Michigan Department of Community Health

2011 Health Equity Report

Released May 2011

2011 Health Equity Report
Executive Summary

The Michigan Department of Community Health (MDCH) completed its fifth annual assessment of departmental efforts to reduce racial and ethnic health disparities. The 2011 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. Additionally, it documents the progress that MDCH and its partners have made in addressing priority recommendations of the *Michigan Health Equity Roadmap: A vision and framework for improving the social and health status of racial and ethnic minority populations in Michigan*. The Roadmap was released June 2010 and 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 direction to expand their efforts to reduce health disparities and achieve health equity.

The 2011 Health Equity Report is aligned with the five major recommendations in the *Michigan Health Equity Roadmap*.

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

Attachment A provides a cross-walk illustrating the alignment between the Roadmap recommendations and the House Bill No. 4455 – PA 653 requirements.

Data presented in this report were obtained from several sources, including an online survey of MDCH administrations and bureaus, key informant interviews, and document review. The 2011 online survey data reflect responses from representatives in the overarching MDCH organizational units, typically called "administrations" and their sub-units, generally called "bureaus." The 2011 survey respondents represent seven of the eight administrations and 19 of the 24 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 2011, 690,352 people from these various groups were served by MDCH funded programs and services.

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

- Implementation of the *Michigan Health Equity Roadmap*.
- Maintenance of a health equity data set.
- Training on social determinants of health and other health equity topics.
- Continued funding of community capacity building grants.

The 2011 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 content or focus areas highlighted in this report, contact Sheryl Weir, Manager, Health Disparities Reduction and Minority Health Section (HDRMHS), (313) 456-4355 or at weirs@michigan.gov.

2011 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.

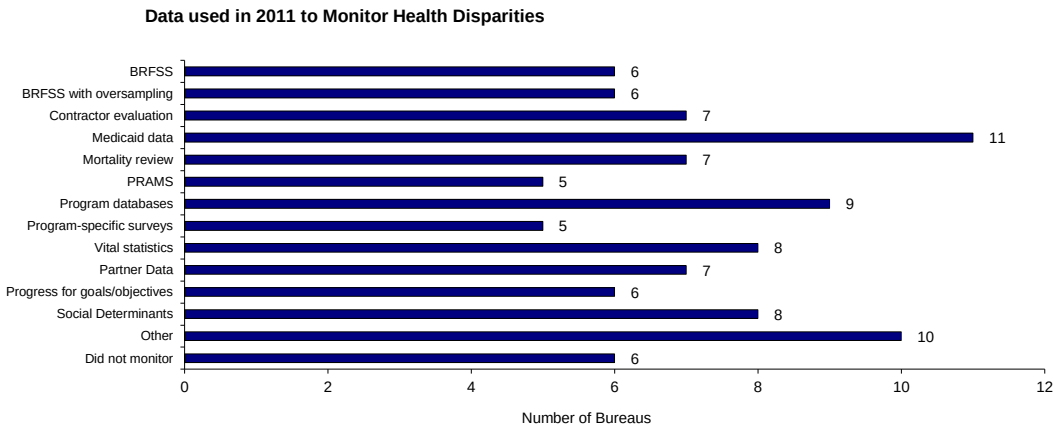
Data presented in this report document progress made in 2011 by the Michigan Department and Community Health (MDCH) and its partners toward achieving the Roadmap recommendations. The data come from several sources, including an online survey, key informant interviews, and document review. The *Michigan Health Equity Roadmap* can be accessed at the MDCH Health Disparities Reduction and Minority Health Section (HDRMHS) website at www.michigan.gov/minorityhealth.

Race/Ethnicity Data

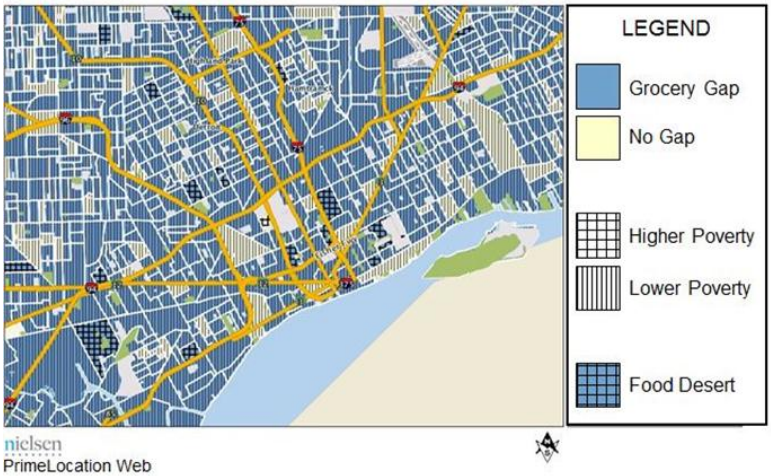
Recommendation 1: Improve race/ethnicity data collection/data systems/data accessibility.

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 2011, MDCH tracked and monitored these data through several mechanisms at the state and local level. These data will be collected over time to monitor health equity achievement.

Of the 21 MDCH administrations and bureaus that responded to the online survey, 13 (62%) reported using data to monitor racial and ethnic health disparities in 2011.They used prevalence, incidence, mortality, morbidity, access to services, and utilization data to identify and monitor racial and ethnic disparity trends. Data were also used to identify populations at highest risk or need, plan interventions, and monitor performance and impact of funded programs and contractors. A variety of data collection sources and mechanisms were identified including state surveys and databases, web-based data collection, and use of national data sources. The most commonly used data are identified in the following chart.



In 2011, MDCH had an opportunity to use a new data source. Michigan was one of 12 states to receive funding for access, tools and technical assistance to use market research data to target interventions. The data source was used to specifically address food deserts in low-income neighborhoods and communities and to identify areas across the state to support physical activity for community members. This map is an example of how the data were used to document access to grocery stores, food deserts, and poverty. The map was one of many presented at the 2011 Michigan Call to Action to Reduce and Prevent Obesity Summit. For more information, see the Spotlight "Applying Market Research Data and Approaches to Public Health Issues" on page 6.



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

In 2011, 12 (57%) of the MDCH administrations and bureaus reported collecting race and the same 12 reported collecting ethnicity data on participants they served; 9 (43%) collected preferred language data on the participants they served.

Spotlight
Applying Market Research Data and Approaches to Public Health Issues

The MDCH Chronic Disease and Injury Prevention Section was awarded a one-year license to use Nielsen market research data and technology to guide outreach, education and programming that is based on the overlay of data such as demographic, geographic (census or zip codes), consumer behavior (purchases, how they spend time, where they get information) and sales. The combination of these variables affords pinpointing areas of greatest need and how best to reach out and assist both the public and private sector in overcoming health inequities. Rebecca Coughlin, HRDMHS epidemiologist, speaks to the opportunities in applying these data *"the combination of market research data with demographic data allows us to identify protective factors and risk factors for health in small populations and small geographic areas. Additionally, these data describe social factors that we can't understand from other data sources. This is essential information if we are to understand how to reduce racial and ethnic health inequities in Michigan."* These data will guide and target interventions to focus on health inequities.

HDRMHS staff trained colleagues across MDCH to use these data and tools to guide strategic direction and implementation. Exemplary projects to date include: developing maps targeting both rural and urban food deserts and providing Capacity Building Grantee projects with a broad spectrum of data from demographic profiles to maps of fast food, grocery store, and health care facilities and hospitals.

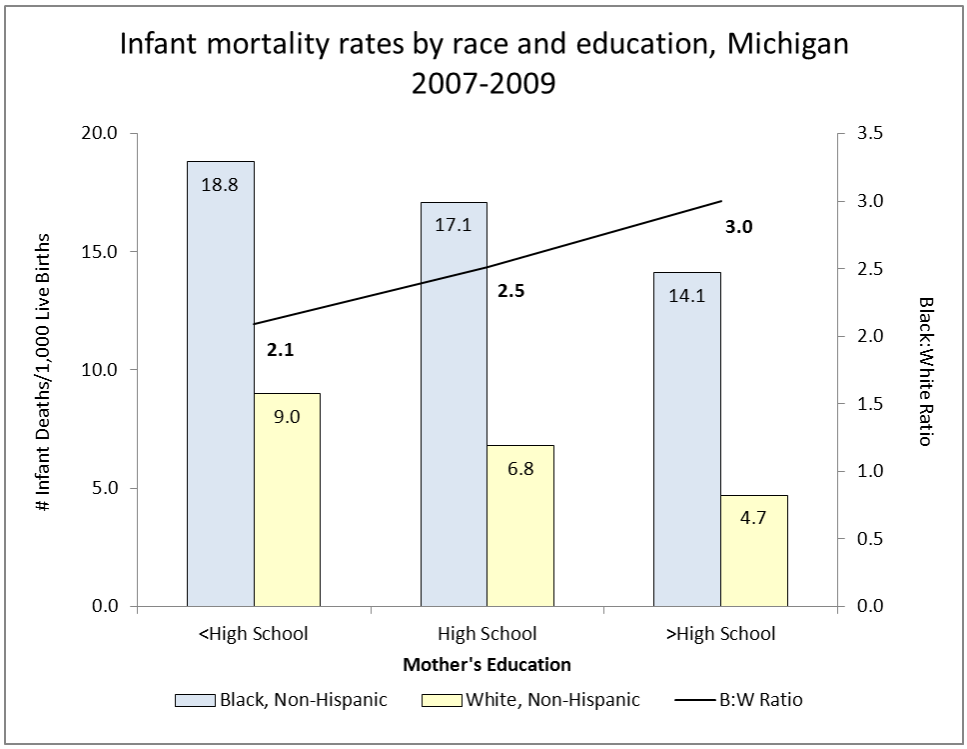
Recommendation 1b: Identify and establish a health equity data set to be maintained within the Health Disparities Reduction and Minority Health Section.

An important requirement for monitoring health equity is standardized, complete, and consistent data collection over time. 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. The *Michigan Health Equity Data Tables and Related Technical Documents, 2000-2009*, was prepared and posted on the HDRMHS website in 2011.

Equity is measured on two levels:
1) *Pairwise Equity:* comparing each population to the white (reference) population.
2) *Population Equity:* comparing all groups' distance from the population average.

Change over time in Pairwise and Population Equity continued to be monitored to determine Michigan's overall progress toward health equity. By gathering comparable data for each race/ethnicity in multiple time periods, and by combining all indicators in one place, the MHEDS allowed the HDRMHS and its partners to monitor progress

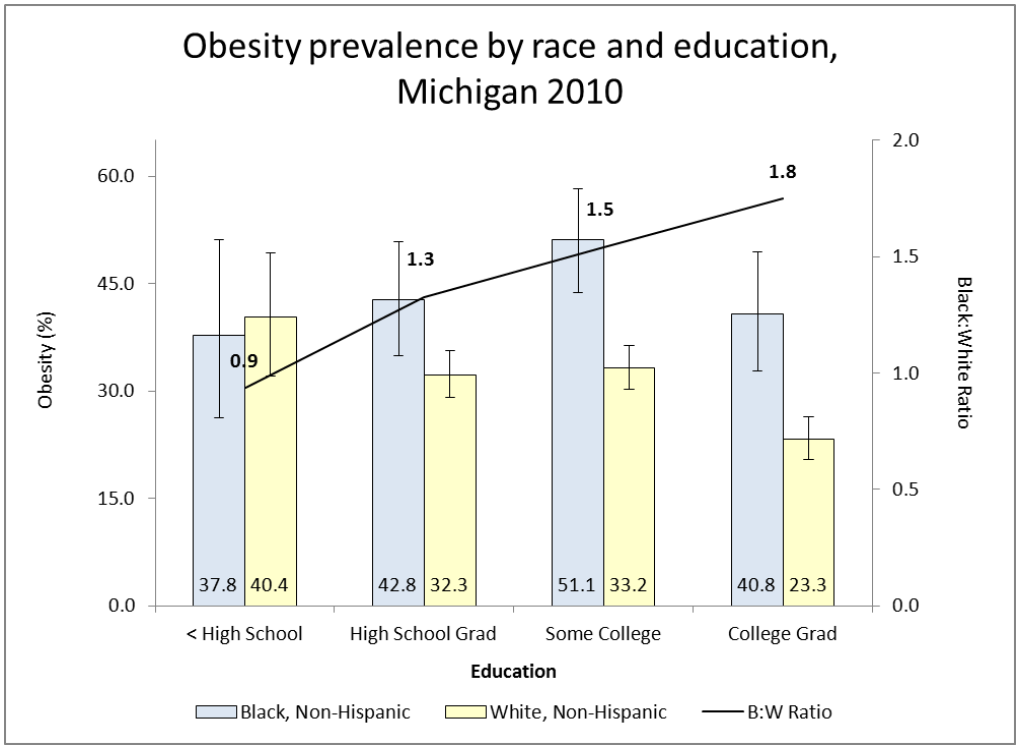
toward achieving equity in many areas that contribute to long-term and sustainable racial and ethnic health equity in Michigan. The following graphs provide examples of how HDRMHS is applying an “equity lens” to analyze Michigan health data.



Data source: P. McKane, 2007-2009 Michigan live birth and infant death files, Michigan Department of Community Health

Black:White disparities in infant mortality rates in Michigan, by mother’s education (2007-2009)

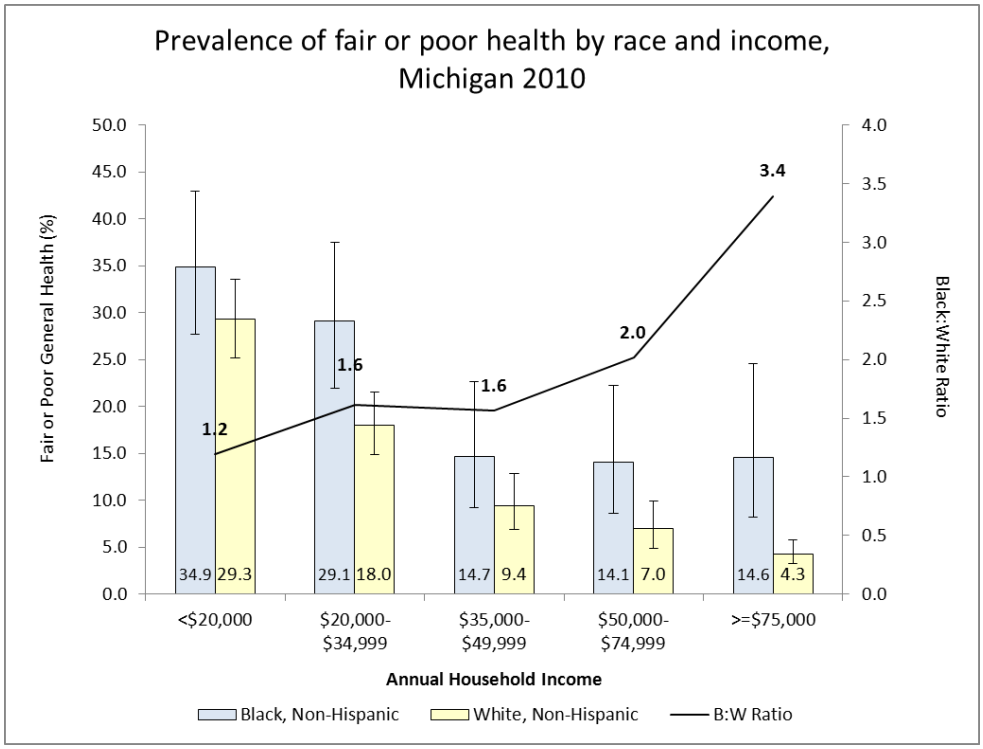
As presented in the previous chart, infant mortality rates decline as the mother’s level of education increases. However, at all levels of education infant mortality rates are higher among African Americans than among Whites. In fact, infant mortality rates are worse among African American women who have more than a high school education than among White women who have not graduated high school. The black line shows the disparity between African American and White infant mortality rates, measured by a ratio (African American rate divided by White rate). As education levels increase the disparity between African American and White infant mortality increases, and the gap between the two groups gets worse. The difference between African American and White infant mortality rates in Michigan cannot be explained by differences in a mother’s education alone.



Data source: C. Fussman, 2010 Michigan Behavioral Risk Factor Survey, Michigan Department of Community Health

Black:White disparities in obesity prevalence in Michigan, by education (2010)

At all levels of education the obesity prevalence is higher among African Americans than among Whites, except among individuals with less than a high school education. Among Whites, obesity prevalence declines as education levels improve. Among African Americans there is no significant change in obesity with education levels. The black line in the above graph shows the disparity between African American and White obesity prevalence, measured by a ratio (African American prevalence divided by White prevalence). As education increases the disparity between African American and White obesity prevalence increases. Among individuals with less than a high school education, the obesity prevalence among African Americans is approximately equal to that among Whites. Among college graduates the obesity prevalence among African Americans is 1.8 times greater than the obesity prevalence among Whites. The difference between African American and White obesity prevalence in Michigan cannot be explained by differences in education levels alone.



Data source: C. Fussman, 2010 Michigan Behavioral Risk Factor Survey, Michigan Department of Community Health

Black:White disparities in fair/poor health in Michigan, by annual household income (2010)

As income levels increase, the percent of respondents who reported their health was fair or poor decreases. However, at all levels of income the percent of respondents who reported that their general health was fair or poor was higher among African Americans than among Whites. The black line shows the disparity between African American and White prevalence of fair/poor health, measured by a ratio (African American prevalence divided by White prevalence). As income levels increase the disparity between African American and White prevalence increases. Among people making less than $20,000 per year, the African American prevalence is 1.2 times greater than the White prevalence. Among people making greater than or equal to $75,000, the African American prevalence of fair/poor health is 3.4 times greater than the White prevalence. The difference between Black and White health in Michigan cannot be explained by differences in income levels alone.

Additional data documenting equity and disparity data were collected through an oversampling of the Hispanic/Latino and Native American/American Indians as part of Michigan's 2011 Behavioral Risk Factor Surveillance System (BRFSS) survey. BRFSS is a telephone survey that tracks health conditions and health risk behaviors among

adults. A BRFSS-like survey was conducted among the Arab/Chaldean population in Southeast Michigan as a partnership with the Arab Community Center for Economic & Social Services. The oversampling of these minority populations allows for more accurate and comprehensive analyses of health conditions, risk factors, and health-related behaviors that affect minority groups in Michigan. Data from the 2011 BRFSS will be available in 2012.

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.

For several years, the HDRMHS has maintained and expanded the MDCH Health Disparities Reduction and Minority Health webpage. During 2011, this webpage provided access to the Section's vision, mission, strategic framework, data, resources, and tools, as well as the Michigan Health Equity Roadmap which features health equity data and recommendations. The HDRMHS 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. The website also included a link to the *National Partnership for Action (NPA) to End Health Disparities*. NPA, an initiative of the U.S. Department of Health and Human Services, seeks "to mobilize a nationwide, comprehensive, community-driven, and sustained approach to combating health disparities and to move the nation toward achieving health equity." In 2011, the Michigan Health Equity Data Set was also added to the HDRMHS webpage.

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

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

Health Equity Website

In 2011, a community health equity website, sponsored by Capacity Building Grantees (CBG), was launched. The purpose of this website is to facilitate community engagement and discussion in addressing health equity, including health disparities and social determinants of health. This website can be accessed at www.healthequitymi.com.

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 2011, the Health Disparities Reduction/Minority Health (HDRMHS) Section continued to lead MDCH efforts to achieve health equity and reduce health disparities; to ensure policies, programs and strategies were culturally and linguistically appropriate; and to collaborate with state, local and private partners to advance health promotion and disease prevention strategies. The HDRMHS developed, promoted, and administered health promotion programs for communities of color, including African American, Hispanic/Latino, American Indian/Alaska Native, Asian American/Pacific Islander, and Arab and Chaldean American.

Health equity programs that have systems approaches and accountability are more likely to be effective and often involve strategic planning and goal setting. Reaching these goals requires partnerships and collaborations across a wide variety of organizations, as well as consumer involvement. Developing capacity requires resources from several sources, and these resources must be focused on strengthening infrastructure, cultivating and leveraging partnerships and relationships, and developing programs and services.

Of the 21 MDCH administrations and bureaus responding to the online survey, 90% (19) provided data on the racial and ethnic minority populations they served. The following data provide a snapshot of the population groups served in 2011.

100% (19) served all racial and ethnic population groups

- African American
- Hispanic/Latino
- American Indian/Alaska Native
- Asian American/Pacific Islander
- Arab and Chaldean American

57% (12) served all age groups

100% (19) served females and males

690,352 individuals served[1]

- 352,936 African American
- 104,362 Hispanic/Latino
- 50,365 American Indian/Alaska Native
- 25,781 Asian American/Pacific Islander
- 31,892 Arab and Chaldean American
- 125,016 Other

[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.

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 2011, the HDRMHS continued to fund agencies to build capacity through Phase II of the Capacity Building Grants (CBG) program. Phase I, completed in 2010, awarded planning grants to 16 organizations to develop a comprehensive proposal for funding in 2011 (Phase II). Of the 16 Phase I projects, seven were funded to implement and evaluate their projects in 2011. Phase II funding ranged from $30,000 to $55,000 per project. Funded projects addressed one or more of three focus areas: 1) improvement of minority health data collection and accessibility; 2) curricula or training to improve health equity; and 3) implementation of programs and activities to address social determinants of health. Additional information on these projects is found on pages 18-21, and the spotlight that follows presents key evaluation results.

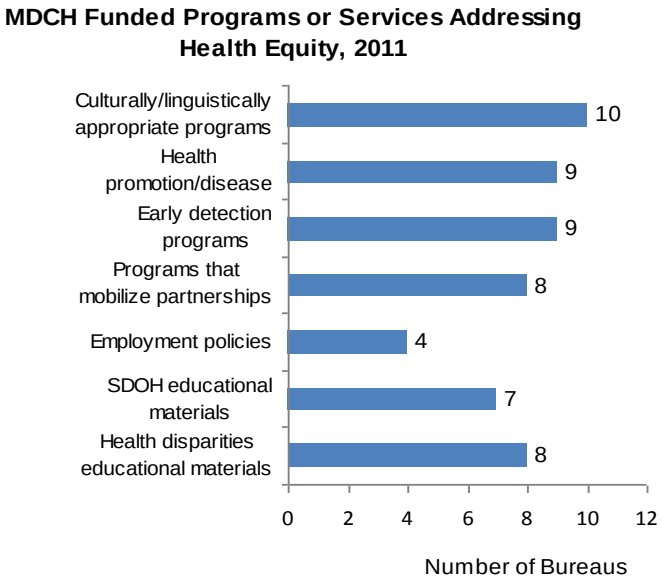
Spotlight
CBG Overall Outcomes Across Sites, 2011

- Retention (85% of original 121) and expansion of active community partners (up to 149)
- Leveraged MDCH funding for an additional $384,376 for community projects
- Improved systems for on-going data collection for race, ethnicity and language
- Established mechanisms for on-going community education and training on social determinants of health, health and safety issues
- Trained and engaged community members in community garden, nutrition and healthy eating initiatives and community patrols with documented decreases in crime incidents
- Expanded dissemination of health disparity and equity data through reports, web pages, and photovoice projects

In addition to HDRMHS funding, several MDCH administrations and bureaus dedicated funding to address health equity, health disparities, or social determinants of health. The 2011 survey responses revealed that 57% (12) of the administrations and bureaus received or redirected existing funding to improve health equity for racial and ethnic minority populations. Among these 12 administrations and bureaus, funding sources were Federal, 83%; State, 58%; and Foundation, 25%.

Funding levels did not necessarily remain level from 2010. Of the 12 Administrations and bureaus that *received or redirected* funding, 3 (25%) noted they had less state funding and 5 (42%) noted less federal funding in 2011 as compared to 2010.

Of the 21 respondents, 13 reported they *funded programs, services or activities* to address health equity. This reported funding was used in a variety of ways.



In 2011, some MDCH administrations and bureaus reduced or eliminated programs or services focused on addressing health equity. Of the 21 respondents, three (14%) eliminated and reduced and five (24%) reduced but did not eliminate programs, services or activities.

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, state and local public health, community and faith based organizations, health and health care professionals, researchers and academic institutions. 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 health outcomes. The Roadmap's centerpiece is its recommendations developed after an extensive review of health equity policies and programs implemented nationally and in Michigan, coupled with feedback from government agency staff, community organizations and members, and stakeholders from various sectors. Accomplishing these recommendations requires a sustained commitment and innovative, multi-sector collaboration focused on addressing social

determinants of health and strengthening community capacity. The HDRMHS widely disseminated the Roadmap, and it is also posted on the HDRMHS webpage.

As part of its continued efforts to cultivate and mobilize partnerships with various community organizations and sectors, the HDRMHS sponsored a number of collaborative events in recognition of Minority Health Month in April 2011. Through a mini-grant process, funds were awarded to 17 organizations to host events related to the Minority Health Month theme, “Empowerment Through Education and Awareness: Impact of Health Care Reform on Racial and Ethnic Minority Populations in Michigan.” A total of 57 activities focused on assuring health equity for racial and ethnic minority populations in Michigan and related to the Patient Protection and Affordable Care Act (PPACA) and/or healthy nutrition and lifestyles for children. The Minority Health Month initiative united diverse partners and community members to raise awareness and educate individuals about key provisions of the PPACA and healthy nutrition for youth, as well as encouraging empowerment as it relates to minority health improvement.

In addition to HDRMHS, several administrations and bureaus had a structured approach to impacting health equity. These systems level approaches were anchored with relevant goals and objectives necessary for program success. Of the 21 MDCH administrations and bureaus responding to the 2011 online survey:

- 57% (12) had a strategic plan with goals/objectives related to health equity/health disparities.
- 62% (13) had program goals/objectives related to health equity/health disparities.

In 2011, the MDCH Division of Health, Wellness and Disease Control (DHWDC) released its 2011-2015 strategic plan to address health equity. This strategic plan provides a blueprint and clear priorities to guide the work of the DHWDC, including the Health Disparities and Minority Health Section, over the next five years. It was developed with the active involvement of the entire Division and the advice and input of stakeholders including other MDCH bureau and division directors, representatives of local health departments, and program experts from outside the State. The Division’s vision is for Michigan to be a state where health equity is a core focus in prevention, care, and treatment for all residents and:

- New HIV/AIDS, hepatitis C, and STD infections have been eliminated.
- Residents receive culturally appropriate, quality prevention, care/treatment, and support services.
- Discrimination, stigma, homophobia, and racism have been eliminated.
- Health disparities for racial/ethnic and sexual minorities have been eliminated.

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, wealth
- *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 2011, the HDRMHS developed a *Michigan Health Equity Toolkit*. This toolkit was developed to raise awareness about the social and environmental factors that play a role in the health outcomes of racial and ethnic minority populations in Michigan. Included was a six-part video series with information on the social determinants of health, health disparities and health equity, and food access; health care access and cultural competency (parts 1 and 2); education; and stress. The toolkit will be distributed to local health departments, community and faith-based organizations, agencies serving minorities, and others throughout the Michigan. The release of the toolkit is scheduled for spring 2012.

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

- 38% (8) used social determinants of health related data sources.
- 33% (7) used funding for educational materials focused on social determinants of health.
- 38% (8) funded programs that mobilized partnerships to address social determinants of health among racial and ethnic minority populations.

Of the 17 administrations and bureaus that worked with local public health, minority health coalitions, or community organizations, 53% (9) supported community-based efforts to help mobilize partnerships to address social determinants of health.

Spotlight

MDCH *Practices to Reduce Infant Mortality through Equity* (PRIME)

MDCH Bureau of Family and Maternal Child Health (BFMCH) initiated *PRIME* with a vision to identify and implement changes in state public health practices to reduce Michigan's African American and American Indian infant mortality rates, thereby reducing the primary disparities in infant mortality. The *PRIME* goals are: (1) to identify and eliminate MDCH maternal and child health (MCH) institutionalized discriminatory policies and practices and (2) to focus more MCH funding, policy and practice on monitoring and addressing social determinants of racial disparities in infant mortality. In 2011, the *PRIME* Steering Team and workgroups began productive efforts. In May, trainers from The People's Institute for Survival and Beyond conducted a two-day training on *Undoing Racism* for 158 MDCH employees and community members. "*Evaluations indicated staff gained understanding and competency related to racism and on the historical factors that play a role in disparities and the impact on health outcomes*," elaborated Brenda Jegede, Project Coordinator. "*Many staff were unaware of the historical factors and left the workshop with a significantly different understanding and a paradigm shift that we hope will impact their work daily*." Later in the year, 87 MDCH staff, PRIME Steering Team and Local Learning Collaborative members attended Ingham County Health Department's 2 1/2 day Health Equity and Social Justice Workshops. The workshops reviewed conceptual frameworks for adopting a health equity/social justice framework in the department. The workshop also stressed the necessity and value of addressing racism, classism, sexism, and other forms of oppression *explicitly* as root causes of health inequity.

In 2011, the Ad Hoc Native American Data Group began developing a Native American specific Pregnancy Risk Assessment and Monitoring System survey (PRAMS). This will afford the collection of Michigan specific, population-based data on Native American maternal attitudes and experiences before, during and after pregnancy to better tailor funding, policies and practices. Additionally, the Local Learning Collaborative engaged local stakeholders in *PRIME.* As a first effort they compiled a compendium of community health equity experiences, learning and tools to share broadly and specifically to incorporate in state strategies. This will provide the opportunity for MDCH to better understand how to effectively engage stakeholders in policy making decisions as the effort moves forward. Over time, *PRIME* will not only lead the statewide effort to reduce racial disparities in infant mortality, but will provide a training module and tool-kit that MDCH and potentially other state departments may use to address disparities in other health outcomes. The tool-kit will include strategies and tools to promote continuous quality improvement, collaboration and accountability, and public sharing of measurable outcomes that reflect racial and health equity.

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 offered 41 trainings or other continuing education sessions focused on topics identified in the recommendation (3b). These were only open to MDCH staff. Survey respondents reported training that collectively reached 4,225 participants.[2]

- Most common venues: employee meetings, workshops, and trainings.
- Most frequent topics: cultural competency/cultural sensitivity, racism, health equity, social determinants of health, and health literacy

Some MDCH staff also participated in external events noted elsewhere in this report.

Of the 21 MDCH administrations and bureaus responding to this survey, 71% (15) expressed an interest in providing or sponsoring health equity staff training in 2012.

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 health care system. In order to achieve health equity, efforts must be made to increase access to affordable health care, as well as assuring the health care provided is high quality and culturally acceptable.

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

In 2011, a variety of MDCH efforts continued that will inform the future process (es) to develop the department-wide standards for CLAS services. The CLAS standards applied to services developed, coordinated or funded by MDCH provides valuable information on promising practices and lessons learned.

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

In October 2011, the MDCH Division of Health, Wellness and Disease Control hosted a day-long, statewide Summit addressing the National Partnership for Action to End Health Disparities, the National AIDS Strategy and Implementation Plan, the Division of

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

Health, Wellness and Disease Control Strategic Plan and recommendations from the Health Equity Roadmap. The Summit featured plenary and breakout sessions facilitated by national and state experts in minority health and HIV/AIDS. An estimated 200-250 people attended, representing various disciplines and organizations. The Summit helped to foster collaboration on state and local approaches to reduce health disparities.

In 2011, MDCH administrations and bureaus conducted a variety of activities that helped to increase culturally competent care. These included the following:

- Of the 13 online survey respondents that offered programs, services or activities, 31% (4) reported employment policies to enhance minority employee recruitment and retention.
- Administrations and bureaus responding to the survey collectively held 63[3] cultural competency and cultural sensitivity continuing education sessions. These sessions occurred primarily through trainings, workshops, staff meetings, and conferences at the local, regional and state level. Survey respondents reported that 8,019[4] state and local public health and health care professionals participated.
    - 29 sessions were offered exclusively to MDCH staff, with respondents reporting 4,071 participants
    - 34 sessions were offered to public health and health care professionals with 3,948 participants
- Survey respondents reported 43[3] workshops were offered on racism, reached 2,050 public health and health care professionals.
    - 18 were offered to all public health and health care professionals with 1,218 participants
    - 25 were offered to MDCH staff only with 832 participants
- Administrations and bureaus responding to the survey reported 22 educational sessions were offered on health literacy, with 2,325 public health and health care professionals attending.
    - 17 were offered to public health and health care professionals with 2,225 participants
    - 5 were offered to MDCH staff only with approximately 100 participants

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

Three HDRMHS-funded Phase II CBG implemented plans for their 2011 projects that focused on addressing language barriers to accessing health care.

[3] Some sessions addressed more than one topic.
[4] Participants were counted once for each training session they attended.

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

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

Several HDRMHS-funded Phase II CBG implemented projects in 2011 to increase collection of and use of individual and community data on race, ethnicity, preferred language, other demographic, cultural and epidemiological data.

- The Asian Center – Southeast Michigan: Analyzed data from Phase I to understand Asian Americans' health and health care matters; and developed detailed sub-group specific profiles of social determinants and health for Chinese, Filipino, Korean, Vietnamese, and Indian communities.
- Berrien County Health Department: Developed BRFSS questions in order to collect new health disparity data on race and social context.
- Grand Rapids African American Health Institute: Conducted health equity data mapping to assess community needs and assets and to plan interventions.
- Muskegon Community Health Project: Improved the collection race, ethnicity and preferred language and other healthcare information, especially involving patient experience and barriers to access.
- Washtenaw County Public Health: Developed a community-level health equity data set used to develop a Health Equity Report Card to increase knowledge/awareness of health disparities and to influence resource allocation decisions.

In addition to these efforts, 13 of the 21 MDCH administrations and bureaus indicated they provided programs, services or activities designed to achieve health equity, address health disparities, or impact social determinants of health. Several of these are related to the CLAS standards. Of the 13 that provided programs, services or activities:

- 69% (9) provided programs or interventions that assured or provided access to early detection services.
- 69% (9) provided programs or interventions that included health promotion and disease prevention strategies.
- 77% (10) provided programs or services that were culturally/linguistically appropriate.

Community Engagement and Empowerment

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

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

Spotlight
St. John's Neighborhood Health & Safety Initiative
Building Skills and Capabilities of Community Members

St. John Community Health Investment Corporation is one of seven grantees of the MDCH CPG Program. They have focused their collaborative partnership on implementation of activities to address health equity through social determinants of health and on building skills and capabilities of community members. Their initiative, "*Neighborhood Health & Safety,"* engages existing collaboratives such as: Detroit Community Initiative, Healthy Neighborhoods Detroit, Maintaining A Neighborhood (MAN) Network, and Nortown Community Development Corporation, as well as and the St. John Providence Health System and affiliates including local block clubs, law enforcement, churches and schools. The St. John Neighborhood Health &Safety Office serves as a broker for health resources, especially for the uninsured and underinsured, as well as an intermediary for community safety through a community patrol partnership**.** Cassandra Jackson, Program Manager, reflected on the distinctive attributes of this project, "*This effort is unique nationally; few partnerships and projects have focused on preventing unhealthy outcomes that combine both health and safety and the conditions and situations that cause them."*

Community members have guided the project from the beginning. In Phase 1, residents, business owners and individuals who worked in the Conner Creek Village District of Detroit were surveyed about health and safety needs. This input guided the project. As Ms. Jackson, so eloquently expressed, *"Our goal is to mobilize and empower community members to transform <u>their</u> community -- to look out for and help one another. We show and train them on what's possible and how it can be done. Areas like Conner Creek heretofore have not benefited from philanthropic funding or empowerment zone resources*." The HDRMH funding has been

leveraged to more than double the MDCH investment through St. John Health System's match, a grant from Blue Cross Blue Shield of Michigan and the in-kind time and resources from community members and businesses.

Among the 2011 accomplishments of the St. John's HDRMH Capacity Building Grant are:

- Referred 48 un/under insured, low-income residents to affordable health clinics and energy assistance programs.
- Identified crime "hotspots," then mobilized strategic efforts -- trained 38 new volunteer patrol officers and logged 1500 community patrol hours with the following representative crime incident decreases from 2010 to 2011 in the targeted patrol areas manned by community volunteers:
    - Assault -- 16%
    - Burglary – 26%
    - Larceny – 26%
    - Property Crime – 19%
    - Damage to Property – 34%.
- Identified and reported unsafe properties, stray dogs, and blight -- 99.8% of residential and 75 % of commercial streets and alleys (in target area) were cleaned of debris, environmental hazards and vegetation overgrowth; over 250 large garbage bags of debris were disposed; and 12 OAD homes were boarded.
- Several educational and training opportunities were offered to community residents on such topics as crime and technology, drug, fire and back to school safety and health disparities, with over 10,000 educational materials disturbed.

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 2011, the HDRMHS convened a Statewide Health Equity External Advisory Group (EAG).The role of this group is to provide guidance and expertise to the MDCH HDRMHS in identifying priorities, data needs, strategic initiatives and best practices to achieve health equity for racial and ethnic minority populations in Michigan. The EAG is comprised of a diverse group of individuals representing various organizations throughout the state (see Attachment C for a list of members). The specific objectives of the group are to: 1) champion health equity and the work of the HDRMHS; 2) advise on current and future HDRMHS initiatives/activities/priorities; and 3) assist in identifying funding sources for health equity work/projects. Achievement of these objectives will help to ensure that MDCH through the HDRMHS is effective in serving the needs of racial and ethnic minority populations in Michigan. The EAG met twice in 2011 and is scheduled to meet three times in 2012.

In addition to the EAG, the HDRMHS continued to coordinate an intra-departmental Health Disparities Reduction Workgroup. As in previous years, members represented a cross-section of MDCH administrations and bureaus (Attachment D). In 2011 the workgroup engaged in a re-visioning process in order to identify ways to improve the group's effectiveness and impact. This process involved 1) reviewing the history, progress, and current functioning of the workgroup; 2) sharing thoughts, experiences and insights into the challenges and opportunities the workgroup has faced in trying to achieve its goals; and 3) identifying actions or strategies to improve the workgroup's capacity to accomplish its goals in the coming years. During this re-visioning process, participants were asked to consider what they need to do to make the workgroup a meaningful and effective vehicle for eliminating health disparities through public health policy and practice.

MDCH Health Equity Steering Committee

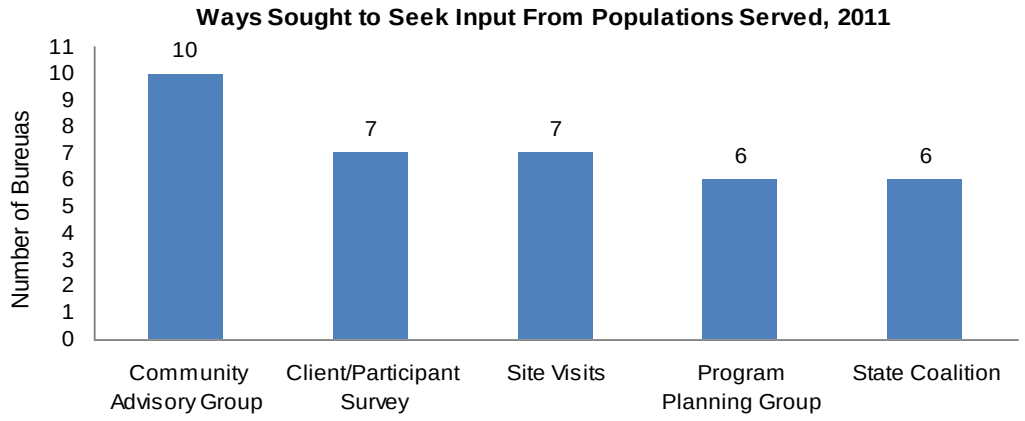
VISION

Racial and ethnic health equity will be a priority of all MDCH programs and in all MDCH policy as evidenced by implementation of health equity best practices throughout the Department.

MISSION

The Health Equity Steering Committee (formerly Health Disparities Workgroup) is committed to communicating with, serving as a resource to, and actively involving MDCH Administrators and other staff in our work to achieve racial and ethnic health equity.

Through open discussions, brainstorming, and structured exercises, the group arrived at a number of recommendations to strengthen the workgroup's structure, accountability, activities, influence, and integration within MDCH. The group also decided to change its name from the MDCH Health Disparities Workgroup to the MDCH Health Equity Steering Committee. As a steering committee, the group is responsible for "steering" the focus of the Department as it relates to health disparities/health equity issues including, working with other MDCH units to provide input on how to infuse health equity into the day-to-day working environment, disseminating information externally, and ensuring that Departmental activities and policies are in alignment with national efforts. The group further reached consensus on a new steering committee vision and mission statement.



In 2011, MDCH administrations and bureaus expanded the ways they sought to receive input from consumers, public and private stakeholders, and policy makers. Of the 21 respondents, 62% (13) 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 chart above.

The 13 respondents who noted they collected input used the information in many ways:

- 85% (11) enhanced program/service delivery or performance.
- 85% (11) developed or revised education materials.
- 77% (10) tailored technical assistance for service providers.
- 77% (10) identified barriers to participation.
- 69% (9) integrated into state or community strategic or program plans.

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 17 MDCH administrations and bureaus that indicated they worked with local or community organizations:

- 41% (7) assisted with capacity development.
- 53% (9) helped mobilize partnerships.
- 76% (13) provided technical assistance on program design, program implementation, etc.
- 47% (8) developed evidence-based interventions.
- 65% (11) provided data or analyzed data.
- 65% (11) provided program/service funding.
- 47% (8) provided training on cultural competency and related topics.

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

17 of the 21 MDCH administrations and bureaus that responded to the on-line 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.) Exemplary of this work is the WISEWOMAN Program highlighted in the following Spotlight.

Spotlight
MICHGAN's *WISEWOMAN* PROGRAM

WISEWOMAN (**W**ell-**I**ntegrated **S**creening and **E**valuation for **WOM**en **A**cross the **N**ation) is a program that instills lasting, healthy lifestyle changes in women at risk for heart disease, stroke and other chronic diseases. Michigan is one of 19 states funded by the Centers for Disease Control and Prevention (CDC) since 2001 to serve low-income, underinsured and uninsured women between the ages of 40 and 64.The core of the WISEWOMAN program is: screening for hypertension, cholesterol and diabetes; offering strategies for healthy eating, physical activity and smoking cessation; assisting in setting goals and developing support to meet goals; facilitating referrals for needed treatment and medication; and monitoring and evaluating progress. MDCH contracts with nine local health departments, one federally qualified health center, and one free clinic, and partners with a broad array of public health and health advocacy organizations to offer WISEWOMAN in 29 counties across the state. In 2011, the Michigan program screened 4, 554 women, approximately seven percent were African American, 4% Hispanic, 3% multi-racial, less than one percent Native American, and about half of one percent Asian. In Detroit, however, 96% were African American, 2% multi-racial, and 2% Hispanic. In Lenawee county over 21 percent screened were Hispanic. In Genesee County, approximately 31% were African American and 3% for both Hispanic and multi-racial. Over 98% screened in McAuley Health Center in Detroit were African American and in Hackley Community Care Center in Muskegon, 27% were African American, 14% Hispanic and 7% multi-racial. Of the women screened, approximately 65% participate in lifestyle interventions. Examples of WISEWOMAN creative partnering are *Market Fresh* and *Entrepreneurial Gardening Project*. Both efforts were implemented to increase participants' access to fresh fruits and vegetables. WISEWOMAN *Market Fresh* offers participants $20 coupons to purchase Michigan-grown fruits and vegetables in a few select locations. This popular program is done in collaboration with the Michigan Office of Services to the Aging (OSA).Eighty-two percent of recipients redeemed coupons. With funding from CDC, WISEWOMAN partners with MSU Extension in a few counties for the *Entrepreneurial Gardening Project* that offers participants training on nutrition, gardening basics and marketing skills. Participants not only save money in growing their own fruits and vegetables, but are able to make money selling their produce.

Accomplishments and Conclusion

In 2011, 690,352 people from targeted racial and ethnic minority groups were served by MDCH funded programs and services. In addition to building upon and continuing its work to address health disparities, MDCH HDRHMS achieved several accomplishments that provide the strong foundation needed to shift from a focus on health disparities to achieving health equity. Among the accomplishments responsible for the shift are:

- Continued implementation of the *Michigan Health Equity Roadmap.*
- Maintenance of a health equity data set.
- Expanded training on social determinants of health and other health equity topics.
- Continued funding of community capacity building grants (CBG).

In addition, the following activities identified in the MDCH 2010 Health Disparities Report under the *2011 Minority Health Related Activities and Timeline Section* were completed.

- Behavioral Risk Factor Surveillance Survey Oversample
- HDRMHS Continued Funding Phase II Capacity Building Grants
- HDRMHS Phase II Capacity Building Grant Ongoing Evaluation
- Health Equity Curriculum and MDCH Staff Training
- Minority Health Month Mini-Grant Activities Conducted
- Health Equity Priority Data and Equity Tables Online
- Health Equity Factsheets Produced and Online
- Health Equity Toolkit/Video Series Complete
- Health Equity, HIV/AIDS, STD, and Hepatitis C Summit

In 2011, Michigan Department of Community Health experienced both challenges and opportunities related to its work to address racial and ethnic health disparities. The provisions put forth in the Michigan Public Act 653 and the recommendations of the *Michigan Health Equity Roadmap* provide the focus for meeting an enormous opportunity to implement activities to improve racial and ethnic health equity in Michigan. On the other hand, MDCH HDRHMS experienced the challenge of reduced funding for these activities. The result was a more coordinated approach to identify fundamentally different ways to approach their work and assure health equity for all Michigan citizens. Some of the efforts described in this report include the PRIME Project, the Capacity Building Grant (CBG) Project, and Undoing Racism training among others.

In reflecting back on 2011, the CBG's had many accomplishments in the broadening of the engagement and leveraging of resources through partnerships and collaborations.

Each of the seven funded community-based programs reported impressive impacts. Among the reported outcomes were: improved systems for on-going data collection for race, ethnicity and preferred language; the establishment of mechanisms for on-going community education and training on social determinants of health, health and safety issues; engagement of community members in community garden, nutrition and healthy eating initiatives and community patrols with documented decreases in crime incidents; and the expanded dissemination of health disparity and equity data through reports and web pages. Further, the constructive use of learning collaboratives extended synthesis and cross division, bureau and local public health and community-based organization application of insights and best practices. The outreach to and sharing of the learning from others in the country that have been effective in approaching health equity and disparities is a key to the effective technical assistance MDCH HDRHMS staff offer within MDCH and across the state.

Two additional significant 2011 efforts included the establishment of the HDRHMS External Advisory Group and the re-visioning of the MDCH Health Equity Steering Committee. Taken together these two bodies will provide valued guidance on MDCH health equity priorities as well as provide needed expertise to extend the health equity work of HDRMHS. With the input of the two groups, HDRHMS has identified the following 2012 work plan and timeline to meet recommendations.

2012 Minority Health Related Activities and Timeline

Behavioral Risk Factor Surveillance Survey Oversample (Hispanic and Asian American)	January – December 2012
HDRMHS Phase II Capacity Building Grants	January 2012 and Ongoing
HDRMHS Phase II Capacity Building Grant Evaluation	January 2012 and Ongoing
Health Equity and Cultural Competency Training (MDCH staff, HDRMHS Grantees)	January 2012 and Ongoing
Health Equity Toolkit/Video Series Distribution	April 2012 and Ongoing
Minority Health Month Mini-Grant Activities Conducted	May – September 2012
Health Equity Factsheets Produced and Online	June 2012
Cultural Competency Curriculum/Web-based Version	October 2012

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	• Develop structure to address health disparities • Develop and implement awareness strategies targeted at health and social service providers • Identify and assist in the implementation of culturally and linguistically appropriate programs (non-health care)
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	• Establish a web page on the department's website • Utilize resources to fund minority health programs AND Provide funding to support evidence-based programs [specific to coalitions] • Provide the following through interdepartmental coordination: data and technical assistance and measurable objectives to minority health coalitions and other local health entities AND Provide technical assistance to local communities • Promote the development and networking of minority health coalitions • Appoint a department liaison to provide services to local minority health coalitions

Attachment B: 2011 Health Equity Survey Respondents by Administration

Bureau	Division
OFFICE OF THE DIRECTOR	
Health Information Technology*	
Policy and Planning*	
	Office of the Chief Nurse Executive
	Health Policy and Access
Office of Recipient Rights*	
Michigan Developmental Disabilities Council*	
MEDICAL SERVICES ADMINISTRATION	
Bureau of Medicaid Policy and Health Systems Innovation*	
	Program Policy
	Actuarial
	Long Term Care Services
Bureau of Medicaid Financial Management & Administrative Services*	
	Medicaid Payments
	Third Party Liability
	Hospital and Health Plan Reimbursement
Bureau of Medicaid Program Operations and Quality Assurance*	
	Customer Service
	Managed Care
	Office of Medical Affairs and Pharmacy
	Program Review
OPERATIONS ADMINISTRATION	
Bureau of Budget and Audit*	
	Office of Audit
	Budget
	Grants & Purchasing
	Accounting
	Medicaid, Mental Health and MAIN Support
Bureau of Legal and Policy Affairs*	
	Crime Victims and EMS
	Office of Legal Affairs and FOIA
PUBLIC HEALTH ADMINISTRATION	
Bureau of Local Health and Administrative Services*	
	Chronic Disease and Injury Control

Bureau	Division
	Local Health Services
	Vital Records and Health Statistics
Bureau of Family, Maternal and Child Health*	
	Women, Infants, and Children (WIC)
	Family & Community Health
	Children's Special Health Care Services
Bureau of Epidemiology*	
	Genomics, Perinatal Health, and Chronic Disease Epidemiology
	Environmental Health
	Immunization
Bureau of Laboratories*	
	Infectious Disease
	Chemistry and Toxicology
	Quality Assurance
Division of Health, Wellness and Disease Control*	
Office of Public Health Preparedness*	
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION	
Bureau of Substance Abuse and Addiction Services*	
	Prevention, Treatment, and Recovery Services
Bureau of Hospital, Center and Forensic Mental Health Services*	
	Center for Forensic Psychiatry
	Walter P. Reuther Psychiatric Hospital
	Community Living and Long Term Care Planning
	Kalamazoo Psychiatric Hospital
	Caro Center
	Hawthorn Center
Bureau of Community Mental Health Services*	
	Program Development, Consultation and Contracts
Office of Psychiatric/Medical Services*	
OFFICE OF SERVICES TO THE AGING*	
	Quality Operations
OFFICE OF INSPECTOR GENERAL*	
	Medicaid Integrity Program

*"Bureau-level" categorization used for data analysis

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

Tom Costello
Michigan Roundtable

Monty Fakhouri
Beaumont Hospitals

Art Franke
National Kidney Foundation of MI

Dr. Herbert Smithermann, Jr.
Detroit Medical Center/WSU

L. John Lufkins
Inter-Tribal Council of Michigan

Ruben Martinez
Michigan State University – Julian Samora Research Inst.

Dr. Khan Nedd
Grand Rapids African American Health Institute

Dr. Othelia Pryor
Michigan Minority Health Coalition

Debra Riddick, JD, RN
School Community Health Alliance

Karen Schrock
Adult Well Being Services

Shenlin-Chen
Association of Chinese Americans

Pam Smith
Urban Regeneration, LLC

HDRMHS Staff
Sheryl Weir, HDRMHS Manager

Jacquetta Hinton
Program Coordinator

Attachment D: 2011 MDCH Health Equity Steering Committee (formerly Health Disparities Workgroup)

Name	Bureau	Division/Section/Unit
Alethia Carr	Family, Maternal & Child Health	
Amna Osman		Health, Wellness & Disease Control
Amy Peterson		Health, Wellness & Disease Control
Anne Esdale	Local Health and Administrative Services	Chronic Disease & Injury Control Diabetes & Kidney Unit
Ann Garvin	Local Health and Administrative Services	Chronic Disease & Injury Control Breast/Cervical Cancer Control
Brenda Fink	Family, Maternal and Child Health	Family and Community Health
Brenda Jegede	Family, Maternal and Child Health	
Carol Callaghan	Bureau of Local Health and Administrative Services	Chronic Disease & Injury Control
Damita Zweiback	Local Health and Administrative Services	Chronic Disease & Injury Control Cardiovascular Health, Nutrition
Debra Duquette	Epidemiology	Genomics & Genetic Disorders
Emily Moreno	Laboratories	Chemistry and Toxicology Analytical Chemistry
Fawzia Ahmed	Epidemiology	Vital Records & Health Statistics Health Data Analysis Services

Name	Bureau	Division/Section/Unit
Frances Pouch Downes	Laboratories	
Geraldine Motley		Health, Wellness & Disease Control Health Disparities Reduction and Minority Health
Holly Nickel		Health, Wellness & Disease Control Health Disparities Reduction and Minority Health Section
Jacquetta Hinton		Health, Wellness & Disease Control Health Disparities Reduction and Minority Health
Janet Kiley	Local Health and Administrative Services	Chronic Disease & Injury Control Tobacco Prevention & Control
Jean Chabut	Public Health Administration	
John Dowling	Local Health and Administrative Services	Chronic Disease & Injury Control Diabetes & Other Chronic Diseases
Judi Lyles	Local Health and Administrative Services	Chronic Disease & Injury Control Diabetes & Other Chronic Diseases Other Chronic Disease Unit
Karen MacMaster	Epidemiology	Communicable Diseases HIV/AIDS Surveillance
Kari Tapley	Epidemiology	Immunization

Name	Bureau	Division/Section/Unit
Kathleen Stiffler	Medicaid Program Operations and Quality Assurance	Managed Care Plan
Kathryn Macomber		Health, Wellness & Disease Control
Kimberly Snell		Health, Wellness & Disease Control HIV/AIDS Prevention/ Intervention
Konrad Edwards	Local Health and Administrative Services	Local Health Services
Monica Kwasnik	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 Health Disparities Reduction and Minority Health Section
Rhonda Bantsimba		Health, Wellness & Disease Control HIV/AIDS Prevention/ Intervention
Robert Cochran		Health, Wellness & Disease Control Sexually Transmitted Disease

Name	Bureau	Division/Section/Unit
Rose Mary Asman	Family, Maternal and Child Health	Family and Community Health
Sheila Embry	Medicaid Program Operations & Quality Assurance	Quality Improvement & Program Development
Sheryl Weir		Health, Wellness & Disease Control Health Disparities Reduction and Minority Health Section
Shronda Grigsby		Health, Wellness & Disease Control Health Disparities Reduction and Minority Health Section
Sonji 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