Michigan Department
of Community Health

2009 Health Disparities Report

Released February 2010

EXECUTIVE SUMMARY

Health disparities are significant differences in the rate of disease incidence, prevalence, morbidity, mortality, or survival in a specific population as compared to the general population.[1] Simply put, health disparities refer to measured health differences between two populations, regardless of the underlying reasons for the differences. In Michigan, as in the United States, racial and ethnic minority populations carry a disproportionately heavy burden from health disparities. This burden is manifested in increased risk for disease, delayed diagnosis, inaccessible and inadequate care, poor health outcomes and premature death, much of which is preventable. See Table 1 for a summary of Michigan's most significant health disparities.

To effectively eliminate health disparities, the Michigan Department of Community Health (MDCH) supports the use of a comprehensive strategy using surveillance; awareness and education; policy; partnerships; and programs, services and system changes. Collectively, these efforts will improve the health of Michigan's racial and ethnic minority populations. The strategy focuses on improving access to, quality of, and opportunities for healthier environments and preventive and other health care services. To be effective this requires a dedicated and coordinated effort involving all MDCH administrations, bureaus, divisions, and sections, and its external partners.

Toward that end, the MDCH is pleased to present a snapshot of its current strategy in this *2009 Health Disparities Reduction Report.* This report, submitted in response to the House Bill 4455 – PA 653 requirement, provides information on the Department's health disparities-related activities during calendar year 2009 (January to December). Some of the Department's accomplishments in 2009 include:

- **Serving 2.05 million people** from racial and ethnic minority populations. (Duplicated count)
- **Providing 50 different programs or services** designed to reduce health disparities.
- Assuring that structural elements to address health disparities, such as capacity, policies, and programs/services are in place.
- Using more than 18 national, state, and local surveillance and evaluation data sources to identify and track health disparities and monitor progress.
- Seeking and using federal, state, foundation and other private resources to fund health disparities reduction services and programs.
- Providing training, technical assistance and consultation to state and local programs to enhance their capacity to address health disparities.
- Using employee recruitment and retention strategies to increase racial and ethnic diversity among Michigan's public health, health care and social services workforce.

[1] Minority Health and Health Disparities Research and Education Act *United States Public Law 106-525* (2000), p. 2498

In addition, the MDCH began an initiative in 2009 to develop a Health Equity Roadmap that will provide direction for future health disparities reduction efforts. MDCH identified priority areas of focus and ways in which the Department could strengthen relationships with local health departments, community organizations, minority heath coalitions, and other stakeholders to more effectively work to eliminate racial and ethnic health disparities in Michigan. This Roadmap will be finalized in 2010.

Table 1: Health Disparities in Michigan, 2009[2]

Indicator	Black	Hispanic	AI/AN	Asian	White
Overall Mortality rate	1,041.7	582.9	877.2	358.1	768.5
Infant Mortality rate	16.5	10.3	11.1	5.6	5.8
Heart Disease Mortality rate	313.8	151.4	243.3	98.7	210.2
Stroke Mortality rate	55.5	34.6	N/A	32.7	40.8
HIV/AIDS prevalence rate	575	159	92	27	67
Diabetes prevalence (%)	14.7	12.4	16.5	10.8[3]	7.3
Diabetes Mortality rate	38.3	35.3	47.5	N/A	24.5
Cancer incidence	544.0	350.5	302.6	253.5	487.0
Cancer Mortality rate	230.5	117.5	176.2	86.5	181.4
Suicide rate	5.2	5.9	N/A	N/A	11.9
Homicide rate	31.9	5.8	N/A	N/A	2.3
Gonorrhea prevalence	480.1	N/A	38.1	8.5	19.6
Chlamydia prevalence	904.4	N/A	147.5	61.8	102.8

N/A – some rates are not available due to small population sample size
Numbers in purple are the highest for that indicator; in blue, the second highest
AI/AN: American Indian/Alaska Native

The following report provides more detailed information on the work of the Michigan Department of Community Health in its efforts to address health disparities in 2009. For more information on this report, please contact Sheryl Weir, Manager, Health Disparities Reduction and Minority Health, (313) 456-4355.

[2] Notes: All mortality rates have been age-adjusted to control for differences in population size and age composition of racial/ethnic groups. HIV/AIDS prevalence refers to either HIV or AIDS infection; cancer incidence and mortality refer to all cause cancers (excluding some skin cancers); Gonorrhea and Chlamydia prevalence is calculated from reported cases (actual number of cases is estimated to be 1/3 to 1/2 higher); diabetes prevalence is estimated from Michigan Behavioral Risk Factor Surveillance System (BRFSS). All statistics are as recent as are available, though are not necessarily from the same year due to surveillance and programmatic differences in collection and reporting.

[3] This estimate is not statistically different than White.

2009 REPORT

Survey Description

The Michigan Department of Community Health (MDCH) completed its third annual survey to assess and track its efforts to reduce racial and ethnic health disparities. This report, provided in response to House Bill No. 4455 – PA 653, is a compilation of administration, bureau, division, and section responses to a web-based survey conducted in November-December 2009. The MDCH, Health Disparities Reduction and Minority Health Section (HDRMH), worked with an independent contractor to design and execute the survey, analyze survey data, and report the results. Administration and bureau directors were encouraged to have their division directors and section managers complete the survey. To maximize the response rate, two email reminders were sent, as was an email extending the due date.

Respondents

MDCH has eight overarching organizational units: five Administrative Units, the Director's Office, Office of Services to the Aging, and the Office of Drug Control Policy. For the purposes of data analysis, these were labeled "administrations." The administrations were further divided into 24 sub-units, typically, but not exclusively, titled "bureaus." The Operations Administration was exempt from completing the survey, as they had not provided or funded public health services in 2009; this administration had 3 bureaus. **The total eligible respondent pool represented 7 administrations with 21 bureaus.**

Year	Response Rate (Percent)	
	Administration	Bureau
2009	71	57
2008	86	88

The overall response rate to the survey was 57%, with 12 of the 21 bureaus responding. This represented 5 of the 7 administrations or 71% (see Attachment A). Response to the 2009 survey was lower than in 2008; at that time, 86% of administrations and 88% of bureaus responded. Data from 29 individual responses were subsequently aggregated and analyzed into 12 different units. These units were identified with an asterisk (*) in Attachment A. The survey results are reported by category as listed in PA 653.

Results

Develop and Implement a Structure to Address Racial and Ethnic Health Disparities in the State

The **HDRMH, Division of Health, Wellness, and Disease Control** served as the primary MDCH structure to address racial and ethnic health disparities. This Section focused the Department's efforts on achieving health equity and eliminating health disparities; ensured policies, programs and strategies were culturally and linguistically appropriate; and collaborated with state, local and private partners to advance health promotion and disease prevention strategies. The HDRMH Section developed, promoted, and administered health promotion programs for communities of color, including African American, Hispanic/Latino, American Indian/Alaska Native, Asian American, and Arab American/Chaldean. In 2009, the Section used the MDCH Health Disparities Strategic Framework to guide its work; this framework was posted on the Section's website at http://www.michigan.gov/mdch/0,1607,7-132-2940_2955_2985---,00.html.

Health equity is the absence of systematic disparities in health and its determinants between groups of people at different levels of social advantage.[1] Health equity falls under the umbrella of social justice which refers to equitable allocation of resources in society. To attain heath equity means to close the gap in health between populations that have different levels of wealth, power, and/or social prestige. For example, low-income persons and racial/ethnic minorities generally have poor health relative to people who have more economic resources or who are members of more powerful and privileged racial groups. Eliminating health disparities and health inequities between racial and ethnic populations moves us toward our goal of health equity, and a significant focus of this effort is to address the social determinants of health that influence our priority public health outcomes.[4]

The HDRMH Section activities in 2009 focused on achieving the following objectives:

1. Provide leadership, technical assistance and expertise to MDCH bureaus and divisions related to the statewide strategic plan to reduce disparities.
2. Provide technical assistance and expertise to, and collaborate with, local public health agencies, community-based organizations/agencies, and state and local health coalitions related to health disparities, health equity and minority health.
3. Monitor and make available surveillance and evaluation data on health disparities related to ethnic and racial populations.
4. Identify public health programs and policies that can be effective in reducing health disparities and promoting health equity for racial and ethnic populations in Michigan.
5. Identify/fund health disparities reduction best practices initiatives for replication with ethnic and racial populations in Michigan.

[4] Braveman P, Gruskin S. Defining equity in health. J Epidemiology and Community Health (2003), pp. 254-258.

6. Identify public health policies that can be effective in reducing health disparities for racial and ethnic populations in Michigan.
7. Serve as a clearinghouse for information, research and best practices related to health disparities reduction and minority health.
8. Serve as the lead to assure that PA 653 mandated health disparities reduction/minority health activities are evaluated annually.

Spotlight

Michigan's *You Decide*
Data Improvement Campaign

Accurate and complete data are fundamental to quality service provision, valid epidemiology, and the development of targeted interventions. The Infertility Prevention Project (IPP) of the Michigan Department of Community Health (MDCH), Division of Health, Wellness and Disease Control, STD Program has created the *You Decide* data improvement campaign.

In 2008, the Michigan IPP applied for, and was awarded, a small grant from the Region V IPP coordinating agency, to develop a plan to improve the completeness and quality of race and ethnicity data in Michigan. The *You Decide* Campaign materials have been developed as one tool to improve the completeness of these data.

The two target audiences for the campaign are the provider who completes forms and reports morbidity, and the patients who are asked to provide demographic information at the time of service. The *You Decide* materials were developed with target community input, and are written at a 4th grade reading level. The campaign messages focus on why race and ethnicity data are important. The key messages include: 1) race and ethnicity are two different concepts, 2) complete data helps to improve services to diverse communities, and 3) it is important to answer all race and ethnicity questions when they are presented.

Materials developed for distribution include: posters, folders, and privacy flaps. Items were distributed to the 250 agencies who submit specimens to the MDCH Bureau of Laboratories for STD testing. Local health departments were enlisted as a secondary distribution network for dissemination of *You Decide* materials to STD reporting agencies in their geographic area. MDCH provided technical assistance and training on the use of the *You Decide* materials and on data collection practices in early 2009. The impact of the campaign will be assessed beginning in 2010.

The campaign was developed with public dollars and materials are available for public use. For more information about the campaign, or to request sample materials, contact Amy Peterson at 313-456-4425, or petersonam@michigan.gov.

The Section coordinated an intra-departmental Health Disparities Reduction Workgroup (Attachment B). 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 bureaus. The HDRMH Section Manager served as the Chair.

In addition to the HDRMH Section, the Department's bureaus had established other structural elements to address health disparities. These elements were categorized into three strategic areas: capacity; policy; and programs/services.

Structural elements related to capacity included data; staffing and training; partnerships and coalitions; and evaluation.

Policies related to addressing health disparities included federal/state laws and department rules/regulations. In addition to formal policies, there were informal policies such as integrating program goals and objectives to address health disparities into state strategic plans, and using science to guide programs and services.

The bureaus funded and implemented *numerous programs, services*, and *communication mechanisms* specifically designed to address health disparities. Collectively, survey respondents identified 50 programs and services implemented in 2009. Examples of all of these structural elements were provided throughout this report.

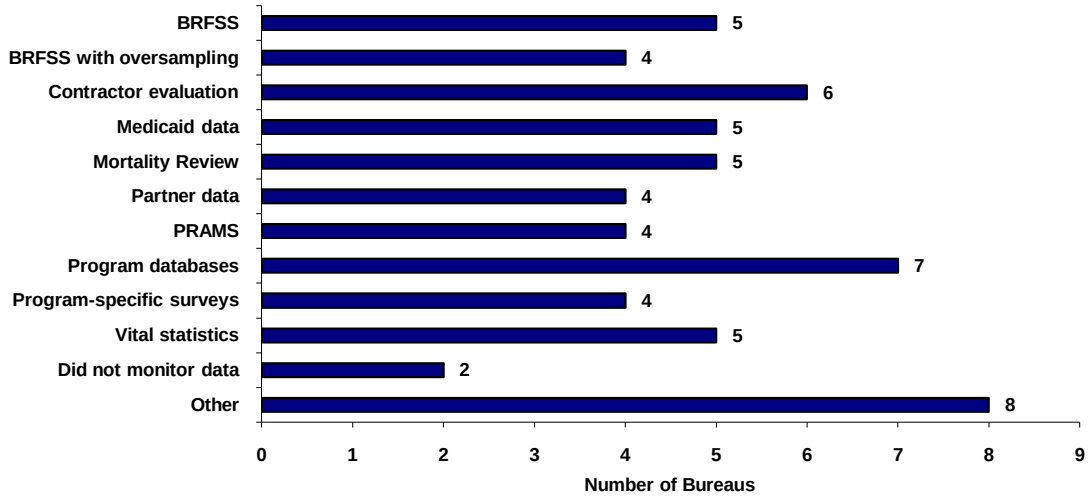
Monitor Health Progress

MDCH tracked and monitored health disparities progress through several ways. At the state level, data for health, disease, and social determinants of health were collected, analyzed, or used. In addition to providing statewide data, data were available for racial and ethnic populations. These data were collected over time, allowing for trend analyses.

- 67% (8) of respondents reported implementing surveillance, data collection, and monitoring activities to address health disparities.
- 67% (8) identified at least one data source their bureau used to monitor health disparities.

Respondents used data for several purposes. They used prevalence, incidence, mortality, morbidity, access to services, and utilization data to identify and monitor racial and ethnic disparities trends. They used data to identify populations at highest risk or need and to plan interventions. Data were collected to monitor performance of funded programs, contractors, and state programs, including achieving goals and objectives and improving health outcomes. 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.

Data Sources used in 2009 to Monitor Health Disparities



Spotlight

Health Disparities Trends

HIV/AIDS continued to disproportionately affect African Americans in Michigan. African Americans made up 14 percent of the state's population, but accounted for nearly 60 percent of all new HIV/AIDS cases, with a rate over ten times higher than that among whites (37.6 vs. 3.5 cases per 100,000). While the rate among white males decreased, there was a significant increase in the rate of new diagnoses among black males.

Following the national trend, the rate of new diagnoses among 13 to 19 year olds in Michigan more than doubled between 2003 and 2007 (from 3.2 to 7.3 cases per 100,000); 85 percent of these new diagnoses were African American and almost two thirds (62%) were African American males having sex with males (MSM).

MDCH continued to focus its prevention resources on communities that HIV and AIDS had the greatest impact. In 2008, 40% of all the HIV tests performed in public sites were for individuals under age 25, and almost 1 out of 4 (24%) individuals receiving health education/risk reduction services were African American MSM.

MDCH also received funding to link persons with HIV/AIDS to essential medical services and the AIDS Drug Assistance Program. This program, *Youth Link*, focused on provision of outreach efforts targeting African American youth living with HIV/AIDS in Detroit. In the latest grant year, 27 HIV positive African American youth were linked to care and treatment services.

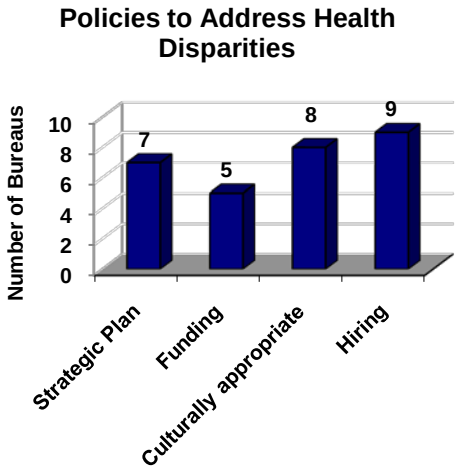
"Other" data sources identified by the respondents included: Michigan Inpatient Database, Healthcare Effectiveness Data and Information Set (HEDIS), Michigan Cancer Registry, National Health and Nutrition Examination Survey (NHANES), CDC, CDC-SEALS (dental sealants), Birth Defects Registry, and Children's Special Health Care Services.

Bureaus monitored health progress by establishing program goals and objectives, identifying health indicators, and determining long, intermediate, and short term outcomes. Progress toward achieving these were usually monitored annually, with long term progress measured through three to five year goals. Of the 12 responding bureaus, seven (58%) indicated that they had evaluated progress toward achieving their health disparities goals and objectives during 2009.

Establish Minority Health Policy

The MDCH followed all federal and state policies and regulations related to minority health. In 2009, the bureaus reported program policies focusing on racial and ethnic health disparities that included:

- Strategic plans, frameworks, or objectives.
- Funding to programs and services to serve racial and ethnic minority populations.
- Developing awareness and educational material using culturally and linguistically appropriate language.
- Minority employee recruitment and retention strategies.



Bureaus that had health disparities-related strategic plans, frameworks, or objectives generally integrated them into state strategic or program work plans. Bureaus reported having services, materials, and forms regularly reviewed for cultural appropriateness and translated materials into several languages, e.g., Spanish, Arabic, and Chinese. Minority employee recruitment and retention strategies included following EEO regulations and department hiring policies, maintaining an existing diverse workforce, using specific recruitment strategies, and training managers and staff.

Develop and implement an effective statewide strategic plan for the reduction of racial and ethnic health disparities.

In November 2006, the HDRMH Section and its partners created Michigan's *Strategic Framework for Racial and Ethnic Health Disparities Reduction.* This framework defined the Department's vision priorities and goals. In 2009, the HDRMH Section began a planning process to develop a health equity plan for Michigan as described on page 17. In addition to having state strategic framework and plan, 58% (7) of the bureaus reported integrating health disparities objectives into their strategic plans. Several respondents noted integrating health disparities reduction objectives into their program work plans and logic models.

Strategic Framework for Racial and Ethnic Health Disparities Reduction Goals

- Reduce racial and ethnic health disparities across the state.
- Consumers, stakeholders (both public and private) and policy-makers will be involved in policy design, implementation and evaluation.
- Design, coordinate and integrate data systems to provide more robust state and local public health data to better serve the public.
- Develop and implement improved policies and procedures for accountability and continuous quality improvement.
- Recruit and hire a highly qualified and diverse workforce.
- Develop and implement a plan for recruitment, training, retention and succession of our state and local public health workforce.
- Develop and implement an internal and external communication plan.
- Develop and implement innovative strategies for informing policy-makers on public health issues and accomplishments.
- Preserve and enhance state funding for public health priorities.

Utilize Federal, State, and Private Resources to Fund Minority Health Programs, Research, and Other Initiatives

Using a combination of federal, state, and private resources, MDCH funded programs to reduce racial and ethnic health disparities. These included affordable, acceptable, and appropriate health promotion, disease prevention, and early detection services.

Funding

Of the responding bureaus, 67% (8) reported *receiving* funding to address health disparities or minority health. Among these 8 bureaus:

- 88% (7) received federal funds;
- 63% (5) received state funds; and
- 13% (1) received foundation funds.

Five (42%) of the bureaus reported they *provided* funding for health disparities reduction or minority health activities, programs or services. Among the seven bureaus that had worked with local health departments, minority health coalitions, or community organizations in 2009, 71% (5) reported providing funding to these local entities for programs or services related to health disparities reduction.

Populations Served

MDCH reported more than 2.05 million people received health disparities reduction program services in 2009. This figure represents a duplicated count; that is, the same individual may have received services from more than one program. This figure is an under-representation of the actual number served, as it was not possible for all bureaus to collect and report these data. The number of people served (duplicated count) in 2009 from the primary racial and ethnic minority populations in Michigan were:

- **African American: 1,255,094**
- **Hispanic/Latino: 260,029**
- **American Indian/Alaska Native: 48,747**
- **Asian American: 130,954**
- **Arab American/Chaldean: 269,491**
- **Other: 83,693.**

Services or Programs

In total, the bureaus provided data for **50 different programs or services** designed to reduce health disparities. *Examples* were:

- Asthma Case Management - Bureau of Local Health and Administrative Services
- Birth Defect follow up - Bureau of Epidemiology

- Check Up or Check Out Program - Division of Health, Wellness and Disease Control
- Dental Sealants programs - Bureau of Family, Maternal and Child Health and Division of Health, Wellness and Disease Control
- Faith, Knowledge and Action = Health program - Bureau of Local Health and Administrative Services
- Genomics education - Bureau of Epidemiology
- Gonorrhea and Chlamydia screening - Bureau of Laboratories and Division of Health, Wellness and Disease Control
- Health Promotion for People with Disabilities - Bureau of Local Health and Administrative Services
- Healthy Asian American Project - Division of Health, Wellness and Disease Control
- Healthy Together Support Groups: Hypertension education and management for seniors - Division of Health, Wellness and Disease Control
- Lead poisoning prevention - Bureau of Family, Maternal and Child Health
- Health promotion/improved access to health care for migrant families/children - Bureau of Family, Maternal and Child Health
- Meals and nutrition education (congregate and home delivered venues) - Office of Services to the Aging
- Newborn screening Follow up - Bureau of Epidemiology
- Promoting smoke-free housing in locations where Native Americans reside - Bureau of Local Health and Administrative Services
- Reducing Disparities at the Practice Site - Bureau of Medicaid Program Operations & Quality Assurance

Spotlight

Faith, Knowledge and Action = Health Program

The *Faith, Knowledge, Action = Health* Cardiovascular Health Toolkit was developed by the Michigan Public Health Institute Cardiovascular Health (CVH) staff in collaboration with the MDCH CVH, Nutrition and Physical Activity Section. The program focused on a toolkit, training and resources to educate congregations on the following:

1. Increase awareness of signs and symptoms of heart attack and stroke.
2. Prepare leadership and individuals for cardiovascular emergencies by increasing the number of congregation members who are CPR/AED trained and have an emergency plan established.
3. Encourage congregation members to discuss the possible cardio-protective effects of low-dose aspirin and the benefits of risk factor management.

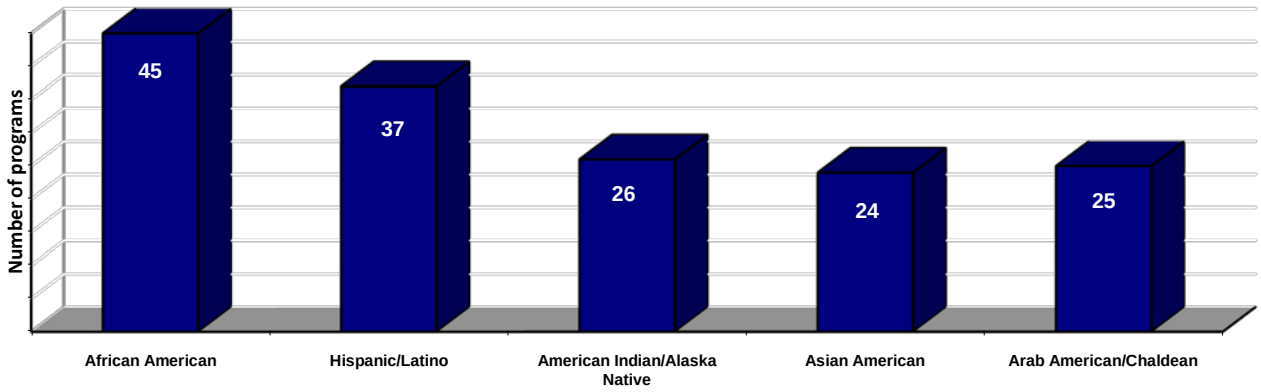
This 8-week program was disseminated to more than 150 churches with a focus on African American congregations. Since 2006 over 80,000 congregation members were impacted.

- There were 115 AEDS placed in the churches and over 600 congregation members were trained in CPR and AED use
- Survey results showed an overall increase in knowledge of signs and symptoms of heart attack and stroke
- There was a 17% increase in level of understanding of importance of calling 911 in the event of a heart attack or stroke
- Nine percent of participants reported talking with their healthcare provider about the possible cardio protective effects of low dose aspirin as a result of participating in this program.

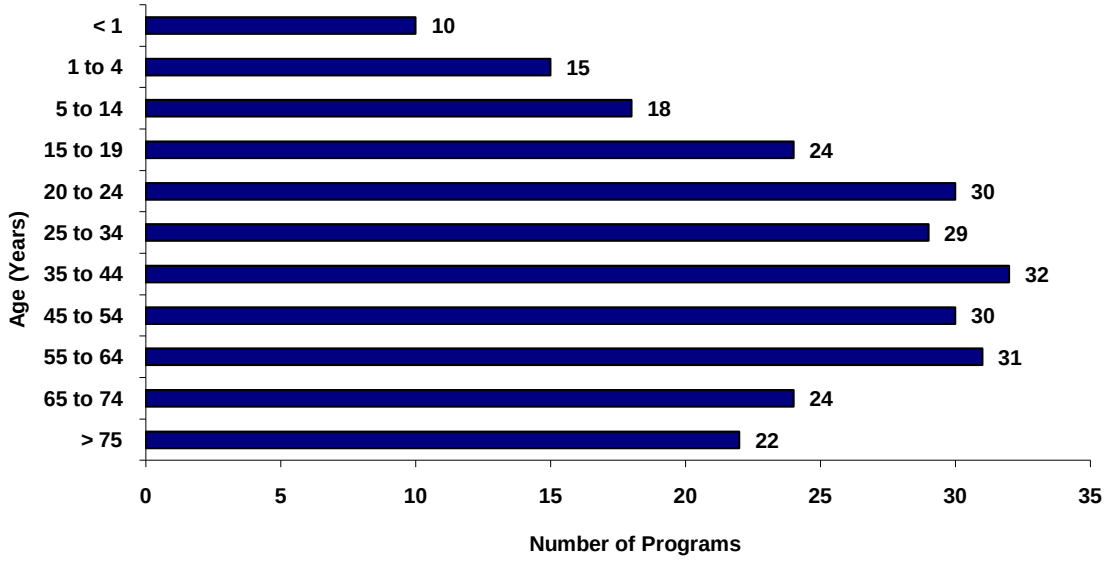
- SPLASH school nutrition and physical activity program - Bureau of Local Health and Administrative Services
- Unintended pregnancy prevention - Bureau of Family, Maternal and Child Health
- Youth Link - Division of Health, Wellness and Disease Control

Most of the programs served females and males, with 94% (47) serving females and 84% (42) serving males. Other demographic characteristics of the populations served follow.

Populations Served: Race/Ethnicity, 2009



Populations Served: Age, 2009



One-half (25) of the programs were offered statewide. Of the 25 programs not offered statewide:

- Six were offered in Southeast Michigan.
- Three were offered in Northeast Michigan.
- Three were offered in Northwest Michigan.
- Three were offered in Southwest Michigan.
- Three were offered in the Upper Peninsula.

Specific counties served included those with significant racial and ethnic minority populations, e.g., Wayne (6), Washtenaw (4), Berrien (3), Genesee (3), Kalamazoo (3), Kent (3), Muskegon (3), and Oakland. Some of the specific cities served included: Detroit (12), Grand Rapids (2), Pontiac (2), Dearborn (1), Highland Park (1), and Saginaw (1). Some programs were offered in more than one region, county and/or city.

Provide the following through interdepartmental coordination:

- **Data and technical assistance to minority health coalitions and any other local entities addressing the elimination of racial and ethnic health disparities**
- **Measurable objectives to minority health coalitions and any other local health entities for the development of interventions that address the elimination of racial and ethnic health disparities.**

Spotlight

Fact Sheets

In 2009 the Health Disparities Reduction and Minority Health (HDRMH) section created a series of racial and ethnic fact sheets or "snapshots". These informational one-pagers focused on the major health issues for each racial and ethnic population group the Section serves: African American, American Indian/Alaska Native, Arab American, Asian American and Hispanic/Latino. Each sheet includes data about the social factors (determinants) that affect health, including information on median salary, health insurance coverage, home ownership rates, and residential segregation. These indicators were chosen because of their impact on individual and neighborhood health. Each "snapshot" was developed for a specific racial/ethnic group and designed to meet the information needs of that specific audience, as identified through focus group input and key stakeholder interviews. The goal was to create brief, easy-to-read and relevant informational pieces that would: 1) raise awareness around the State about the most serious health issues affecting each group, and 2) be used by community groups and others for planning and advocacy. (See Attachment C)

Bureaus that had worked with local health departments, minority health coalitions, or community organizations provided data on related activities. Of the 12 bureaus responding to the survey, 7 or 58% had worked with these local entities in the following capacities:

- Developed evidence-based interventions: 42% (5)
- Provided data: 58% (7)
- Provided technical assistance on program design and implementation, materials development, etc.: 50% (6)
- Funded programs and services: 42% (5)
- Provided training on cultural competency and related topics: 33% (4)
- Assisted with capacity development in strategic planning, fund development, grant writing, etc.: 42% (5).

Establish a web page on the department's website, in coordination with the state health disparities reduction and minority health section that provides information or links to all of the following:

- **Research within minority populations**
- **A resource directory that can be distributed to local organizations interested in minority health**
- **Racial and ethnic specific data, including but not limited to, morbidity and mortality.**

The HDRMH Section website was found at http://www.michigan.gov/mdch/0,1607,7-132-2940_2955_2985---,00.html. This web page provided access and linkage to the Section's vision, mission, and strategic framework. A PowerPoint presentation, African American fact sheet, and *Color Me Healthy: A Profile of Michigan's Racial/Ethnic Populations* (May 2008) report highlighted the health of racial and ethnic minority populations in Michigan and documented related health disparities.

Links to events and funded agencies provided information on local organizations involved and interested in minority health. A summary of agencies funded by the HDRMH Section was featured on the website, as was a map depicting the service area for their programs. A link to Michigan's Minority Health Bill – Public Act 653 of 2006 and the 2007 and 2008 reports to the legislature were also posted on the website. Information on research was available through the link to the federal Office of Minority Health. In addition to this website, additional information on Michigan's health disparities, 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.

Develop and implement recruitment and retention strategies to increase the number of minorities in the health and social services professions.

> "We are a motivated, dedicated, diverse team that values each individual. We establish and maintain strong collaborative relationships with all our partners."
>
> Bureau of Laboratories

In 2009, MDCH was committed to recruit and retain a qualified and diverse public health workforce. Of the 12 responding bureaus, 9 (75%) had implemented specific activities to recruit and retain minority employees. Strategies noted included: following Equal Employment Opportunity, Civil Service and department hiring practices. Others noted using recruitment strategies to actively seek qualified employees representing minority populations. Some bureaus noted that their workforce was already diverse.

In addition, the MDCH Workforce Transformation Unit increased activity through participation in numerous career fairs in Michigan, including fairs targeted to the areas of diversity and health care professions. The Diversity Workgroup established a subgroup, charged with looking at recruitment and selection practices at MDCH, with a focus on increasing our diversity recruitment efforts.

Develop and implement awareness strategies targeted at health and social service providers in an effort to eliminate the occurrence of racial and ethnic health disparities.

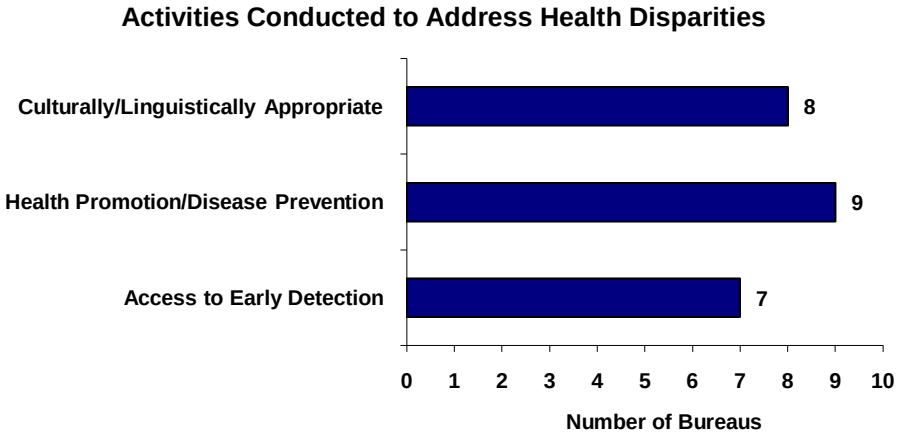
Bureaus worked to develop and implement awareness strategies targeted at health and social service providers at the state and local level. As previously noted, 42% (5) of the bureaus assisted with capacity development in strategic planning, fund development, grant writing, and other areas; 42% (5) helped them to develop evidence-based interventions; and 33% (4) providing training on cultural competency and related topics. The Bureau of Local Health and Administrative Services, Cardiovascular Health, Nutrition, and Physical Activity Section provided training to more than 200 faith-based organizations to build their organizational capacity. The Office of Services to the Aging worked with local public health departments, coalitions, and community-based organizations to provide training, data, and capacity building. The Bureau of Family, Maternal and Child Health's Reproductive Unit provided training on cultural sensitivity to service providers that provided family planning contraceptive services.

Social determinants of health refer to social, economic, and environmental factors that contribute to the overall health of individuals and communities. *Social factors* include racial and ethnic discrimination; political influence; and social connectedness. *Economic factors* include income, education, employment, and wealth. *Environmental factors* include living and working conditions, transportation, and air and water quality. A focus on health equity calls for more targeted efforts to address these social determinants of health in order to optimize health promotion and disease prevention efforts.

In addition to reaching providers external to the department, nine of the 12 (75%) reported providing or offering cultural competency training to their staff. Four of the nine (44%) noted offering this type of training on an annual basis. Following up from 2008, some bureaus continued to view the PBS documentary *"Unnatural Causes: Is Inequality Making Us Sick?* to increase awareness of the social determinants of health and their impact on health disparities. The Tobacco Section, for example, viewed and had discussions about the documentary. As follow-up, this section is participating in further activities to discuss and increase understanding about the Social Determinants of Health, Social Justice and Health Equity by participating in four-day long sessions facilitated by Ingham County Health Department.

Identify and assist in the implementation of culturally and linguistically appropriate health promotion and disease prevention programs that would emphasize prevention and incorporate an accessible, affordable, and acceptable early detection and intervention component.

MDCH and its bureaus utilized a variety of strategies to identify and assist implementing culturally and linguistically appropriate health promotion and disease prevention services. Many of these were described throughout this report and examples provided. The following examples supplement other illustrations noted in this report.



Culturally and Linguistically Appropriate Services

- The Tobacco Control Program provided technical assistance to coalitions and communities of color agencies to ensure that programs were population specific and culturally appropriate.
- The HIV-AIDS Prevention and Intervention Section integrated "Culturally and Linguistically Appropriate Services" (CLAS) standards into provider contracts and offered related training.
- The Michigan Asthma Program engaged Detroit-based asthma and public health leaders at the Detroit Asthma Mortality Summit to discuss health disparities relating to asthma and develop action plans on how these disparities can be addressed.
- Many bureaus translated educational and other materials into languages other than English, including Arabic, Chinese, and Spanish.

Health Promotion/Disease Prevention Services

- The Michigan Arthritis Program implemented PATH (Stanford Chronic Disease Self-Management Program) in the African American, Arab American/Chaldean, Asian American, Hispanic, and American Indian/Alaska Native communities.
- The Michigan Multicultural Tobacco Prevention Network members were funded to provide preventive and educational services within the ethnic population they represent.

Access to Early Detection Services

- The Early Hearing Detection and Intervention (EHDI) program improved the rate of infants and children who received follow-up diagnostic testing and early intervention services, specifically in the City of Detroit and Wayne County
- Osteoporosis screening and referral services were provided to high risk, underserved individuals at federally qualified health clinics in Calhoun, Kent, and Kalamazoo counties.
- HIV tests were given in publicly supported sites; of the 70,000 tests provided in 2009, 57% percent of clients tested were African American and 5% were Hispanic/ Latino.

Spotlight

Early Detection: Chlamydia and Gonorrhea

Chlamydia (CT) and gonorrhea (GC) are the two most commonly reported communicable diseases in Michigan; in 2009, a total of 59,536 combined cases were diagnosed. In 2008, the MDCH Sexually Transmitted Diseases (STD) Program was awarded State funding of $750,000 annually for 2009-2013 to implement the Gonorrhea/Chlamydia Reduction Plan. The goal of the plan was to decrease the overall prevalence of GC and CT by identifying and treating infected individuals at a faster rate than new infections occur. The Plan included eight components:

1. Increase school-based screening
2. Implement universal screening of males in local health department STD clinics
3. Increase private sector screening
4. Support alternative site high-risk screening, targeting individuals ages 15 - 24
5. Implement CDC re-testing guideline
6. Utilize electronic medium to notify partners
7. Encourage field-delivered therapy for identified cases
8. Improve partner management in public and private sector.

Due to national and state economic challenges, the 2009 award was reduced to $570,000 and funding for future years was eliminated. Although funding only lasted one year, the initiatives had impact. More than 10,000 CT and GC tests were conducted, identifying 1,076 cases of Chlamydia and 415 cases of Gonorrhea. These cases would have gone undetected as most were asymptomatic.

To be most effective, the Plan focused on identifying and treating infection in the highest risk populations. Among the populations most impacted by these diseases are adolescents and young adults and Black non-Hispanics. The latter had rates of CT nine times greater than their white counterparts, and GC rates over 25 times that of whites. As part of the GC/CT Reduction Plan, the STD Program released a request for proposals to fund programs serving those at highest risk and in areas of Michigan with the highest GC and CT rates. Programs proposing to serve a cohort with at least 50% Black non-Hispanic received bonus points in the scoring of applications.

Six programs were funded to screen high-risk Black non-Hispanics 15-24 years of age outside of traditional clinical settings. Successful applicants included a juvenile detention facility, HIV outreach testing provider, urban university setting, and three local health departments. Contracts began April 1, 2009 and ended September 30, 2009 due to loss of funding. **Combined, the grantees conducted 1,914 CT and GC tests over the nine-month period, identifying 167 cases of CT and 48 cases of GC. Nearly 90% of those tested and treated were African American, and positivity rates for both infections exceeded the statewide average for publicly-supported tests.** These high rates of infection reflect how well the services were targeted to those who would most benefit.

Promote the development and networking of minority health coalitions

Of the 12 bureaus, five (42%) provided support to local agencies, including minority health coalitions. Efforts to promote the development and networking of these coalitions were previously described.

Appoint a department liaison to provide the following services to local minority health coalitions:

- **Assist in the development of local prevention and intervention plans**
- **Relay the concerns of local minority health coalitions to the department**
- **Assist in coordinating minority input on state health policies and programs**
- **Serve as the link between the Department and local efforts to eliminate racial and ethnic health disparities.**

Spotlight

Community Conversations

In the summer of 2009 the MDCH Health Disparities Reduction and Minority Health Section sponsored 22 community conversations throughout Michigan. Local organizations and public health agencies served as host agencies for these events. The community conversations engaged residents, agency staff and others in dialogue about issues affecting the health status of Michigan's racial and ethnic populations. Participants were asked about health concerns and conditions that impact the health of their community. Other discussion items included community assets and needs, ways to engage other partners and recommendations for policy and practice changes that would most effectively improve the health of their community. The information is being used to develop the HDRMH report – *A Roadmap To Achieving Health Equity in Michigan*. Members of the five racial and ethnic populations served by the HDRMH (African American, American Indian/Native American, Arab American/Chaldean, Asian American and Hispanic/Latino) were recruited as participants. Conversation facilitators were selected for their experience and competence in working with the one or more of the five population groups. Conversations were held in the following Michigan Counties: Chippewa, Genesee, Ingham, Kent, Muskegon, Oakland, Saginaw, Washtenaw and Wayne including Detroit. A total of 505 persons participated in the community conversations.

As previously noted, 42% (5) of bureau respondents worked to build capacity among local minority health coalitions and other local entities. This assistance included helping them to develop local plans. Many more bureaus (9 or 75%) had mechanisms in place to solicit input and feedback from the populations they served.

Feedback was sought through a variety of mechanisms; client and other types of surveys, and focus groups were the most frequently noted. Other ways the bureaus sought feedback were through consumers and stakeholders involved with advisory committees and planning groups; one-on-one contact between the client and the service provider; and site visits.

Consumer feedback was used in a variety of ways. Many used the information to improve their program's performance and delivery. Others used it to identify barriers, develop materials, and tailor technical assistance provided. In some instances, the feedback was integrated into the development of the state strategic plan.

Provide funding, within the limits of appropriations, to support evidence-based preventative health, education, and treatment programs that include outcomes measures and evaluation plans in minority communities.

Information on bureaus providing funding for programs and services was previously noted in the report.

Provide technical assistance to local communities to obtain funding for the development and implementation of health care delivery system to meet the needs, gaps and barriers identified in the statewide strategic plan for eliminating racial and ethnic health disparities.

Bureaus provided technical assistance and capacity building support to local communities related to obtaining funding, with seven bureaus (58%) providing data and technical assistance; and five bureaus (42%) assisting with capacity development in strategic planning, fund development, grant writing, and other areas.

Next Steps: How did we do and what's next?

The MDCH identified four minority health priority areas for 2009. They included: to review and revise the Strategic Framework for Racial and Ethnic Health Disparities Reduction; to work toward improving race/ethnicity data collection; to enhance efforts to partner with local health departments, local and statewide organizations and others to eliminate health disparities; and, to improve documentation of effective health disparities programs.

Strategic Framework

In June 2009 the HDRMH Section began work to develop a white paper – *A Roadmap to Achieving Health Equity in Michigan* - detailing priority issues and strategies for eliminating health disparities. This process and the resulting document will describe the current state of minority health in Michigan; present a public health and economic case for health equity; include broad community input on racial and ethnic minority health issues and on strategies to improve health; discuss current data and program best practices; and, present priority recommendations for achieving health equity in Michigan. *A Roadmap to Achieving Health Equity in Michigan* will be available early in 2010.

Race and Ethnic Data Collection

Another priority was to improve race and ethnicity data collection among MDCH programs, a critical element to understanding the extent of racial and ethnic health disparities. Progress on this priority was not fully realized in 2009.

The HDRMH Section's work on the white paper prompted an additional data-related priority – development of a health equity data set. In addition to health status measures, this data set will track individual (behavior) and community (social determinants) level indictors associated with health status such as: household income, educational attainment, residential segregation, air quality, tobacco use, homicide rates, etc. Taken together the health equity data set will provide a more comprehensive picture of how these various factors work together to influence health and, of how MDCH might better target public health and other resources to address health disparities in Michigan.

The HDRMH Section and the MDCH Health Disparities Workgroup are finalizing the MDCH health equity data set. The goal is to compile the data and publish the findings annually.

Enhance efforts to partner with local health departments, local and statewide organizations and others to eliminate health disparities

The Health Disparities and Minority Health Section collaborated with local health departments, the Michigan Intertribal Council and community-based agencies to host 22 community conversations throughout the state as part of the MDCH effort to solicit input on improving the health status of Michigan's racial and ethnic populations.

The HDRMH Section hosted a Health Equity Summit in September 2009. Participants included staff from state and local public health departments, universities, legislative offices, community- and faith-based organizations, statewide coalitions, as well as individual community members. The Summit was organized as strategic conversations on how local communities, local public health, state public health, and business can most effectively respond to eliminating health disparities. The information was used to develop the recommendations and strategies included in the HDRMH white paper - *A Roadmap to Achieving Health Equity in Michigan.*

Improve documentation of effective programs

Based on health disparities best practice research and key stakeholder and community input during the 2009 planning process, the MDCH, HDRMH Section will re-focus its program funding priorities. For 2010, HDRMH funding will support efforts to increase and/or enhance the capacity of communities to achieve health equity/eliminate health disparities, particularly as related to addressing the social determinants of health. The new requests for proposals will be issued in the spring of 2010.

2010 Minority Health Related Activities and Timeline

PA 653 Report to the Legislature	January 2010
Health Equity Data Set	February 2010
MDCH/HDRMH White Paper *A Roadmap to Achieving Health Equity In Michigan*	February 2010
HDRMH Michigan Minority Health Mini Grants Requests for Proposals Issued	March 2010
HDRMH Local Public Health and Community Organization Health Equity Capacity Building Grants – Phase I	April 2010
Requests for Proposals Issued Minority Health Statewide Events	March – May 2010
Statewide Capacity Building Grant Implementation - Phase I	May – December 2010
MDCH-Health Disparities and Minority Health Section – 2010 Health Disparities Conference	November 2010

Conclusion

In 2007, the MDCH conducted its first annual survey to assess and track its progress in reducing racial and ethnic health disparities in Michigan. Reports from 2007 and 2008 were given to the Michigan Legislature and posted on the MDCH Health Disparities Reduction and Minority Health Section's website. Building on information gleaned from that assessment, the MDCH recently executed the 2009 MDCH Health Disparities survey. This survey captured the Department's work to address racial and ethnic health disparities in calendar year 2009.

MDCH bureau accomplishments and assets to address health disparities were presented throughout this report. For example, the Department implemented 50 services to address health disparities in 2009, reaching at least 2.05 million participants. In some cases, these services were offered statewide; in other cases, they were targeted to reach specific areas, especially Southeast Michigan and the city of Detroit. MDCH looked inward at ways to reduce health disparities through tracking and using surveillance data, setting goals and objectives and integrating these into state strategic plans, focusing funding on programs to address health disparities, training employees on cultural competency, and establishing minority employee recruitment and retention strategies. MDCH expanded its efforts through its work with local health departments, minority health coalitions, and community organizations.

While much was accomplished in 2009, the MDCH has an opportunity to improve its efforts to reduce health disparities experienced by Michigan's minority populations. The Department remains committed to increasing the scope, impact, and effectiveness of its work as outlined in House Bill 4455 – PA 653. It will continue to work toward institutionalizing health equity policies within bureaus; integrating health equity goals and objectives into all bureau strategic plans; expanding hiring practices to facilitate workforce diversity; providing and promoting evidence-based and culturally/linguistically appropriate programs and services; and enhancing opportunities to build community partnerships to reduce health disparities among minority populations. This work and related progress to address health disparities remain within the confines of available funding. Where resources are not available, the Department will explore new and innovative sources of funding and other ways to support Departmental efforts to address health disparities reduction.

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

Martin Luther King, Jr.

Attachment A

2009 Health Disparities Reduction Survey Respondents by MDCH Administration

Bureau	Division	Section	Unit	Other (please specify)
BUREAU OF ORGANIZATIONAL SUPPORT AND SERVICES*				
HEALTH POLICY, REGULATION, AND PROFESIONAL ADMINISTRATION				
Health Professions*				
MEDICAL SERVICES ADMINISTRATION				
Medicaid Program Operations and Quality Assurance*				
MENTAL HEALTH AND SUBSTANCE ABUSE ADMINISTRATION				
Bureau of Administration*				
Bureau of Hospital & Center, and Forensic Mental Health Services*				
Bureau of Community Mental Health Services*				
	Division of Program Development, Consultation and Contracts			
	Division of Quality Management and Planning			
	Mental Health Services to Children and Families			
OFFICE OF SERVICES TO THE AGING*				
PUBLIC HEALTH ADMINISTRATION				
Bureau of Epidemiology*				
	Genomics, Perinatal Health and Chronic Disease Epidemiology			
	Vital Records and Health Statistics			
Bureau of Family, Maternal and Child Health*				
	WIC			
	Family and Community Health	Administration		
	Family and Community Health	Women, Infant, and Family	Infant Health	

Bureau	Division	Section	Unit	Other (please specify)
	Family and Community Health	Women, Infant, and Family	Reproductive Health	
	Family and Community Health	Child & Adolescent Health	Adolescent and School Health	
	Family and Community Health	Child & Adolescent Health	Child Health	
Bureau of Laboratories*				
Bureau of Local Services and Administration	Division of Health, Wellness and Disease Control*			
	Health, Wellness and Disease Control	HIV-AIDS Prevention and Intervention	Continuum of Care	
	Health, Wellness and Disease Control	HIV-AIDS Prevention and Intervention	Community Partnerships	
	Health, Wellness and Disease Control	Sexually Transmitted Diseases		
	Health, Wellness and Disease Control	Health Disparities Reduction & Minority Health		
Bureau of Local Health and Administrative Services*				
	Chronic Disease and Injury Control	Administration		
	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			

*"Bureau-level" categorization used for data analysis
One respondent – Public Health Administration, unknown Bureau, not included in this table

Attachment B

Michigan Department of Community Health
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
Audrea Woodruff		Health, Wellness & Disease Control Sexually Transmitted Diseases
Betsy Pash	Local Health & Administrative Services	
Brenda Fink	Family, Maternal & Child Health	Family and Community Health
Carlton Evans	Laboratories	Infection Disease Division B & P Serology Unit
Carol Callaghan	Local Health and Administrative Services	Chronic Disease & Injury Control
Corey Ridings	Epidemiology	Health, Wellness & Disease Control
Damita Zweiback	Local Health and Administrative Services	Chronic Disease & Injury Control Cardiovascular Health, Nutrition
Daniel Diepenhorst	Local Health and Administrative Services	Chronic Disease & Injury Control Diabetes & Kidney Unit
Debra Duquette	Epidemiology	Genomics & Genetic Disorders
Debra Szwejda		Health, Wellness & Disease Control HIV/AIDS Prevention/Intervention
Fawzia Ahmed	Epidemiology	Vital Records & Health Statistics Health Data Analysis Services
Frances Pouch Downes	Laboratories	
Gregory Holzman	Medical Director	
Henry Miller	Local Health and Administrative Services	Chronic Disease & Injury Control Heart Disease & Stroke Prevention
Jacquetta Hinton		Health, Wellness & Disease Control Health Disparities Reduction
Janet Kiley	Local Health and Administrative Services	Chronic Disease & Injury Control Tobacco Prevention & Control
Jean Chabut	Public Health Administration	
Jennifer Edsell	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
Karla McCandless	Family, Maternal & Child Health	Children's Special Health Care Service; Plan Management & Program Development

Name	Bureau	Division/Section/Unit
Kathleen A. Stiffler	Family, Maternal & Child Health	Children's Special Health Care Services
Kim Walsh	Local Health and Administrative Services	Chronic Disease & Injury Control Diabetes & Other Chronic Diseases
Kimberly Snell		Health, Wellness & Disease Control HIV/AIDS Prevention/Intervention
Kimberlydawn Wisdom	Surgeon General	
Konrad Edwards	Local Health and Administrative Services	Local Health Services
Patricia Blake-Smith	Local Health and Administrative Services	Chronic Disease & Injury Control Injury & Violence Prevention
Patrick Jackson		Health, Wellness & Disease Control Health Disparities Reduction
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
Rhonda Bantsimba		Health, Wellness & Disease Control HIV/AIDS Prevention/Intervention
Robert Cochran		Health, Wellness & Disease Control STD
Rosalyn Beene-Harris	Local Health and Administrative Services	Chronic Disease & Injury Control Cancer Prevention and Control
Rose Mary Asman	Family, Maternal and Child Health	Family and Community Health
Sheila Embry	Medicaid Operations & Quality Assurance	Quality Improvement & Program Development
Sheryl Weir		Health, Wellness & Disease Control Health Disparities Reduction
Shronda Grigsby		Health, Wellness & Disease Control Health Disparities 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
Viki Lorraine	Local Health and Administrative Services	Chronic Disease & Injury Control Breast/Cervical Cancer

Attachment C

Michigan Department of Community Health

Health Disparities Fact Sheets 2009

http://www.michigan.gov/mdch/0,1607,7-132-2940_2955_2985---,00.html

2009

Michigan Health Disparities Dashboard: Burden of Disease

Michigan Department of Community Health
Department of Health, Wellness and Disease Control
Health Disparities Reduction/Minority Health Section

What are Health Disparities and how are they measured?

Health disparities are differences in health status that exist between populations. Racial and ethnic health disparities refer to differences that are seen between different racial and ethnic groups, such as higher rates of diabetes in American Indians than in Whites, or lower cancer rates in Asian Americans than in African Americans. Health disparities are usually presented by comparing rates for a certain disease between two or more groups. Rates, usually age-adjusted rates, are used because they take into account the number of individuals in a group and the average age differences that may exist between groups. By using age-adjusted rates, we are able to better compare the effects of sickness and death across groups. It is important to remember that health disparities are the *what*, not the *why* of health. For example, having asthma does not explain why a person has asthma. The *why* has to do with different factors including genetics, personal lifestyle choices, and the social determinants of health. The social determinants of health, which are estimated to account for 70-80% of the why, are factors that influence an individual's health but are not biological; they are related to the social, economic, and environmental situation that a person lives their life in.

Why should I care?

Data in Michigan show that there are wide differences in disease across racial and ethnic groups—leading to increased death and sickness among certain groups. These differences are preventable, and thus raise a flag to policy makers, clinicians, and the public that action can be taken to save and improve lives across the state. Health disparities don't just affect communities of color, they affect everyone in Michigan. The economic cost to the state from health disparities is in the millions, and the health care system as a whole becomes less efficient and more costly when groups systematically experience unequal burdens.

Who is Health Disparities Reduction/Minority Health (HDR/MH)?

The HDR/MH section at MDCH seeks to provide a persistent and meaningful effort to eliminate health disparities in Michigan by working with communities/stakeholders and the State of Michigan to address the social determinants of health through effective programming, equitable and compassionate policymaking, and supporting community health groups through data and expertise. This burden of disease dashboard illustrates the difference in illness and death between populations in Michigan, focusing on the diseases that have been identified by public health practitioners and communities as being the most harmful to communities of color. Please see other publications from the HDR/MH section for more about the social determinants of health, or for more information about your racial/ethnic group or neighborhood.

What does it mean?

Overall Mortality Rate: This measure examines the differences in death from all causes, singularly showing the difference across populations. Note: Mortality rates are nearly always measured as the number of deaths per 100,000 people. For example, if 450 people in a town that had 200,000 residents died in one year from disease X, then the disease X mortality rate would be 225.

Infant Mortality Rate: This measure examines infant death, an indicator that is accepted world-wide as in marker of community health because of its multi-factor causation. It is the number of deaths per 1,000 live births.

Cardio Vascular Disease (CVD): Heart Disease Prevalence: The estimated percentage of people that have been told they have an angina or coronary heart disease.

*CVD: Heart Disease Mortality Rate***:** The rate of all deaths from heart disease.

CVD: Stroke Prevalence: The estimated percentage of people that have been told by a medical professional that they have had a stroke.

CVD: Stroke Morality Rate: The rate of all deaths from stroke

HIV/AIDS Prevalence Rate: This prevalence rate is the number of individuals, out of 100,000, that have HIV/AIDS.

HIV/AIDS Mortality Rate: The rate of deaths from HIV/AIDS

Diabetes Prevalence: The estimated percentage of people that have diabetes

Diabetes Mortality Rate: The rate of death from diabetes

Cancer Incidence: The number of new cases of any type of cancer within one year, averaged from 2001-2005.

Cancer Morality Rate: The rate of death from any type of cancer

*Cancer 5-year Survival***:** The percentage of people who have any type of cancer (excluding some mild forms of skin cancer), and survive for five years following their initial diagnosis. In calculating this, the type of cancer is taken into account.

Violence: Suicide Rate: The rate of death from suicide

Violence: Homicide Rate: The rate of death from homicide

Accidental Death Rate: The rate of death from any type of accident

Asthma Prevalence: The estimated percentage of adults, people 18 years and older, that have asthma

Asthma Morality Rate: The rate of death from asthma, or any death where asthma was determined as the major underlying cause.

Sexually Transmitted Diseases (STDs): Gonorrhea prevalence rate: The rate of reported gonorrhea infection

STDs: Chlamydia prevalence: The rate of reported chlamydia infection

Please note! that prevalence is an estimation—data is taken from a sample of state residents and then used by epidemiologists to create a statewide estimate. Some estimates, while different from each other, may not be statistically different, meaning that they may represent a trend but mathematically are not different from each other, and caution must be used when interpreting and using these numbers.

** Fact: Between 2003-2006 the combined costs of health disparities and premature death in the US was $1.24 trillion*

Michigan 2009

Indicator	Black	Hispanic	AI/AN	Asian	White
Overall mortality rate	1041.7	582.9	877.2	358.1	768.5
Infant mortality rate	16.5	10.3	11.1	5.6	5.8
CVD: Heart Disease					
Prevalence (%)	4.5*	3.1*	6.5*	1.2*	4.7
Mortality rate	313.8	151.4	243.3	98.7	210.2
CVD: Stroke					
Prevalence (%)	4.9	3.4*	5.2*	n/a	2.4
Mortality rate	55.5	34.6	n/a	32.7	40.8
HIV/AIDS					
Prevalence rate	575	159	92	27	67
Mortality rate	8.6	n/a	n/a	n/a	.7
Diabetes					
Prevalence (%)	14.7	12.4	16.5	10.8*	7.3
Mortality rate	38.3	35.3	47.5	n/a	24.5
Cancer					
incidence	544.0	350.5	302.6	253.5	487.0
Mortality rate	230.5	117.5	176.2	86.5	181.4
5-yr survival (%)	53.7	n/a	n/a	n/a	60.7
Violence					
Suicide rate	5.2	5.9	n/a	n/a	11.9
Homicide rate	31.9	5.8	n/a	n/a	2.3
Accidental death rate	37.8	31.8	34.7	13.9	34.5
Asthma					
Prevalence (%)	11.1*	12.6*	12.6*	4.2*	9.0
Mortality rate	28.7	n/a	n/a	n/a	9.7
STDs					
Gonorrhea prev.	480.1	n/a	38.1	8.5	19.6
Chlamydia prev.	904.4	n/a	147.5	61.8	102.8

* this estimate is not statistically different than White

Please see notes and sources

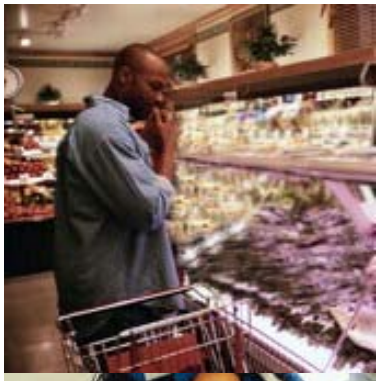
Notes:

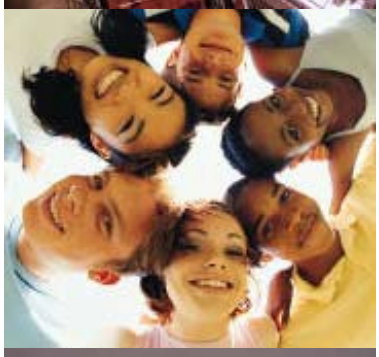
All statistics are recent as possible, although due to different surveillance methods across indicators, may not be from the same year. Missing values (n/a) are a result of small population size or a small number of individuals affected; rates in some cases cannot be calculated. Cancer incidence and mortality rates are inclusive of all cancer types. Asthma prevalence rates are for adults only. All rates are calculated as deaths per age-adjusted 100,000 persons, with the exception of infant deaths which are calculated as deaths per 1,000 live births.

** MI Fact: Michigan's African American infant mortality rate, when compared to all nations in the world, places 81st...just behind Syria and Belize*

Data Sources:

Overall death rate: 07 MI Vital Statistics
(www.michigan.gov/mdch > Statistics and Reports > Vital Statistics)
Infant mortality rate: 07 MI Vital Statistics
CVD Heart Disease prevalence: 06-08 MI BRFSS
(www.michigan.gov/brfs)
CVD Heart Disease mortality rate: 07 MI Vital Statistics
CVD Stroke prevalence: 06-08 MI BRFSS
CVD Stroke mortality rate: 07 MI Vital Statistics
HIV/AIDS prevalence: 08 Michigan HIV/AIDS report
(www.michigan.gov/mdch > Physical Health & Prevention > HIV/STD > Statistics and Reports)
HIV/AIDS mortality rate: 07 MI Vital Statistics
Diabetes prevalence: 06-08 MI BRFSS
Diabetes morality rate: 07 MI Vital Statistics
Cancer incidence: SEER 01-05
(http://statecancerprofiles.cancer.gov/index.html)
Cancer mortality rate: 07 MI Vital Statistics
Violence suicide rate: 07 MI Vital Statistics
Homicide rate: 07 MI Vital Statistics
Accidental death rate: 07 MI Vital Statistics
Asthma prevalence rate: 06-08 MI BRFSS
Asthma mortality rate: 04-06 MI Vital Records





What can I do to make a difference?

Seeing a health care provider regularly and maintaining a healthy lifestyle are two ways to avoid serious illness and catch potentially life-threatening diseases early. Being a community health advocate through involvement such as community gardening, promotion of community safety, or supporting clean air initiatives will improve your health as well as the health of your entire neighborhood.

COLOR ME Healthy

FOR MORE INFORMATION:
www.michigan.gov/mdch
Health Disparities Reduction/Minority Health section: (313) 456.4355
E-mail: colormehealthy@michigan.gov

Special thanks to:
Beth Anderson, Michael Beebe, and Chris Fussman

2009

African American in Michigan: Health Snapshot

Concerns:

Cardiovascular disease and other diet-related illness are major concerns for African Americans in Michigan. **African Americans have a significantly higher prevalence of diabetes, stroke, and obesity** than the State average. Availability of nutritious foods has been identified as a key barrier to better health. African Americans have the highest infant mortality rate and HIV/AIDS rates of any racial/ethnic group in the State; teen pregnancy and STDs are identified as major concerns by African Americans across Michigan. Violence remains the number one cause of death for Black men ages 15-35. **Unemployment, racism, and mistrust of medical and government systems** have also been identified as reasons for lack of access to medical care, and likewise as reasons for increased levels of stress and depression.

Doing better:

African Americans in Michigan are less likely to engage in risky drinking behaviors, both heavy and binge drinking, and are more likely to have had a routine checkup in the last year than Whites. African Americans under 65 years are more likely to have had an HIV test as well.

Total Population:
1,425,269
% of population: 14.3
Age Distribution:
under 5: 7.6%
5-17: 22.8%
18-65: 60.9%
over 65: 8.7%

Key social and environmental health determinants:

The April 2009 **unemployment rate for African Americans in Michigan was 19.5%, the highest in the country**. The median household income among this racial group is $31,534 with a total of 30.6% living below the poverty line. Among those 25 years and older, 80.2% are high school graduates and 14.1% have a bachelor's degree or higher. 56.8% are cost-burdened renters (rent ≥ 30% of income). 50.1% live in owner-occupied homes. The Detroit – Ann Arbor – Flint metropolitan area has a Black/White tract dissimilarity index of 83.5, showing that Black and White communities would need to exchange about 83% of their residents to achieve integration. This represents one of the most segregated geographic areas in the country. Dissimilarity (geographic segregation) is a known factor for poor community health.

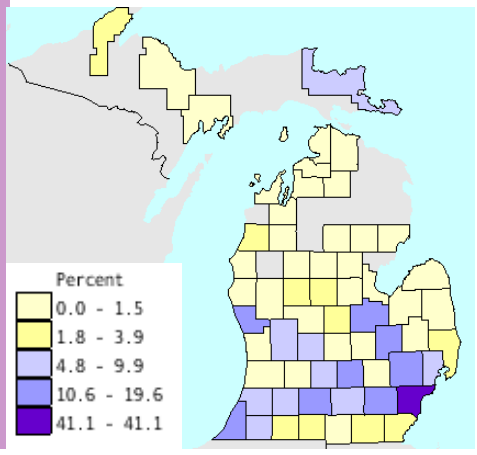
Key health status, behavior, and healthcare access indicators:

African American men have a 7.6 year shorter life expectancy than White men; females 3.5 years. Among non-elderly African Americans (<65 years) **19.0% do not have health insurance**, 46.2% receive coverage from their employer, and 30.8% receive coverage from Medicaid. African Americans report cost as a barrier to healthcare access and report being dissatisfied with life at a higher rate than average for Michigan.

Looking Forward:

Keys for improving the health of African Americans in Michigan were solicited through a series of community conversations held across the state in the fall of 2009. Some of the priorities identified include:

- Cultural competency, provider trust, and health insurance coverage for all are key areas for improvement within the medical system.
- Block clubs and faith-based initiatives are widely recognized as benefiting the community's health.
- A disconnect to policy makers at all levels is identified as a strong barrier to overall community improvement and health promotion.
- Collaboration between the State, individuals, community- and faith- based organizations, and other stakeholders, as well as increased investment in school-based health centers, are recommended as a key steps towards health improvement.



Percent African American, 2005-07

Sources: Michigan BRFSS, 06-08 bridged estimates; Michigan Vital Statistics 07 data; American Community Survey 05-07 (US Census); US Census 08 population estimates; Kaiser Family Foundation State Health Facts 07; Racial Res. Segregation Measurement Proj., MSU, 2000. 2009 Community Conversations, MDCH. Please contact the Health Disparities Reduction/ Minority Health section at colormehealthy@michigan.gov for more information.

HEALTH DISPARITIES REDUCTION/
MINORITY HEALTH SECTION, MDCH

2009

Hispanic/Latino in Michigan: Health Snapshot

Concerns:

Hispanics living in Michigan are more likely to be obese than White Michiganders, and report rarely or never receiving the social/emotional support they need. Hispanics have the second highest rate of HIV/AIDS in Michigan, and have a higher infant mortality rate than the average for Michigan. Nutritional knowledge and access, diabetes, and asthma are identified as leading health concerns in the community, especially for youth. Neighborhood concerns such as safety, law enforcement, and toxic spaces are indentified as key barriers to a healthier community. Access to culturally appropriate care and information due to language, culture, and economic status are also major concerns. Depression and stress have been identified as important issues that are largely unaddressed. The majority of Michigan's 90,000 migrant laborers and laborer families are Hispanic, and little is known about the health of this vulnerable subgroup.

Total Population: 394,829
% of MI population: 3.9
Age Distribution:
under 5: 5%
5-17: 25.6%
18-65: 59.7%
over 65: 4.3%

Doing better:

Hispanics are more likely than Whites to have had a routine checkup in the last year. As well, 18-64 year old Hispanics are more likely to have had an HIV test. Hispanics have the second lowest overall mortality rate of any racial/ethnic group in the state.

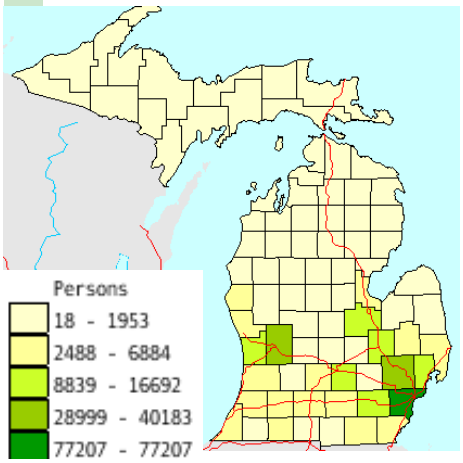
Key social and environmental health determinants:

The median household income (2005-2007) was $38,187 for this ethnic group. Among those 25 years and older, 65% are high school graduates, and 14% have a bachelor's or higher. 46.2% are cost-burdened renters (rent ≥ 30% of income). 29.1% are foreign born, and 58.1% speak a language other than English at home. The Detroit-Ann Arbor-Flint metropolitan area has a Hispanic/White tract dissimilarity index of 43.2, showing that Hispanic and White communities would need to exchange about 43% of their residents to achieve integration. 21.1% of non-elderly Latinos are uninsured, 27.3% are covered by Medicaid, and 44.6% are covered through their employer. 16.4% of Hispanics report having no health care access in the last year due to cost.

Looking Forward:

Keys for improving the health of Michigan Hispanics were solicited through a series of community conversations held across the state in the fall of 2009. Some of the priorities identified include:

- Increased cultural competency at both policy and provider levels.
- Making communities more conductive to healthy lifestyles, especially food availability and recreational opportunities for youth.
- Increased awareness of Hispanics in Michigan.
- More communication between the Hispanic community and state/local agencies and policy makers needed for sustainable change to both empower individuals through health education and increased services and to engage state leaders in an ongoing process that continually addresses and improves Hispanic health.



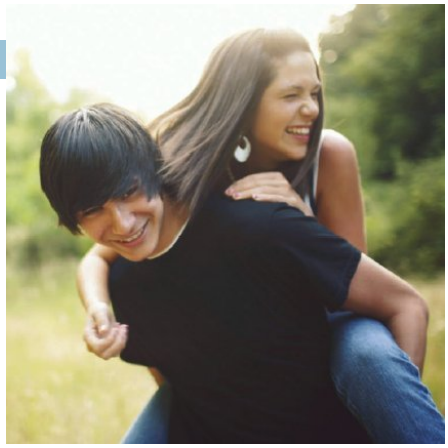
Hispanic Population, 2000

Sources: Michigan BRFSS, 06-08 bridged estimates; Michigan Vital Statistics 07 data; American Community Survey 05-07, US Census; US Census 08 population estimates; US 2000 Census; Kaiser Family Foundation State Health Facts 07; Racial Res. Segregation Measurement Proj., MSU, 2000. 2009 Community Conversations, MDCH. *Please contact the Health Disparities Reduction/Minority Health section at colormehealthy@michigan.gov for more information.*

HEALTH DISPARITIES REDUCTION/
MINORITY HEALTH SECTION, MDCH

2009

American Indian/Alaska Native in Michigan: Health Snapshot



Concerns:
American Indians (including Alaska Natives) have higher rates of diabetes, heart attack, and obesity than the Michigan average. They also report more activity limitation in the last month, and needing special equipment more often. 30.4% of new moms reported smoking while pregnant in 2007, the highest rate in the state of any racial/ethnic group. American Indians also reported fair or poor health status and rarely or never receiving the social/emotional support needed at higher rates than the overall population.

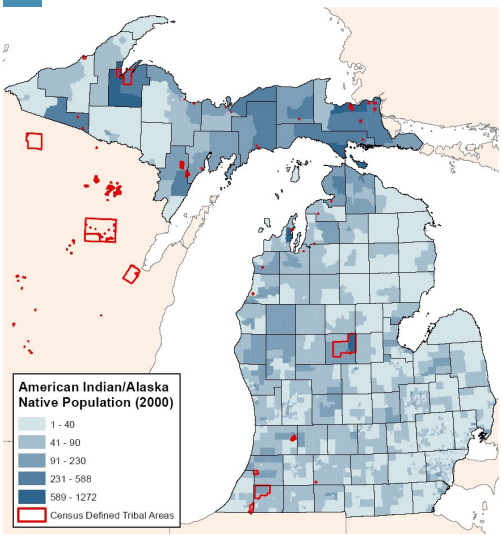
Doing better:
American Indians have the lowest prevalence of HIV/AIDS in the state

Key social and environmental health determinants:
The median household income (05-07) was $36,087. Among those 25 years and older, 34.3% are high school graduates, and 8.5% have a bachelor's or higher. 49.7% are cost-burdened renters (rent ≥ 30% of income).

Total Population: 53,178
% of MI population: 3.9
Age Distribution:
under 5: 5.1%
5-17: 19.2%
18-65: 68.8%
over 65: 6.8%

Key health status, behavior, and healthcare access indicators:
American Indians report higher rates of no health care access in the last year due to cost, with 20.7% reporting no health care coverage. 35.7% reported currently smoking, a rate significantly higher than the overall population.

Notes:
Due to the relatively small population of American Indians in Michigan, understanding the health status through traditional surveillance methods can be difficult or impossible. Alternative data sources, such as the 2006 Inter-tribal BRFS, are key to understanding the health needs of this population, and to build programming and policy that effectively meets the needs of the community.



AI/AN Population, 2000

Sources: Michigan BRFSS, 06-08 bridged estimates; Michigan Vital Statistics 07 data; American Community Survey 05-07 (US Census); US Census 08 population estimates; 2006 Michigan Residents Birth File; 2006 Inter-tri bal BRFS

HEALTH DISPARITIES REDUCTION/
MINORITY HEALTH SECTION, MDCH

2009

Asian American in Michigan: Health Snapshot

Concerns:

Asian Americans in Michigan report inadequate physical activity more than the state average, and report rarely or never receiving the emotional support needed more than Whites. They are also less likely to have ever received an HIV test when compared to the state average. There is an identified lack of access to insurance and culturally-competent services as key blockages to improving the health of Asian Americans. With 71.2% of the Michigan Asian American population foreign-born, issues around immigration, language, traditional diet, and clinical continuity with traditional medicine are considered barriers to a healthier Asian American community. 12.0% report no access to healthcare in the last month due to cost.

Doing better:

Asians report better physical health in the past month, and have lower rates of obesity and activity limitation. Asian Americans have the lowest overall mortality rate of any racial/ethnic group in the state, as well as the lowest infant mortality rate. Asian Americans report smoking and drinking less than the average Michigander.

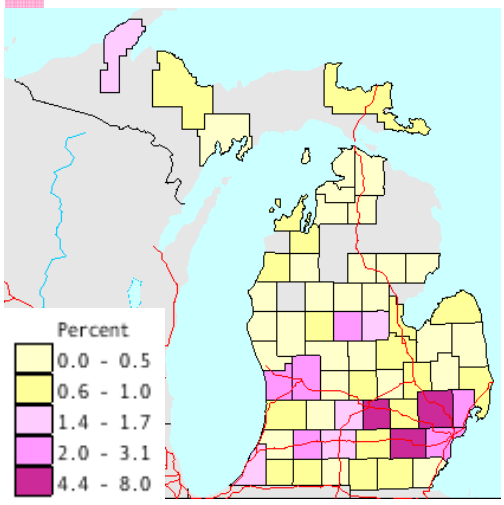
Key social and environmental health determinants:

The median household income is $68,611. Among those 25 years and older, 88.3% are high school graduates and 63.0% have a bachelor's degree or higher. 33.0% are cost-burdened renters (rent ≥ 30% of income). 78.1% speak a language other than English in the home. The Detroit – Ann Arbor – Flint metropolitan area has a Asian/White tract dissimilarity index of 51.6, showing that Asian and White communities would need to exchange about 50% of their residents to achieve integration.

Total Population: 235,011
% of population: 2.3
Age Distribution:
under 5: 7.3%
5-17: 18.2%
18-65: 68.9%
over 65: 5.7%

Notes:

Due to the relatively small population and the cultural diversity of Asians in Michigan, understanding health status through traditional surveillance methods can be difficult or impossible. Alternative data sources are needed to build programming and policy that effectively meets the needs of the communities that identify as Asian. This is reflected not only in current data availability, but is identified as a community concern as well. Looking forward, the community has indentified an increase in services for the elderly, community-based services, and universal insurance coverage as measures that can improve the overall health of the community.



Asian population, 2005-07

Sources: Michigan BRFSS, 06-08 bridged estimates; Michigan Vital Statistics 07 data; American Community Survey 05-07, US Census; US Census 08 population estimates; Kaiser Family Foundation State Health Facts 07; Racial Res. Segregation Measurement Proj., MSU, 2000. 2009 Community conversations, MDCH. Please contact the Health Disparities Reduction/Minority Health section at colormehealthy@michigan.gov for more information.

HEALTH DISPARITIES REDUCTION/
MINORITY HEALTH, MDCH

COLOR ME Healthy

2009

Arab American in Michigan: Health Snapshot

Concerns:

CVD is a concern for the Arab American population, with high rates of diabetes, hypertension, and hypercholesterolemia. Almost half of respondents to a 2001 survey* said they have been told they have **high cholesterol**. Cancer, diabetes and HIV have been identified by the community as chronic health concerns: only 26.5% report having been screened for cancer. Through a community focus group, **access to culturally appropriate services** are identified as a blockage to better physical health as well as mental health. It was also identified that drug and **tobacco use** are seen as problems, and immigration policy affects community health.

Doing better:

The use of tobacco and alcohol is lower for Arab Americans than the Michigan average, with 15% reporting smoking, and 6.7% reporting alcohol use. ACCESS, area providers, and Medicare have all been identified as groups currently working to improve the health of Arab Americans.

Key social and environmental health determinants:

The median household income is $45,545. Among those 25 years and older, 76.3% are high school graduates and 28.3% have a bachelor's degree or higher. 57.7% are cost-burdened renters (rent ≥ 30% of income). **44% are foreign born, with 66.5% speaking a language (most commonly Arabic) other than English at home**. Michigan, specifically the greater Detroit area, has the largest Arab population in North America. Lack of transportation and proximity to health centers are identified as blockages to better healthcare. The community also identified a **lack of knowledge about Arab Americans by the population at large** as an issue that affects health at many levels.

Total Population (US Census): 155,351
Total Population (ACCESS* estimate): 300,000
% of population: 1.5-3.0
Age Distribution:
under 5: 10.7%
5-17: 24.3%
18-65: 58.5%

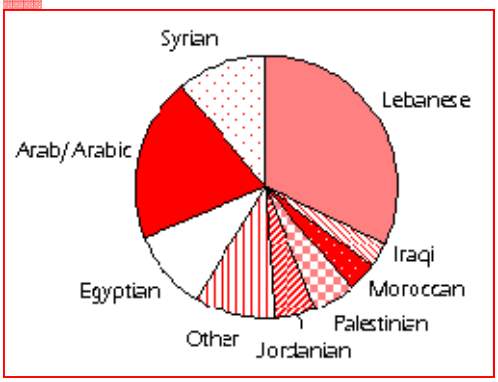
Key health status, behavior, and healthcare access indicators:

Arab Americans report 20.5% uninsured, 18.8% covered by Medicaid, and 60.7 covered through employer or private insurance. 80.0% report eating a healthy diet and 60.0% report exercising. 30.9% of females respondents report using birth control.

Looking Forward:

Keys for improving the health of Arab Americans in Michigan were solicited through a community conversation held in 2009. Some of the priorities included:

- Healthcare system that is accessible to more people and easier to navigate
- Improvement in cultural competence of providers and availability of linguistic services
- Community engagement and education though the media and faith networks
- Change in policies to decrease youth tobacco and drug use



Ancestry of MI Arab Population, 2001

Notes:

Due to the relatively small population of Arabs in Michigan, understanding the health status through traditional surveillance methods can be difficult or impossible. Alternative data sources, such as the 2001 Health Survey conducted by the Arab Community Center for Economic and Social Services (ACCESS), are key to understanding the health needs of this population, and to build programming and policy that effectively meets the needs of the community.

Sources: Michigan Vital Statistics 07 data; *Health Survey of the Arab, Muslim, and Chaldean American Communities in Michigan, 2001American Community Survey 05-07 (US Census); Photo courtesy of Arab American News; 2009 Community Conversations, MDCH. Please contact the Health Disparities Reduction/Minority Health Section at colormehealthy@michigan.gov for more information.

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