-2020

ARAB AMERICAN POPULATION OF MICHIGAN COMPARED TO OVERALL STATE POPULATION



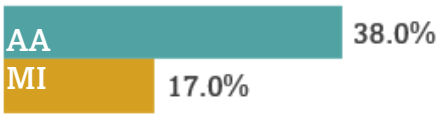
18.4%

of Arab American adults in Michigan **do not have access to healthcare due to cost.**



38.0%

of Arab American adults in Michigan are in **poverty.**



SOCIAL DETERMINANTS OF HEALTH, MORTALITY, AND MORBIDITY PROFILE:

ARAB AMERICAN COMMUNITY AND STATE

SOCIAL DETERMINANT	ARAB AMERICAN	STATE
High school dropout rate, %[a]	****	7.8%
Less than HS diploma persons ≥25 years, %[a]	18.1%	8.1%
Bachelor's degree persons ≥25 years, %[a]	20.4%	27.8%
Median annual household income, $[a]	50387	59234
Poverty rate (population), %[a]	24.8%	12.3%
Female-headed households, %[a]	8.6%	11.9%
Unemployment rate, %[a]	5.1%	4.6%
Percent without health insurance, %[b]	6.6%	6.3%
Poor physical health on at least 14 days in the past month %[b]	11.5%	13.4%
No personal health care provider %[b]	17.9%	14.6%
No health care access during past 12 months due to cost %[b]	18.4%	10.5%
No routine checkup in past year %[b]	20.7%	21.2%
Poverty rate (<18 years) %[a]	38.0%	17.0%
Population 3 years and older enrolled in nursery/preschool[a]	4.1%	7.4%

MORBIDITY INDICATORS	ARAB AMERICAN	STATE
Diabetes prevalence % (ever told)[b]	5.7%	11.7%
Asthma prevalence % (ever told)[b]	13.0%	15.9%
COPD prevalence % (ever told)[b]	4.9%	8.4%
Arthritis prevalence % (ever told)[b]	16.0%	31.0%
Any cardiovascular disease prevalence % (ever told)[b]	5.0%	9.7%
Cancer prevalence % (ever told)[b]	6.8%	12.9%
Kidney disease prevalence % (ever told)[b]	-----	3.4%
Depression prevalence % (ever told)[b]	15.5%	21.4%
Disability prevalence % (ever told)[b]	13.4%	27.7%
Obese prevalence % (ever told)[b]	24.9%	34.7%

HOUSING FACTORS	ARAB AMERICAN	STATE
Living in owner-occupied housing %[a]	75.8%	75.3%
Living in renter-occupied housing %[a]	23.1%	22.0%
Households with no vehicle available %[a]	4.9%	7.9%
Living in different house than last year %[a]	10.9%	11.1%
Household with broadband internet access %[a]	90.8%	85.9%

MORTALITY INDICATORS	ARAB AMERICAN	STATE
All cause mortality per 100,000[c]	873.0	1175.1
Cardiovascular disease mortality per 100,000[c]	230.0	342.3
Heart disease mortality per 100,000[c]	180.4	260.4
Heart failure mortality per 100,000[c]	19.9	31.3
Hypertension mortality per 100,000[c]	28.0	47.5
Hypertensive heart disease mortality per 100,000[c]	20.5	35.2
Stroke mortality per 100,000[c]	34.5	57.1
Diabetes mortality per 100,000[c]	27.5	34.0
All malignant neoplasms (all cancer) mortality per 100,000[c]	157.8	210.8
Liver mortality per 100,000[c]	8.6	22.7
Kidney mortality per 100,000[c]	25.8	19.3
Alzheimer's mortality per 100,000[c]	18.8	41.9
Respiratory disease mortality per 100,000[c]	257.4	262.1
Chronic lower respiratory disease mortality per 100,000[c]	19.4	51.7
Chronic obstructive pulmonary disease mortality per 100,000[c]	18.8	48.2
Asthma mortality per 100,000[c]	****	0.8
Pneumonia and flu mortality per 100,000[c]	11.3	12.9
Septicemia mortality per 100,000[c]	****	12.4
Covid-19 mortality per 100,000[c]	162.6	135.1

a. Data Source: American Community Survey, population profile 3 year estimate 2018-2020; 1 year estimate 2020. For these indicators Asian estimate does not include Pacific Islanders and all races are non-Hispanic. For Indicators of Hispanic estimates, Hispanics include combination with one or more races.
b. Data Source: Michigan Behavioral Risk Factor Survey, 3 year estimates 2018-2020. For these indicators all race and ethnicities are non-Hispanic.
c. Data Source: Division for Vital Records and Health Statistics. Michigan Department of Health and Human Services 1 year estimate 2020.
d. Mortality data was suppressed for having a cell count below 5 deaths and the cell list **** of a percentage.
e. Morbidity data was not available for this year and is represented by -----.

For more information about this report, please contact:
Michigan Department of Health and Human Services
Office of Equity and Minority Health
MDHHS-OEMH@michigan.gov
Phone: 517-730-1692