Michigan Department of Community Health

2010 Health Equity Report

Released April 2011

2010 Health Equity Report
Executive Summary

The Michigan Department of Community Health (MDCH) completed its fourth annual assessment of departmental efforts to reduce racial and ethnic health disparities. This year's report, the 2010 Health Equity Report, has dual purposes. Like previous reports, it serves as the MDCH annual report documenting work to address the requirements of House Bill No. 4455 – PA 653. The second purpose of the report is new. Beginning in 2010, this annual report will document the progress that MDCH and its partners have and will make in addressing priority recommendations of the recently released *Michigan Health Equity Roadmap: A vision and framework for improving the social and health status of racial and ethnic minority populations in Michigan*.

The *Michigan Health Equity Roadmap*, released June 2010, features recommendations to improve the social and health status of Michigan's racial and ethnic minority populations. This integrated focus gives MDCH and its partners the opportunity to expand their efforts to reduce health disparities to also include achieving health equity.

The 2010 Health Equity Report is aligned with the five major recommendations in the *Michigan Health Equity Roadmap*.

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

Attachment A illustrates the cross-walk with Roadmap recommendations to the House Bill No. 4455 – PA 653 requirements.

The data presented in this report were obtained from several sources, including the 2010 online survey of MDCH administrations and bureaus, key informant interviews, and key document reviews. Data from the online survey came from responses from the overarching MDCH organizational units, typically called "administrations" and their sub-units, generally called "bureaus." The 2010 survey respondents represent four of the six administrations and 10 of the 19 bureaus. Attachment B identifies the administrations and bureaus responding to the online survey.

As in previous years, the MDCH continued to focus its work to reduce health disparities on the major racial and ethnic population groups in Michigan: African American, Hispanic/Latino, American Indian/Alaska Native, Asian American/Pacific Islander, and Arab and Chaldean American. In 2010, 2.25 million people from these various groups were served by MDCH funded programs and services. This report features six exemplary programs and services conducted in 2010.

In addition to building upon and continuing its work to address health disparities, MDCH achieved several remarkable accomplishments that provided the strong foundation needed to shift from the focus on health disparities to achieving health equity.

- Release the *Michigan Health Equity Roadmap*
- Create a health equity data set
- Provide training on social determinants of health
- Fund community capacity building grants

The 2010 Health Equity Report provides detailed information on the work of the Michigan Department of Community Health in its efforts to achieve racial and ethnic health equity. For more information on information provided in this report, contact Sheryl Weir, Manager, Health Disparities Reduction and Minority Health Section, (313) 456-4355 or at weirs@michigan.gov.

2010 Health Equity Report

The recommendations and strategies presented in the *Michigan Health Equity Roadmap* are categorized into five areas: 1) race/ethnicity data, 2) government and community capacity, 3) social determinants of health, 4) access to quality healthcare, and 5) community engagement and empowerment. A crosswalk with these recommendations and the House Bill No. 4455 – PA 653 requirements is provided in Attachment A; this crosswalk illustrates the alignment between the Roadmap recommendations and the legislative requirements.

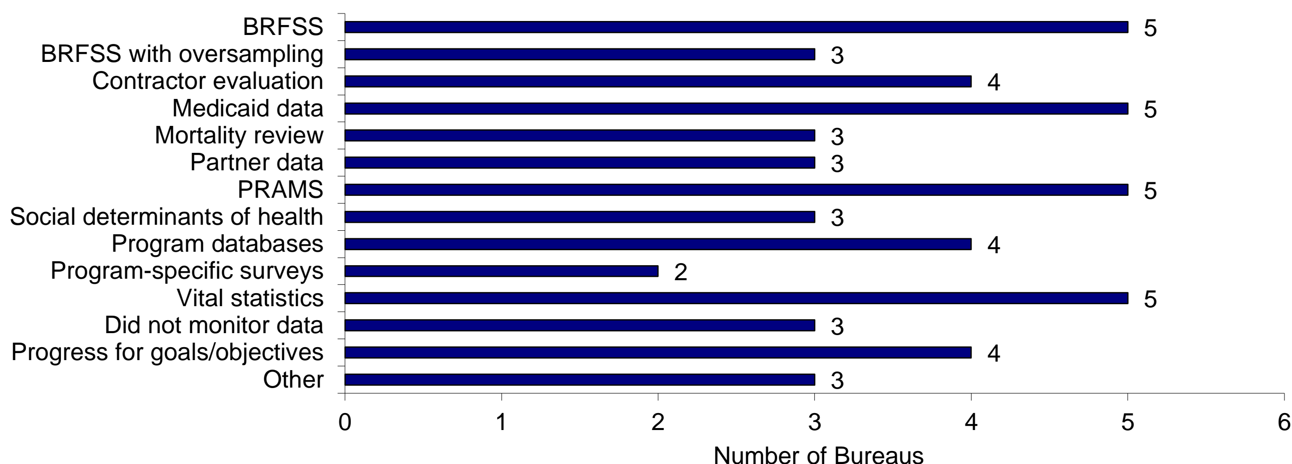
Progress made in 2010 by the Michigan Department and Community Health (MDCH) and its partners toward achieving the recommendations follow. To access the *Michigan Health Equity Roadmap*, go to the MDCH Health Disparities Reduction and Minority Health Section (HDRMS) website at www.michigan.gov/minorityhealth.

Race/Ethnicity Data

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

In order to assess needs, plan programs and policies, and evaluate success in attaining health equity for racial and ethnic minority populations in Michigan, MDCH must monitor social determinants of health data along with health outcome data. In 2010, MDCH tracked and monitored these data through several ways at the state and racial/ethnic minority population levels. These data are to be collected over time to monitor health equity achievement.

Of the 10 MDCH administrations and bureaus that responded to the online survey, six (60%) reported using data to monitor racial and ethnic health disparities in 2010. They used prevalence, incidence, mortality, morbidity, access to services, and utilization data to identify and monitor racial and ethnic disparities trends. Data were also used to identify populations at highest risk or need, plan interventions, and monitor performance of funded programs, contractors, and state programs. A variety of data collection sources and mechanisms were identified including state surveys and databases, web-based data collection, and use of national data sources. The most commonly used data sources are identified in the following chart.



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

In 2010, six (60%) of the MDCH administrations and bureaus reported collecting race and the same six reported collecting ethnicity data on participants they served; four (40%) collected preferred language data on the participants they served.

> "Preferred Language" is defined as the self-identified language of preference to be used, spoken, or written during clinical, service or program encounters. Preferred language facilitates self-identification of the language a person would prefer and the person's English proficiency level.

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

An important requirement for monitoring health equity is standardized, complete, and consistent data collection over time. The HDRMHS designed the Michigan Health Equity Data Set (MHEDS) to provide standardized, complete and consistent data. In addition to presenting estimates for each indicator for two time periods, the data set incorporates four measures to monitor racial and ethnic health equity in Michigan. Equity is measured on two levels:

1) *Pairwise Equity* is measured by comparing each population to the white (reference) population.

2) *Population Equity* is measured by comparing all groups' distance from the population average.

Spotlight

Michigan Health Equity Data Set

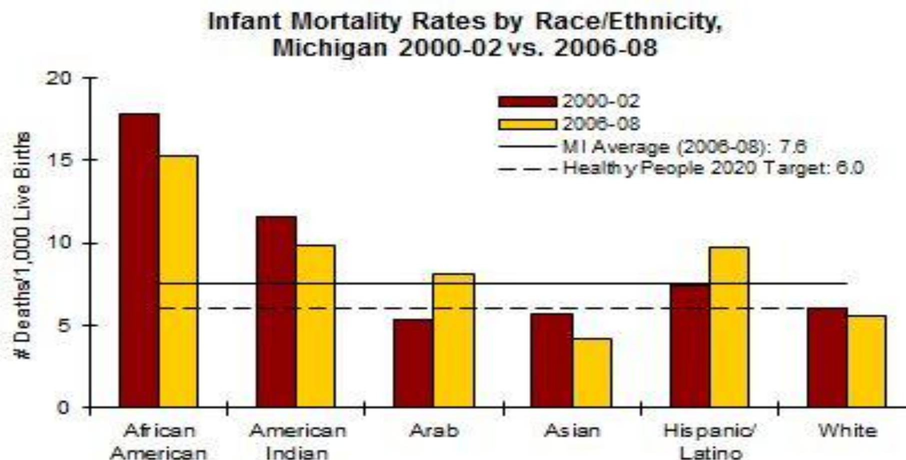
The Michigan Health Equity Data Set (MHEDS) was created as part of the Roadmap to monitor racial/ethnic health disparities and health equity in Michigan. The data set includes 17 priority indicators that include:

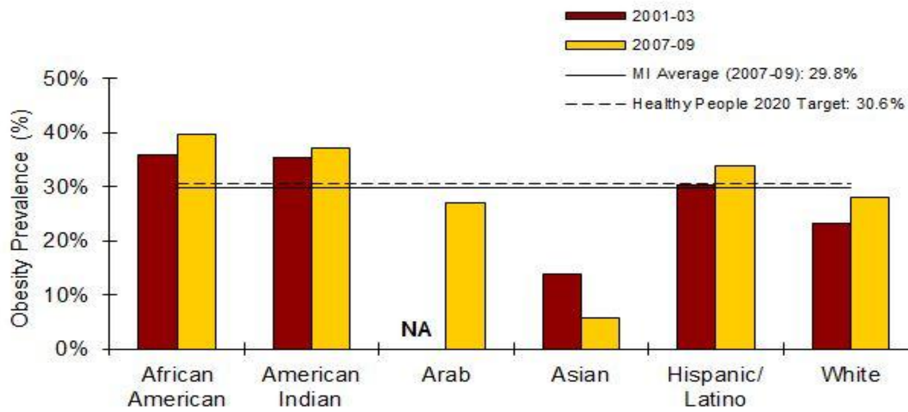
- Health status, health behavior, healthcare
- Social determinants of health, such as social, economic, and environmental determinants of individual and community health
- Health outcomes, such as diseases and deaths

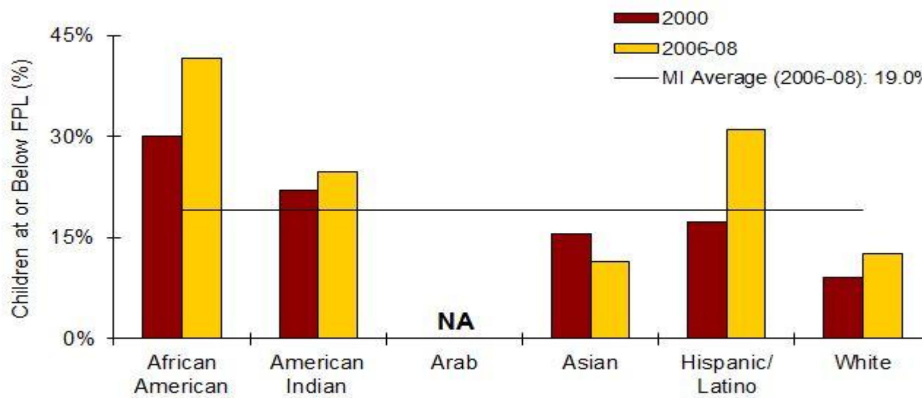
In 2010, the data set was populated with standardized data for the five racial/ethnic minority groups in two time periods (2000-2004 and 2005-2009). The MDCH will continue to review the MHEDS data, and the data set will be used to monitor progress toward achieving long-term and sustainable racial and ethnic health equity in Michigan. The data set will be posted on the HDRMS website in 2011.

Change over time in Pairwise and Population Equity will be monitored to indicate Michigan's overall progress toward health equity. The MHEDS is not intended to be used for statistical analyses. Rather it is intended to present group-level data over time so that disparities between groups can be monitored. By gathering comparable data for each race/ethnicity in multiple time periods, and by combining all indicators in one place, the MHEDS allows the HDRMHS and its partners to monitor progress toward achieving equity in many areas that contribute to long-term and sustainable racial and ethnic health equity in Michigan.

The following graphs provide data from the MHEDS for three of the nine priority indicators. Graphs for the remaining six indicators are found in throughout the report. See Attachment C for the MHEDS data.







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

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

For several years, the HDRMHS has maintained and expanded the MDCH Health Disparities Reduction and Minority Health webpage. During 2010, this webpage provided access to the Section's vision, mission, strategic framework, data, resources, and tools. In 2010, the Michigan Health Equity Roadmap was added as an important document featuring health equity data and recommendations. The HDRMS included

links to its requests for proposals, minority health month activities, and capacity building grantees. Links to Michigan's Minority Health Bill, House Bill No. 4455 – PA 653, and the previous reports to the legislature were maintained on the website. Information on research was available through the link to the federal Office of Minority Health. In 2010, plans were developed to add the Michigan Health Equity Data Set to the HDRMHS webpage; the data set will be added in 2011.

In addition to this website, additional information on Michigan's health equity, including data, resources, and research, were found on other Bureau and Program websites, especially the Health Statistics and Reports webpage at http://www.michigan.gov/mdch/0,1607,7-132-2944---,00.html.

Health Equity Website

Plans to create a Capacity Building Grantees (CBG) sponsored "community health equity website" were completed in 2010. The website, scheduled to be launched in 2011, is intended to facilitate community engagement and discussion in addressing health equity, including health disparities and social determinants of health.

Government and Community Capacity

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

In 2010, the Health Disparities Reduction/Minority Health (HDRMHS) Section led MDCH efforts to achieve health equity and reduce health disparities; to ensure policies, programs and strategies were culturally and linguistically appropriate; and to collaborate with state, local and private partners to advance health promotion and disease prevention strategies. The HDRMHS developed, promoted, and administered health promotion programs for communities of color, including African American, Hispanic/Latino, American Indian/Alaska Native, Asian American/Pacific Islander, and Arab and Chaldean American.

Health equity programs that have systems approaches and accountability are more likely to be effective and often involve strategic planning and goal setting. Reaching these goals requires partnerships and collaborations across a wide variety of types of

organizations, as well as consumer involvement. To develop capacity, resources may come from several sources and will need to be focused on strengthening infrastructure, cultivating partnerships and relationships, and developing programs and services.

Of the 10 MDCH administrations and bureaus responding to the online survey, 80% (8) provided data on the racial and ethnic populations they served. The following data provide a snapshot of the population groups served in 2010.

- 100% (8) served all racial and ethnic population groups
    - African American
    - Hispanic/Latino
    - American Indian/Alaska Native
    - Asian American/Pacific Islander
    - Arab and Chaldean American

- 87.5% (7) served all age groups

- 100% (8) served females and males

- 2,250,707 served[1]
    - 1,315,169 African American
    - 262,865 Hispanic/Latino
    - 31,515 American Indian/Alaska Native
    - 178,230 Asian American/Pacific Islander
    - 420,145 Arab and Chaldean American
    - 42,783 Other

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

In 2010, the HDRMHS shifted its funding focus from funding programs and services to helping agencies build capacity. Using a combination of federal and state funding, the Section created a two-phase Capacity Building Grants (CBG) program to increase the capacity of communities to mobilize local public health, community and faith based organizations, and other key partners to achieve health equity. In May 2010, funding

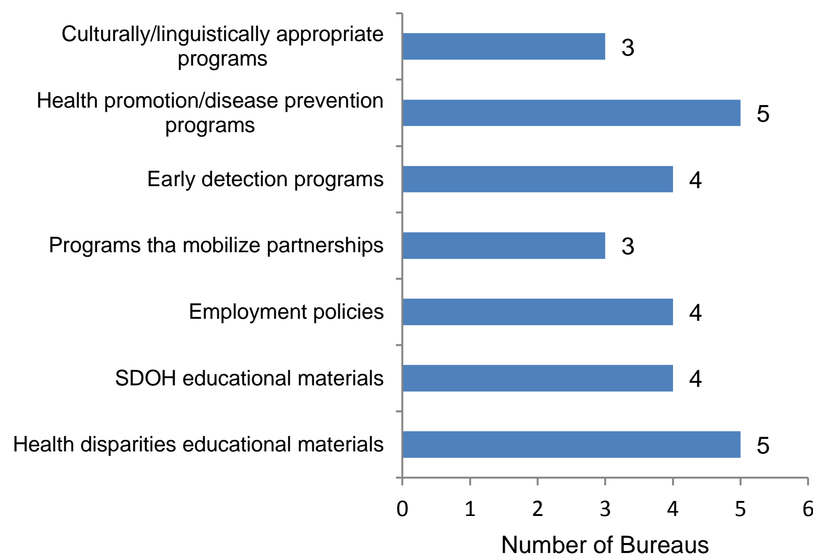
[1] These data may count the same individual more than once, as individuals may have received more than one service. It is not possible to provide the number of unique individuals who received services through all MDCH administrations and bureaus.

was awarded to 16 projects (Phase I) to build sufficient capacity to develop a comprehensive proposal for funding in 2011 (Phase II). In October 2010, the HDRMHS released a competitive request for proposals for Phase II projects, with seven organizations awarded funding for projects to begin in 2011; the funding ranged from $30,000 to $55,000 per project. Phase I grantees not awarded Phase II funding were encouraged to identify other sources of funding to continue their important work. See pages 19-20 and Attachment D for additional information on the CBG program.

In addition to HDRMHS funding, several MDCH administrations and bureaus dedicated funding to address health equity, health disparities, or social determinants of health. The 2010 survey responses revealed that 60% (6) of the administrations and bureaus received or redirected existing funding to improve health equity for racial and ethnic minority populations. Funding sources were:

- Federal, 83%
- State, 33%
- Foundation, 33%.

Funding levels did not necessarily remain level from 2009. Of the six Administrations and bureaus that *received or redirected* funding, two (33%) noted they had less state funding and one noted less federal funding in 2010 as compared to 2009; of these, one funding source had as its sole purpose to reduce racial and ethnic health disparities.



Of the 10 respondents, five reported they *funded programs, services or activities* to address health equity for racial and ethnic minority populations. This funding was used in a variety of ways.

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

The *Michigan Health Equity Roadmap* was created by the HDRMHS together with residents, public health, community and faith based organizations, health and health care professionals, researchers and academic institutions. As previously noted in this report, the Roadmap was created to stimulate coordinated efforts among government, healthcare, and community partners to address and improve social and economic determinants of health and improve specific health outcomes. The Roadmap's centerpiece is the list of recommendations developed after an extensive review of health equity policies and programs implemented by national and Michigan-based organizations coupled with feedback from government agency staff, community organizations and members, and stakeholders from various sectors who provided their suggestions at several forums. Accomplishing these recommendations will require a sustained commitment and innovative, multi-sector collaboration focused on addressing social determinants of health and strengthening community. The HDRMHS widely disseminated the Roadmap, and it is also posted on the HDRMHS webpage.

A systems level approach anchored with relevant goals and objectives is necessary for program success. Of the 10 MDCH administrations and bureaus responding to the 2010 online survey:

- 10% (1) had a strategic plan solely dedicated to achieving health equity
- 20% (2) had a strategic plan with goals/objectives related to health equity/health disparities
- 20% (2) had program goals/objectives related to health equity/health disparities.

In 2010, some MDCH administrations and bureaus reduced or eliminated programs or services focused on addressing health equity. Of the 10 respondents, two (20%) eliminated and reduced programs, services or activities; and one (10%) reduced but did not eliminate programs, services or activities.

Programs or services that were eliminated or reduced included:

- Asthma Community Coalition
- Check Up! Or Check Out! African American Male Health Initiative
- Childhood Lead Poisoning Prevention
- Diabetes Outreach Networks
- Healthy Aging Initiative
- Michigan Dementia Coalition.

Spotlight

2010 Report on the Conditions of Migrant and Seasonal Farmworkers in Michigan

In 2009, the Michigan Civil Rights Commission authorized an investigation of conditions faced by migrant and seasonal farmworkers working in Michigan. To understanding the concerns and challenges faced by these farmworkers, the Commissioners sought their direct feedback through five public forums or written comment provided directly to the Michigan Department of Civil Rights by email or mail. The latter was done by creating "A Record of Concern" form translated into Spanish.

In 2010, the Civil Rights Commission released the *2010 Report on the Conditions of Migrant and Seasonal Farmworkers in Michigan*. The report summarized a number of issues, including unsafe housing, allegations of wage theft and difficulties in accessing certain services due to language barriers. By including a set of 15 recommendations, the report provided a call to action for state and federal agencies, along with non-governmental organizations, to ensure Michigan's migrant workforce is treated fairly. The Report and an Executive Summary is available on the Michigan Department of Civil Rights website at: www.michigan.gov/mdcr.

Social Determinants of Health

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

Many social, economic, and environmental factors contribute to the overall health of individuals and communities. In order to reduce health inequities, it is necessary to address these factors.

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

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

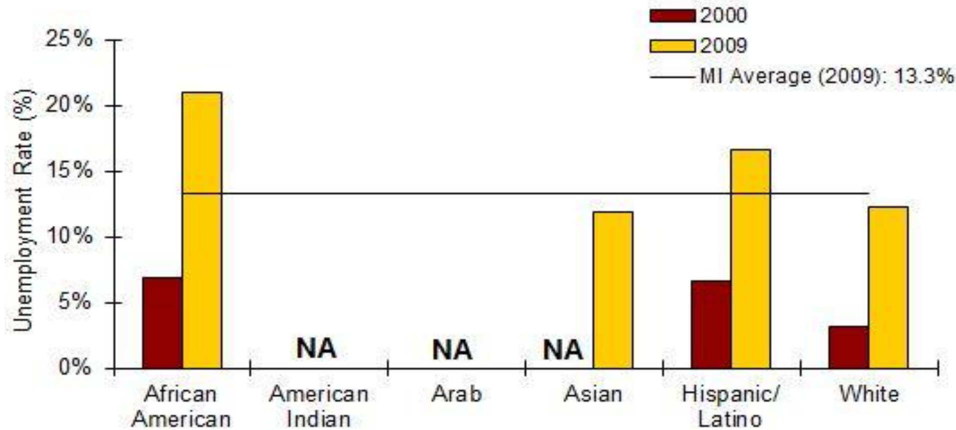
In 2010, the MDCH administrations and bureaus began to work with social determinants of health in a variety of ways.

- 30% (3) used social determinants of health related data sources.
- 40% (4) used funding for educational materials focused on social determinants of health.
- 30% (3) funded programs that mobilized partnerships to address social determinants of health in racial and ethnic minority populations.
- Of the 6 that worked with local public health, minority health coalitions, or community organizations, 83.3% (5) supported community-based efforts to help mobilize partnerships to address social determinants of health.

Spotlight

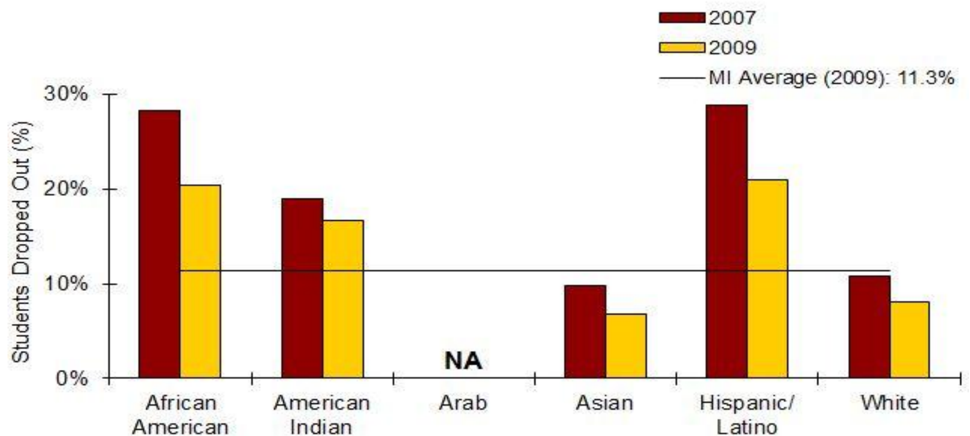
Smoke-free Tribal Housing

The MDCH Tobacco Section received federal funding to increase the percentage of smoke-free public, affordable, and tribal housing in Michigan. The Sault Tribe of Chippewa Indians and the Smoke-Free Environments Law Project (SFELP) worked with other local and state agencies on this initiative. In 2010, the Sault Tribe successfully passed the first smoke-free tribal housing policy in Michigan, ran a culturally specific media campaign, and created culturally specific smoke-free housing signage. South Eastern Michigan Indians, Inc. (SEMII) and the SFELP met with the Nottawaseppi Huron Band of Potawatomi (NHBP) and learned they were already working on three smoke free single family homes, with plans to make five new homes smoke free when built in 2011. NHBP currently has housing that is not smoke free, and SFELP provided tenant surveys to assist NHPB in their goal to become entirely smoke free, SEMII provided a copy of the HUD memo, supporting federally subsidized housing to be smoke free, culturally specific materials for cessation, and tobacco education and prevention. Both SEMII and SFELP have continued to provide support with materials to strengthen and sustain NHBP's smoke free housing policy.



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

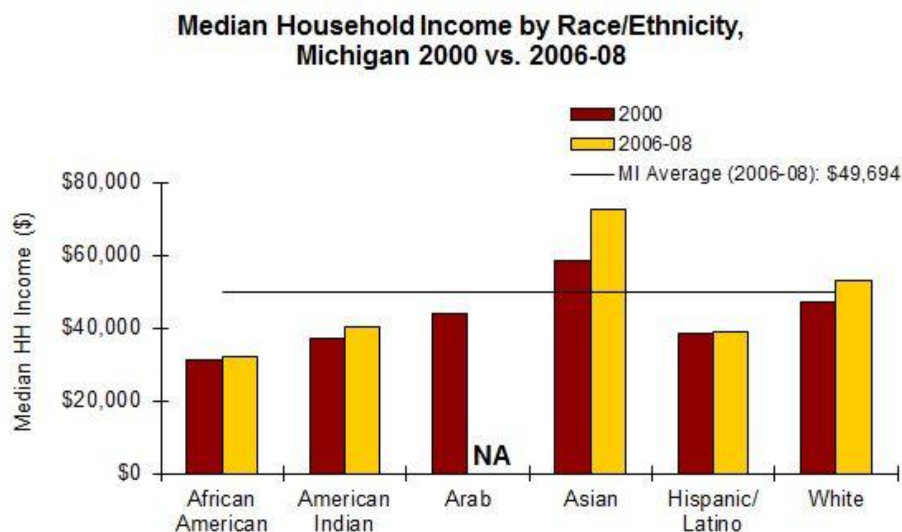
Collectively, the MDCH administrations and bureaus responding to the online survey reported offering 22 training or other continuing education sessions focused on topics identified in the recommendation. These were only open to MDCH staff. There were 705 participants.[2]



- MDCH venues most commonly used were training, staff meeting, and brown bag presentations.
- Topics were: cultural competency/cultural sensitivity, health equity/disparities, social determinants of health, and racism.
- Some MDCH staff also participated in external events noted elsewhere in this report.

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

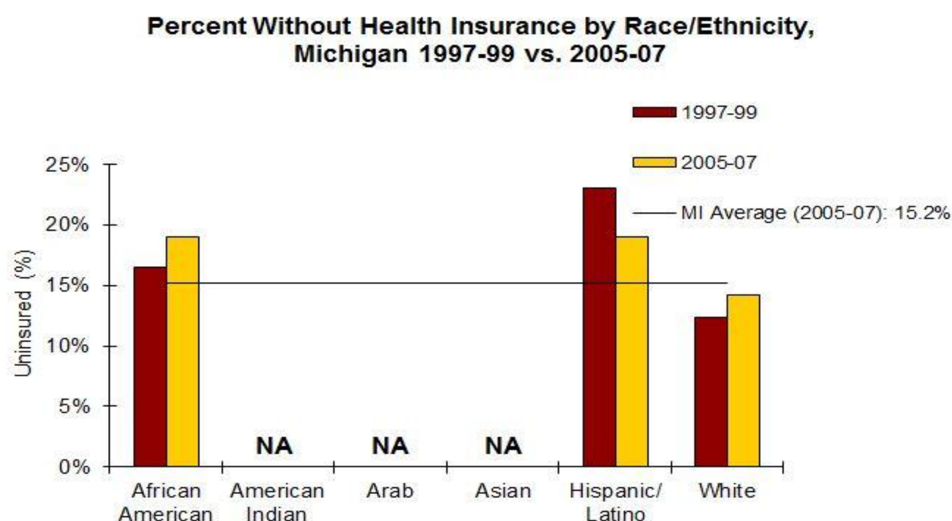
In July and September 2010, the Health Disparities Reduction and Minority Health Section (HDRMHS) coordinated health equity and social justice focused workshops for the MDCH Public Health Administration management team. In July 2010, the team participated in an Undoing Racism Workshop facilitated by the People's Institute for Survival and Beyond. The workshop explored how institutional racism is a root cause of health disparities. In September 2010, the management team participated in a half day workshop to learn more about social determinants of health and the social justice roots of public health. Information presented and discussed explored the scientific evidence and promising practices that linked these concepts to improved health outcomes. Ultimately, the training sessions increased awareness about the opportunity to integrate addressing social determinants of health into public health policies and programs in order to achieve sustained and long-term positive health outcomes.



Access to Quality Healthcare

Recommendation 4: Ensure equitable access to quality healthcare.

Health disparities experienced by racial and ethnic minority populations are widespread in the healthcare system. In order to achieve health equity, efforts



must be made to increase access to affordable health care, as well as assuring the healthcare provided is high quality and culturally acceptable.

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

In 2010, a variety of MDCH efforts were begun or continued that will inform the future process to developing the department-wide standards for CLAS services. The practical application of the CLAS standards in MDCH developed, coordinated, and funded services provided valuable information on promising practices and lessons learned.

CLAS Standards are primarily directed to help health care provider organizations and practices become more culturally and linguistically accessible. There are 14 standards, organized by three themes:
(1) culturally competent care;
(2) language access services; and
(3) organizational support for cultural competence.

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

In 2010, the HDRMHS implemented three required training sessions for the 16 phase I Capacity Building Grantees (CBG). Each CBG could bring a partner to the training, and HDRMHS encouraged the phase II CBG grant reviewers to attend the training. Collectively, 150[3] participants attended the training. Key training concepts were social determinants of health, multiculturalism, the social justice roots of public health, and foundational public health competencies.

In 2010, MDCH administrations and bureaus conducted a variety of activities that helped to increase culturally competent care. These included:

- Of the 5 online survey respondents that offered programs, services or activities, 80% (4) had employment policies to enhance minority employee recruitment and retention.
- 10 cultural competency and cultural sensitivity continuing education sessions were offered in 2010 primarily through training, staff meeting, and statewide conferences; 379 state and local public health and health care professionals were reached.
    - 4 sessions offered exclusively to MDCH staff, with 84 participants
    - 6 sessions offered to all public health and health care professionals with 295 participants
- 2 workshops offered on racism, reaching 60 public health and health care professionals.

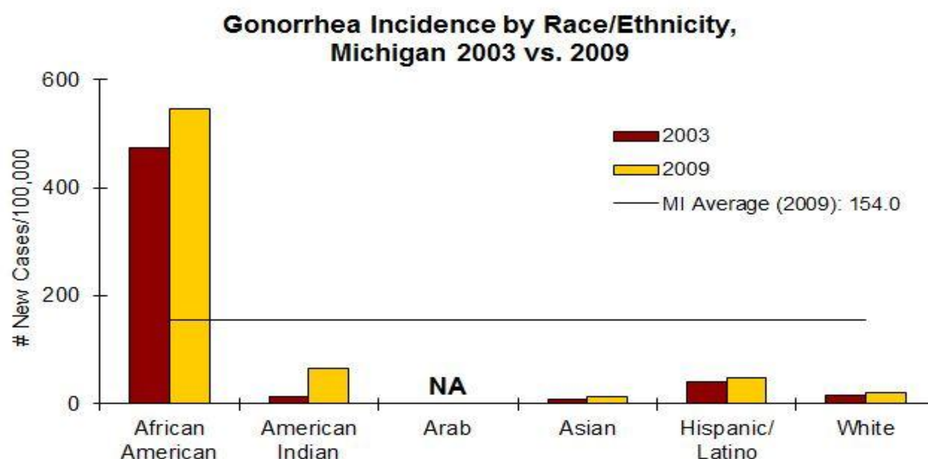
[3] Participants would be counted once for each training session they attended.

    - 1 offered to all public health and health care professionals with 10 participants
    - 1 offered to MDCH staff with 50 participants
- 1 statewide conference offered on health literacy, with 45 public health and health care professionals attending.

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

Two HDRMHS-funded Phase II CBG developed plans for their 2011 projects that will focus on addressing language barriers to accessing health care, including:

- Asian Center – Southeast Michigan: Tailoring English as a Second Language classes to be relevant to Asian Americans and to include health information.
- Washtenaw County Public Health: Translation of the Ann Arbor Transportation Authority Ride Guide and improving signage for public transportation.



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

Several HDRMHS-funded Phase II CBG developed work plans for their 2011 projects ways to increase collection of and use of individual and community data on race, ethnicity, preferred language, other demographic, cultural and epidemiological data.

- Asian Center – Southeast Michigan: Continue survey data collection and analyses from phase I to understand Asian Americans' health and healthcare matters in detail.

- Berrien County Health Department: Collect BRFSS data on race and social context; complete a photo voice project in 6 regions.
- Grand Rapids African American Health Institute: Improve collection of race, ethnicity and language data in ambulatory and inpatient health care settings.
- Muskegon Community Health Project: Improve the collection of healthcare information, especially involving patient experience and barriers to access (hospitals and healthcare providers)
- Washtenaw County Public Health: Develop a community-level health equity data set that will be used to develop a Health Equity Report Card; complete a Latino Health BRFSS.

Spotlight

H1N1 Program Outreach

The MDCH Office of Public Health Preparedness provided funding and other resources to community partners for H1N1 awareness and outreach designed to reach Michigan's racial and ethnic minority populations. Efforts included distribution of H1N1 materials and targeted outreach through relevant associations, groups, and media. Materials translated from English into Spanish or Arabic in 2009 were used in 2010, including:

- Business and workplace posters translated to Spanish: *Are You Sick? Stay Home!*; *Wash Your Hands*; and *Tips for Cleaning Kitchens*.
- *Wash Your Hands* mirror static cling to Spanish
- *Preparing for a Public Health Emergency* booklet translated to Arabic.
- H1N1 multilingual print ads.

Outreach efforts designed to reach racial and ethnic minority populations included:

- H1N1 materials were sent to Michigan's eight regional 2-1-1 call-in centers, as these centers had access to translators for most languages spoken in Michigan.
- Hard copies of posters, booklets, brochures and wallet cards were sent to federally qualified and other community health centers; these centers served underserved and economically disadvantaged individuals, many of whom came from racial and ethnic minority communities.
- Distribution of materials in late 2009 for use in 2010:
    - H1N1 Vaccine fact sheet sent to Tribal Elders
    - *Preparing Your Business* flyer sent to Migrant Labor Housing Site Owners
    - *Wash Your Hands* mirror static cling sent to organizations who could reach Spanish-speaking communities, including two school districts, one local health department, and the Migrant Labor Housing Site Owners.

In addition, five of the 10 MDCH administrations and bureaus responding to the 2010 online survey indicated they provided programs, services or activities designed to achieve health equity, address health disparities, or impact social determinants of health. Several of these are related to the CLAS standards. Of the five that provided programs, services or activities:

- 80% (4) provided programs or interventions that assured or provided access to early detection services.
- 100% (5) provided programs or interventions that include health promotion and disease prevention strategies.
- 60% (3) provided programs or services that were culturally/linguistically appropriate.

Spotlight

MDCH Health Disparities and STD/HIV Conference 2010

The MDCH conducted the 2010 Health Disparities and STD/HIV Conference on November 3-4, 2010. Two hundred and eighty-nine (289) people attended the conference.

- David Williams, PhD, MPH, noted Professor of Public Health from the Harvard School of Public Health spoke about social disparities in health and how they can be addressed. The presentation described the racial and socioeconomic factors that contribute to health disparities and identified best practices to move toward health equity.
- Gottfried Oosterwal, PhD, LittD, spoke about equity in diversity. His presentation detailed his extensive experience living and working around the world. He discussed how people of differing cultures experience health and illness and how awareness and better understanding of cultural differences can assist us in not just culturally competent services, but ultimately health equity.
- James Hildreth, MD, PhD, Director and Professor for the Center for AIDS Health Disparities Research at George Hubbard Hospital and Meherry Medical College spoke about his research team's discovery that cholesterol is active in HIV's ability to penetrate cells and that removing the fatty material from a cell's membrane can block infection, which lead to a deeper understanding of how HIV enters cells and causes infection.

In addition to these dynamic keynote speakers, the workshop categories of policy, program, and data contained a variety of topics ranging from assuring equity in the research process, securing healthy food access in economically distress urban neighborhoods, race based segregation, environmental justice, health equity data, building community capacity to address health equity, and the criminal justice system.

Community Engagement and Empowerment

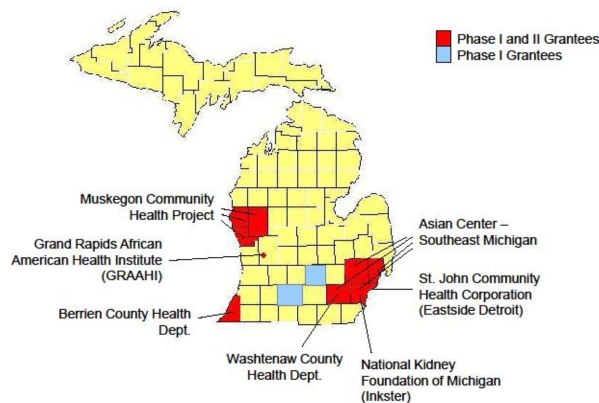
Recommendation 5: Strengthen community engagement, capacity, and empowerment.

Engaging and involving the community in determining the best approaches to achieving health equity, including ways to draw upon existing strengths, is an effective strategy for achieving health equity. In order to effectively engage and involve the community, it must have sufficient resources, infrastructures, relationships and operations that will allow it to create and sustain necessary changes.

Spotlight

Health Disparities Reduction and Minority Health Capacity Building Grants

The Health Disparities Reduction and Minority Health Section (HDRMHS) Capacity Building Grant (CPG) program was designed as a two phase, four year grant project to promote collaboration between MDCH, local public health, community and faith based organizations, and other local entities to achieve health equity for Michigan's racial and ethnic minority populations.



The Phase I goal was to fund planning and training activities that promoted the overall goal of building local capacity and mobilizing communities to address the root causes of health disparities and increase awareness of the linkages between social determinants of health, health disparities, and health equity. HDRMHS funded 16 applicants. Phase I strategies included developing multi-sectored partnerships, conducting needs assessments, participating in health equity trainings, and creating program implementation plans for the second through fourth years of the grant. Phase I efforts resulted in 171 committed community health equity partners, and 13 of the 16 Phase I projects submitted proposals to move forward with Phase II of the Capacity Building Grant program.

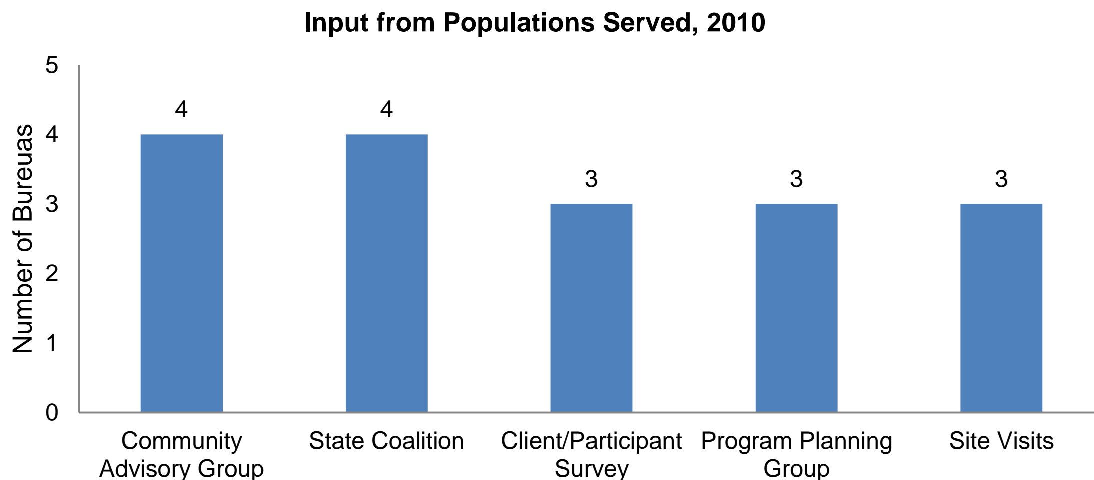
Beginning in 2011, seven grantees will receive Phase II funding for up to $55,000 each year over a three-year period. The Phase II projects will focus on implementing sustainable, multi-leveled programming focused on evidence-based, community focused initiatives designed to address racial and ethnic health inequities. See Attachment D for additional information on Phase II grantees.

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

In lieu of a state-level health equity advisory group, the HDRMHS continued to coordinate an intra-departmental Health Disparities Reduction Workgroup (Attachment E). Workgroup goals were to: (1) increase awareness; (2) collect and disseminate data; (3) identify and promote effective evidence-based public health strategies; and (4) establish a systemic approach to inter- and intra-departmental coordination to reduce health disparities. Members represented a cross-section of MDCH administrations and bureaus. The HDRMHS Manager served as the Chair.

The MDCH administrations and bureaus sought other ways to receive input from consumers, public and private stakeholders, and policy makers.

- 60% (6) of the 10 respondents noted they have mechanisms in place to solicit input and feedback from racial and ethnic minority populations served.
- The most commonly noted ways to seek input are noted in the following chart.



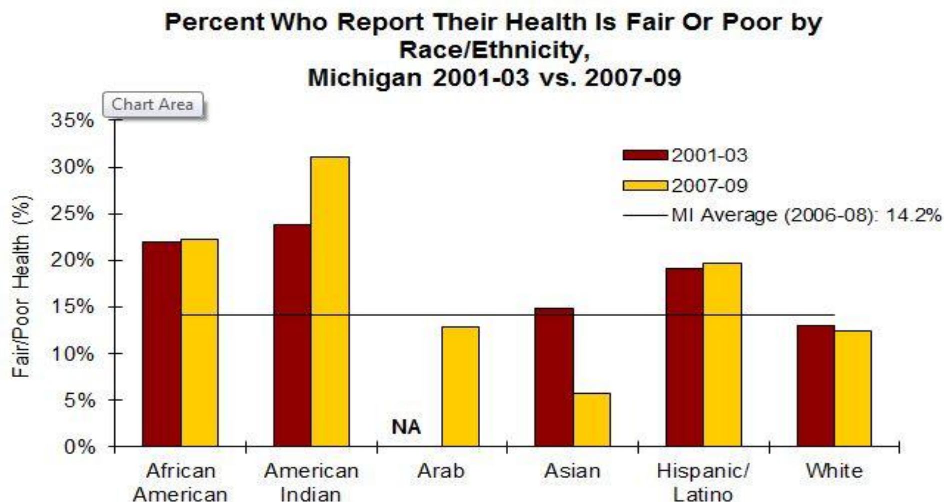
The six respondents who noted they collected input used the information in many ways, including:

- 100% (6) integrated into state or community strategic or program plans
- 83% (5) enhanced program/service delivery or performance
- 83% (5) developed or revised education materials
- 67% (4) tailored technical assistance for service providers
- 50% (3) identified barriers to participation.

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

Of the six MDCH administrations and bureaus that indicated they worked with local or community organizations:

- Five (83%) assisted with capacity development; helped mobilize partnerships; and provided technical assistance on program design, program implementation, etc.
- Four (67%) developed evidence-based interventions; provided data or analyzed data; provided program/service funding; and provided training on cultural competency and related topics.



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

Six of the 10 MDCH administrations and bureaus that responded to the online survey noted they worked with local health departments, minority health coalitions, or community organizations to support their work in health equity, health disparities, and social determinants of health. (See recommendation 5.2 for additional information.)

2010 Accomplishments

The activities identified in the MDCH 2009 Health Disparities Report under the *2010 Minority Health Related Activities and Timeline Section* were completed.

- PA 653 Report to the Legislature (Submitted February 2010)
- Health Equity Data Set Priority Indicators/Equity Tables (Finalized October 2010)

- MDCH/HDRMHS White Paper: *A Roadmap to Achieving Health Equity In Michigan* (Issued June 2010)
- Minority Health Month Requests for Proposals (Issued February 2010)
- Minority Health Month Statewide Events (Conducted March-April 2010)
- HDRMHS Capacity Building Grants – Phase I (Completed September 2010)
- Division of Health, Wellness and Disease Control Health Disparities and HIV/STD 2010 Health Equity Conference (Convened November 2010)

Conclusion

The year 2010 was unique for the Michigan Department of Community Health as it continued to work toward reducing health disparities in Michigan's racial and ethnic minority communities. The 2010 release of *A Roadmap to Achieving Health Equity in Michigan* provided a framework for improving the health and social status of racial and ethnic minority populations. By integrating efforts to address and improve social and economic determinants of health into MDCH's long-standing focus on improving health outcomes, MDCH and its partners were able to expand their focus on reducing health disparities. The recommendations presented in the Roadmap are challenging and will require a coordinated effort, dedicated resources, and empowered communities.

In 2010, MDCH administrations and bureaus made notable progress in planning, implementing and evaluating programs, services, and activities that began to address many of the priority recommendations presented in the Roadmap. In addition, significant work was completed by the Health Disparities Reduction and Minority Health Section (HDRMHS) to establish a strong foundation for future work. This Section created new and strengthened existing infrastructure and support services to facilitate MDCH and its partners in implementing the Roadmap recommendations. Among the most notable were the creation of the Michigan Health Equity Data Set. During 2010, there were changes in funding, program priorities, and training designed to increase capacity among Michigan's racial and ethnic communities to identify and address their communities' unique challenges to achieving health equity. And, work began in earnest to address social determinants of health.

MDCH, under the leadership and guidance of its HDRMHS, will build upon the progress made in 2010 and explore new and innovative ways to address health equity in 2011, including the completion of the activities as noted in the 2011 timeline.

2011 Minority Health Related Activities and Timeline

Activity	Timeline
Behavioral Risk Factor Surveillance Survey Oversample	January – December 2011
HDRMHS Phase II Capacity Building Grants	January 2011 and Ongoing
HDRMHS Phase II Capacity Building Grant Evaluation	January 2011 and Ongoing
Health Equity Curriculum and MDCH Staff Training	February 2011 and Ongoing
Minority Health Month Mini-Grant Activities Conducted	April 2011
Health Equity Priority Data and Equity Tables Online	April 2011
Health Equity Factsheets Produced and Online	June 2011
Health Equity Complete Data Online	August 2011
Health Equity Toolkit/Video Series Complete	April 2011
Cultural Competency Curriculum/Web based Version	October 2011

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

Roadmap Recommendation	PA653 Requirement
Race/ethnicity data	• Monitor health progress • Establish a web page on the department's website
Government and community capacity	• Develop structure to address health disparities • Establish minority health policy • Develop and implement an effective statewide strategic plan • Develop and implement awareness strategies targeted at health and social service providers • Utilize resources to fund minority health programs AND Provide funding to support evidence-based programs • Identify and assist in the implementation of culturally and linguistically appropriate programs (non-health care)
Social determinants of health	No PA653 requirements directly addressing social determinants of health
Access to quality health care	• Identify and assist in the implementation of culturally and linguistically appropriate programs (focused on health care) • Develop and implement recruitment and retention strategies
Community engagement and empowerment	• Utilize resources to fund minority health programs AND Provide funding to support evidence-based programs [specific to coalitions] • Provide the following through interdepartmental coordination: data and technical assistance and measurable objectives to minority health coalitions and other local health entities AND Provide technical assistance to local communities • Promote the development and networking of minority health coalitions • Appoint a department liaison to provide services to local minority health coalitions

Attachment B: 2010 Health Equity Survey Respondents by Administration

Bureau	Division	Section	Unit	Other (please specify)
HEALTH POLICY and REGULATION ADMINISTRATION				
Bureau of Health Systems*				
Bureau of Legal and Policy Affairs*				
	Health Policy and Access			
	Health Policy and Access	Certificate of Need Evaluation		
	Legal Affairs and FOIA			
MEDICAL SERVICES ADMINISTRATION				
Bureau of Medicaid Financial Management & Administration Services*				
	Hospital and Health Plan Reimbursement			
	Medicaid Payments			
Medicaid Program Operations and Quality Assurance*				
	Managed Care			
MENTAL HEALTH AND SUBSTANCE ABUSE ADMINISTRATION				
Bureau of Administration*				
PUBLIC HEALTH ADMINISTRATION				
Bureau of Epidemiology*				
Bureau of Family, Maternal and Child Health*				
	Family & Community Health	Child, Adolescent & Family Health	Adolescent & School Health	
	Family & Community Health	Child, Adolescent & Family Health	Child Health Unit	
	Family & Community Health	Child, Adolescent & Family Health	Oral Health Program Unit	
	Family & Community Health	Women, Infant & Family Health	Reproductive Health**	
	Family & Community Health	Women, Infant & Family Health	Reproductive Health**	

Bureau	Division	Section	Unit	Other (please specify)
	Family and Community health	Women, Infant & Family Health	Perinatal Health Unit	
	Family & Community Health	Women, Infant & Family Health	Infant Health	
	Division of Health, Wellness and Disease Control*			
	Health, Wellness & Disease Control	HIV-AIDS Prevention and Intervention		
	Health, Wellness & Disease Control	Sexually Transmitted Diseases		
	Health, Wellness & Disease Control	Health Disparities Reduction & Minority Health		
Bureau of Local Health and Administrative Services*				
	Chronic Disease and Injury Control	Injury & Violence Prevention		
	Chronic Disease and Injury Control	Cancer Prevention and Control Section		
	Chronic Disease and Injury Control	Diabetes and Other Chronic Diseases	Diabetes and Kidney Disease	
	Chronic Disease and Injury Control	Diabetes and Other Chronic Diseases	Other Chronic Diseases	
	Chronic Disease and Injury Control	Tobacco Prevention and Control		
	Chronic Disease and Injury Control	Cardiovascular Health, Nutrition and Phys. Activity	Administration	
	Local Health Services			
Office of Public Health Preparedness*				

*"Bureau-level" categorization used for data analysis
**Separate responses for same Section; no Unit information provided

Attachment C: Michigan Health Equity Data Set, 2010 Data References

Infant Mortality Rate

(2002-2007) 2002-2007 Michigan Resident Birth and Death Files, Vital Records & Health Data Development Section, Michigan Department of Community Health.

Obesity Prevalence

(2001-2003) 2001-2003 Behavioral Risk Factor Survey. Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section.

(2007-2009) C Fussman. 2010. Preliminary estimates for chronic health conditions, risk factors, health indicators, and preventive health practices by race/ethnicity, State of Michigan: 2007-2009 Behavioral Risk Factor Survey. Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section.

Gonorrhea Incidence

(2003) 2003 Michigan Disease Surveillance System. Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology.

(2009) 2009 Michigan Disease Surveillance System. Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology.

Unemployment Rate

Employment status of the civilian non-institutionalized population in states by sex, race, Hispanic or Latino ethnicity, marital status, and detailed age, 2009 (2000) Annual Averages. Local Area Unemployment Statistics, Bureau of Labor Statistics, U.S. Department of Labor.

High School Dropout Rate

(2007 and 2009) State of Michigan 2007 and 2009 Cohort 4-Year Graduation and Dropout Rate Reports by Subgroup. Lansing, MI: State of Michigan Center for Educational Performance and Information.

Percent Children Living in Poverty

(2000) U.S. Census Bureau, 2000 Supplementary Survey and 2000 Census.

(2006-2008) U.S. Census Bureau, 2006-2008 American Community Survey.

Self-Reported Fair/Poor Health

(2001-2003) 2001-2003 Behavioral Risk Factor Survey. Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section.

(2007-2009) C Fussman. 2010. Preliminary estimates for chronic health conditions, risk factors, health indicators, and preventive health practices by race/ethnicity, State of Michigan: 2007-2009 Behavioral Risk Factor Survey. Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section.

Percent without Health Insurance

(1997-99) 2001. Characteristics of the uninsured and select health insurance coverage in Michigan, non-elderly population: special report. Lansing, MI: Michigan Department of Community Health, Health Legislation and Policy Development.

(2005-07) 2009. Characteristics of the uninsured and individuals with select health insurance coverage in Michigan 2009 Report: CPS 1999-2008. Lansing, MI: Michigan Department of Community Health, Health Policy, Regulation, and Professions Administration.

Median Household Income

(2000) U.S. Census Bureau, 2000 Census.

(2006-2008) U.S. Census Bureau, 2006-2008 American Community Survey.

Attachment D: Phase II Capacity Building Grantees

The seven grantees, identified in the table that follows, represents a diverse group of organization/agency types:

- Minority Health Organization: 2
- Local Health Department: 2
- Voluntary Health Organization: 1
- Community Health Organization: 2

All projects work with partners; 3 of the 7 have engaged and expanded existing community coalitions currently focused on addressing health equity.

Organization	Population(s) of focus	Social determinants of health addressed	Key interventions
Asian Center of Southeast Michigan	Asian Americans	Improve education Reduce language barriers Improve access to transportation	Community awareness and education, including website Community Health Workers (CHW) Tailor existing educational classes (ESL, computer, diet/nutrition, and physical activity) to be relevant to Asian American community Transportation assistance
Berrien County Health Department	African American Individuals with low socio-economic status	Decrease discrimination and racism Improve education Increase socio-economic status	Data collection – race, ethnicity, and social factors Community awareness and advocacy • Community dialogue • Resource and Advocacy Guide • Mass media (billboards)

Organization	Population(s) of focus	Social determinants of health addressed	Key interventions
Grand Rapids African American Health Institute	African American	Improve education Expand availability of healthy foods Increase access to physical activity and recreation	Data collection – race, ethnicity, and language – and reporting (using Maps to overlay health and social outcomes) Community awareness and education • Education programs – adolescents and health disparities; healthy eating and nutrition • Brochures • Online SDOH training (for public)
Muskegon Community Health Project	African American Hispanic/Latino Populations who prefer to speak a language other than English	Improve cultural competency of healthcare providers and systems Increase access to healthcare	Data collection – local healthcare, including patient experiences and barriers Community awareness and education Healthcare provider education CHW – patient navigation and coordinated care
National Kidney Foundation of Michigan	African American	Improve education Expand availability of healthy food Increase access to information	Data collection – race and ethnicity Community awareness and engagement Policy and environmental change

Organization	Population(s) of focus	Social determinants of health addressed	Key interventions
		Create jobs Make neighborhoods safe	Community Health Worker to implement interventions to support healthy lifestyles
St. John Community Health Corporation	African American	Facilitate community cohesion Increase health and safety programs Make neighborhoods safe	Create neighborhood health and safety office to: • Provide safety education • Neighborhood policing and patrol to increase safe environment
Washtenaw County Health Department	African American Hispanic/Latino	Facilitate community cohesion Increase access to healthcare Increase health literacy Improve access to transportation	Data collection – race, ethnicity and language Community and provider education and training Community Health Workers Transportation assistance

Attachment E: MDCH Health Disparities Reduction Workgroup

Name	Bureau	Division/Section/Unit
Alethia Carr	Family, Maternal & Child Health	
Amna Osman		Health, Wellness & Disease Control
Amy S. Peterson		Health, Wellness & Disease Control
Ann Garvin	Local Health and Administrative Services	Chronic Disease & Injury Control Breast/Cervical Cancer Control
Anne Esdale	Local Health and Administrative Services	Chronic Disease & Injury Control Diabetes & Kidney Unit
Brenda Jegede	Family, Maternal and Child Health	
Carlton Evans	Laboratories	Infection Disease Division B & P Serology Unit
Damita Zweiback	Local Health and Administrative Services	Chronic Disease & Injury Control Cardiovascular Health, Nutrition
Debra Duquette	Epidemiology	Genomics & Genetic Disorders
Fawzia Ahmed	Epidemiology	Vital Records & Health Statistics Health Data Analysis Services
Gregory Holzman	Medical Director	
Henry Miller	Local Health and Administrative Services	Chronic Disease & Injury Control Heart Disease & Stroke Prevention
Holly Nickel		Health, Wellness & Disease Control
Jacquetta Hinton		Health, Wellness & Disease Control Health equity Reduction
Janet Kiley	Local Health and Administrative Services	Chronic Disease & Injury Control Tobacco Prevention & Control

Name	Bureau	Division/Section/Unit
Jennifer Edsall	Local Health and Administrative Services	Chronic Disease & Injury Control Diabetes & Other Chronic Diseases Section
John Dowling	Local Health and Administrative Services	Chronic Disease & Injury Control Diabetes & Other Chronic Diseases Section
Judi Lyles	Local Health and Administrative Services	Chronic Disease & Injury Control Other Chronic Disease Unit
Kari Tapley	Epidemiology	Immunization
Kathryn E. Macomber		Health, Wellness & Disease Control
Konrad Edwards	Local Health and Administrative Services	Local Health Services
Monica Kwasnik	Local Health and Administrative Services	Chronic Disease & Injury Control
Orlene Christie	Local Health and Administrative Services	Chronic Disease & Injury Control
Patricia McKane	Local Health and Administrative Services	Chronic Disease & Injury Control
Paulette Dobynes Dunbar	Family, Maternal & Child Health	Family and Community Health
Paulette Valliere	Local Health and Administrative Services	Chronic Disease & Injury Control Breast/Cervical Cancer Control
Rebecca Couglin		Health, Wellness & Disease Control
Robert Cochran		Health, Wellness & Disease Control STD
Rose Mary Asman	Family, Maternal and Child Health	Family and Community Health
Sheila Embry	Medicaid Operations & Quality Assurance	Quality Improvement & Program Development

Name	Bureau	Division/Section/Unit
Sheryl Weir		Health, Wellness & Disease Control Health equity Reduction
Shronda Grigsby		Health, Wellness & Disease Control Health equity Reduction
Sonji L. Smith Revis	Local Health and Administrative Services	Chronic Disease & Injury Control Tobacco Prevention & Control
Sophia Hines	Family, Maternal & Child Health	Perinatal Health
Terry Hunt	Development Disabilities	
Viki Lorraine	Local Health and Administrative Services	Chronic Disease & Injury Control Breast/Cervical Cancer