Michigan Department of Health and Human Services

2018 Health Equity Report

Moving Health Equity Forward

Released April 2019

MDHHS
Michigan Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ROBERT GORDON, DIRECTOR

2018 Health Equity Report
Moving Health Equity Forward

Introduction

The 2018 Health Equity Report, "Moving Health Equity Forward," serves as the Michigan Department of Health and Human Services (MDHHS) annual report documenting efforts to address racial and ethnic health disparities as required by Public Act 653 (PA 653). Also known as Michigan's Minority Health Law, PA 653 was passed in 2006 and enacted in January 2007. It amends the Public Health Code (1978 PA 368; MCL Section 333.2227) and includes provisions for addressing racial and ethnic health disparities, as well as improving health equity throughout the state (see Attachment A).

This year's report provides an overview of current minority health status and prevailing disparities in Michigan, highlights innovative initiatives being implemented within MDHHS to address these disparities, and discusses collaborative efforts involving partners from within and across other state agencies to promote equity. Information presented in this report was obtained through health surveillance systems and data sets, key informant interviews, and a survey of select program areas within MDHHS.

Racial and Ethnic Minority Health Status and Disparities in Michigan

Health disparities refer to measured health differences between two or more populations. In Michigan, as in the United States, racial and ethnic minority populations carry a disproportionately heavy burden of health disparities. This burden manifests in increased risk for disease and often results in delayed diagnosis, poor health outcomes and premature death, much of which is preventable. For example:

- Hepatitis B is a chronic health condition that may lead to liver disease and even death. Asians in Michigan experience hepatitis B at over 18 times the rate of Whites.

- Homicide differentially affects minority populations. Blacks experience homicide at a rate almost 15 times higher than Whites. Furthermore, black youth experience homicide at 17 times the rate of Whites.

- Racial disparities also affect how Michigan babies thrive. Black infants and

American Indian infants die at nearly three times the rate (14.3 and 14.2 per 1,000 respectively) of White infants (4.9 per 1,000).

For more information on hepatitis B, homicide and infant mortality in Michigan, along with the social determinants that affect these conditions, please see the data briefs, "Snapshot of Disparities in Michigan," which are linked here. These and other leading disparities among Michigan's racial and ethnic minority populations are also shown in the tables below. Table 1 displays causes of mortality, Table 2 shows morbidity (or prevalence of disease), and Table 3 depicts select social determinants – economic and social conditions – that affect health and quality of life. Each highlights conditions or indicators that have high population variance by race and ethnicity. Population variance refers to the average disparity in the population between all of the racial and ethnic groups monitored and the total population. Numbers in red and blue font represent the highest and second highest rates (respectively) for each indicator, signifying where the largest disparities exist.

Table 1: Mortality Rates with High Population Variance by Race/Ethnicity in Michigan[1]

Mortality Indicators	Total	White, NH	Black, NH	Hispanic/ Latino[a]	AI/AN	A/PI[b], NH	Arab
Homicide mortality rate, per 100,000	6.8	2.1	30.6	5.9	*	*	3.7
Chronic liver disease mortality rate, per 100,000	10.1	10.3	8.7	15.1	22.0	3.0	7.5
Septicemia mortality rate, per 100,000	10.1	8.9	18.5	7.5	10.0	4.5	19.3
Infant mortality rate, per 1,000 live births	6.8	5.3	13.5	9.1	12.6	3.9	5.9

[1] Numbers in red are the highest for that indicator; the numbers in blue indicate the second highest for that indicator
* = Data Not Available
NH = Non-Hispanic
AI/AN = American Indian/Alaskan Native
A/PI = Asian/Pacific Islander
a: Population defined as "Hispanic" in data sources for "morbidity" and "mortality"
b: Population defined as "Asian" in data sources for "morbidity" and mortality"
Data sources: Mortality – Michigan Resident Death Files/Division of Vital Records & Health Statistics

Table 2: Morbidity Rates with High Population Variance by Race/Ethnicity in Michigan[2]

Morbidity Indicators	Total	White, NH	Black, NH	Hispanic/ Latino[a]	AI/AN	A/PI[b], NH	Arab
Chronic hepatitis B prevalence (2017), per 100,000	12.5	4.6	20.4	3.7	4.7	84.4	*
HIV prevalence[c] (2017), per 100,000	162.8	73.9	659.2	183.6	54.5	47.7	*
Self-reported fair/poor health, %	16.7	15.2	24.5	21.4	24.4	6.6	16.9
Adult COPD[d] prevalence, %	7.7	7.2	10.2	4.3	14.4	*	4.9

Table 3: Social Determinants with High Population Variance by Race/Ethnicity in Michigan[2]

Social Determinants Indicators	Total	White, NH	Black, NH	Hispanic/ Latino[a]	AI/AN	A/PI[b], NH	Arab
Children living below poverty line, %	24.7	15.9	48.4	33.7	33.5	12.7	44.1
Female-headed households, %	12.7	9.4	30.7	19.4	22.2	5.8	10.2
Less than high school diploma[e], %	10.4	8.6	15.8	30.2	13.8	11.4	23.0
Percent of renters paying >30% of income on rent	48.5	45.4	57.7	48.0	52.3	32.7	60.5

[2] Numbers in red are the highest for that indicator; the numbers in blue indicate the second highest for that indicator
* = Data Not Available
NH = Non-Hispanic
AI/AN = American Indian/Alaskan Native
A/PI = Asian/Pacific Islander
a: Population defined as "Hispanic" in data sources for "morbidity" and "mortality"
b: Population defined as "Asian" in data sources for "morbidity" and mortality"
c: HIV prevalence includes reported cases
d: COPD = Chronic obstructive pulmonary disease
e: Percent of population at least 25 years of age with less than a high school diploma
Data sources: Self-reported fair/poor health and Adult COPD prevalence– 2014-2016 Michigan Behavioral Risk Factor Survey (BRFSS) Prevalence Estimates; Chronic Hepatitis B prevalence MDHHS Hepatitis B and C Annual Report; HIV prevalence MDHHS Michigan Statewide HIV Surveillance Report; Social Determinants – American Community Survey/U.S. Census Bureau 2011-2015

As shown in the tables, racial and ethnic minority populations do not have the same experience as their White counterparts when it comes to mortality, morbidity or social determinants of health (SDOH). With regard to SDOH in particular, an increasing body of research has shown these to be linked to health outcomes.[3] For example, living below poverty has been shown to affect children's current and future health.[4] Female-headed households, particularly those led by women of color, are more likely to experience poverty and food insecurity and less likely to be able to afford health care.[5] They may also be exposed to increased stress due to lack of social and economic support; unmarried mothers have been shown to have higher odds of adverse infant health outcomes as compared to married mothers.[6] Life expectancy decreases with lower educational attainment, such as not having a high school diploma;[7] and research has shown that housing burden (e.g., paying more than 30 percent of income on rent) may negatively affect health and access to care.[8,9]

The Black (non-Hispanic) population in Michigan has the highest rate of several indicators shown in the tables, including homicide, infant mortality, HIV prevalence, and self-reported fair/poor health. This population also experiences higher rates for two of the four social determinants shown, such as children living below poverty and female-headed households. When not the highest rate, the Black population has the second highest rate for all indicators shown above except for two (chronic liver disease mortality and less than a high school diploma). American Indian/Alaska Natives have the highest or second highest rate for five of the indicators shown in the tables above (highest: chronic liver disease mortality, adult COPD prevalence; second highest: infant mortality, self-reported fair/poor health, and female-headed households). Hispanic/Latino populations have either the highest or second highest rate for four of the indicators shown (highest: less than a high school diploma; second highest: homicide mortality rate, chronic liver disease mortality, HIV prevalence). Arab Americans in Michigan also

[3] CDC, Social Determinants of Health: Know What Affects Health, CDC Research on SDOH: Economic Stability [webpage]. (2018, May 22). Retrieved (3/13/19) from: https://www.cdc.gov/socialdeterminants/economic-stability/index.htm

[4] Gupta RP, de Wit ML, McKeown D. The impact of poverty on the current and future health status of children. Paediatr. Child Health. 2007 Oct; 12(8): 667–672. PMID: 19030444 Retrieved (3/2/19) from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2528796/pdf/pch12667.pdf

[5] Hunger and Poverty in Female-Headed Households (fact sheet). Washington, DC: Bread for the World. 2016. Retrieved (3/2/19) from: http://www.bread.org/sites/default/files/downloads/female-headed-fact-sheet-2016.pdf

[6] Michigan Health Equity Status Report, Focus on Maternal and Child Health: A joint report of the Practices to Reduce Infant Mortality through Equity Project and the Health Disparities Reduction and Minority Health Section. Lansing, MI: Michigan Department of Community Health. 2013. Retrieved (3/7/19) from: https://www.michigan.gov/documents/mdhhs/HE_Status_Report_506754_7.pdf

[7] Braveman P and Gottlieb L. The Social Determinants of Health: It's Time to Consider the Causes of the Causes. Public Health Rep. 2014 Jan-Feb; 129(Suppl 2): 19–31, doi: 10.1177/00333549141291S206

[8] HealthyPeople.gov. Housing Instability [webpage]. Retrieved (3/7/19) from: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/housing-instability

[9] Kushel MB, Gupta R, Gee L, Haas JS. Housing Instability and Food Insecurity as Barriers to Health Care Among Low-Income Americans. J Gen Intern Med. 2006 Jan; 21(1): 71–77, doi: 10.1111/j.1525-1497.2005.00278.x

have the highest or second highest rate for four of the indicators (highest: septicemia mortality rate, percent of renters paying >30 percent of income on rent; second highest: children living below poverty, less than a high school diploma). Asian/Pacific Islanders have the highest rate for one indicator (chronic hepatitis B prevalence). While not always the lowest rate, the non-Hispanic White population does not have the highest or second highest rate for any of the indicators shown.

Understanding Health and Social Equity

Many of the health/social indicators and disparities displayed in the tables above are preventable and constitute what is known as health inequities. Specifically, these are differences in population health status and mortality rates that are systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill.[10] In contrast, health equity is the fair and just distribution of social resources and opportunities needed to achieve well-being. Achieving health equity requires removing economic and social obstacles for health, such as poverty, discrimination and their consequences.[11] Therefore, it is important to address social determinants. As mentioned, these are the economic and social conditions and systems that influence the health of individuals and communities. This includes conditions/ systems in and under which people are born, grow, live, work, and age – such as race/ethnicity, racism/discrimination, social connections and safety, access to transportation, water quality, safe and affordable housing, quality education, job security, availability of nutritious food, etc.[12] Inequities in these social

Key Definitions

Health Inequities: Differences in population health status and mortality rates that are systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill.[10]

Health Equity: Fair, just distribution of social resources and opportunities needed to achieve well-being. It requires removing economic and social obstacles for health, such as poverty, discrimination and their consequences.[11]

Social Determinants of Health and Equity: The economic and social conditions/systems that influence the health of individuals and communities. The conditions and systems in/under which people are born, grow, live, work and age. Examples include: race/ethnicity, racism/discrimination, social connection and safety, access to reliable transportation, water quality, quality education, criminal justice, safe and affordable housing, job security, availability of nutritious food, etc.[12]

Social Equity: Equity is the full and equal access to opportunities, power and resources necessary for all people achieve their full potential and thrive. The fair, just and equitable distribution of public services and implementation of public policy.[13, 14]

[10] Whitehead M. The concepts and principles of equity and health. International Journal of Health services. 1992; 22(3), 429-445.
[11] Ingham County Health Equity Project; Association of State and Territorial Health Officials (ASHTO), 2000.
[12] WHO Commission on Social Determinants of Health. Executive summary, Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva, Switzerland: World Health Organization (WHO). 2008.

determinants are often due to power imbalances and oppression, such as racism, classism, sexism, etc. Thus, it is equally important to promote social equity. This refers to having full and equal access to opportunities, power and resources necessary for all people to achieve their full potential and thrive. Social equity includes the fair, just and equitable distribution of public services and implementation of public policy.[13,14]

The underlying causes of health and social inequities are varied and complex. Therefore, effectively reducing disparities and achieving equity requires a comprehensive, multi-faceted, collaborative, cross-sector approach. This includes applying various strategies to:

- Build internal organizational capacity and infrastructure;
- Strengthen workforce diversity, competency and skills;
- Establish a culture of diversity, equity and inclusion in the work place;
- Foster community partnerships;
- Cultivate collaborations across government; and
- Implement transformative policy and systems change.[15]

Collectively, these strategies work to improve the health of Michigan's racial and ethnic minority populations, and indeed, all Michigan citizens. However, to be truly effective, a dedicated and coordinated effort involving all MDHHS organizational areas, along with external partners is required. Toward that end, the department engaged in a number of innovative, collaborative and cross-sector efforts in 2018 to further understand and address the root causes of health and social inequities.

Innovative Efforts to Address Leading Disparities

> *Public health practice must be transformed in order to remain relevant, improve people's lives, and ensure that funds are used in the most efficient and effective manner. Public health must innovate and modernize the ways of practice.*
>
> *~ Public Health National Center for Innovations*[16]

[13] Valenzuela M. King County Journey in Institutionalizing Equity and Social Justice. American Society for Public Administration. King County, Washington State. 2017.
[14] National Academy of Public Administration, Standing Panel on Social Equity in Governance. Retrieved (3/10/19) from: https://web.archive.org/web/20090506083627/http://napawash.org/aa_social_equity/index.html
[15] Adapted from HealthEquityGuide.org, A Human Impact Partners Project [website] Retrieved (1/29/19) from: https://healthequityguide.org/
[16] The Public Health National Center for Innovations (PHNCI), a division of the Public Health Accreditation Board (PHAB). Innovation in Governmental Public Health: Building a Roadmap. 2017. Retrieved (1/11/19) from: https://phnci.org/uploads/resource-files/Innovation-in-Governmental-Public-Health-Building-a-Roadmap-02-2017.pdf

Hepatitis B

Hepatitis B has one of the highest population variances (the average disparity in the population between all of the racial and ethnic groups monitored and the total population) among chronic conditions in Michigan. However, hepatitis B is highly preventable and manageable, particularly if diagnosed early. Two primary risk factors for hepatitis B include sharing needles, syringes, or drug preparation equipment with an infected person; and being born to an infected mother. Among the most effective prevention strategies for these risk factors include providing access to clean syringes and drug preparation equipment to people who use drugs, providing hepatitis B vaccine to those at risk of infection, and providing hepatitis B vaccine and hepatitis B immune globulin (a substance that contains antibodies against the hepatitis B virus) to infants born to mothers with hepatitis B.[17] The MDHHS Viral Hepatitis Unit and Perinatal Hepatitis B Prevention Program utilize these strategies, delivered through innovative and evidence-based initiatives, to address health disparities in hepatitis B and improve social equity in prevention and care.

For example, in 2018, the Viral Hepatitis Unit collaborated with the department's HIV Prevention Unit and the Office of Recovery Oriented Systems of Care (OROSC) to provide funding to four local health departments in Michigan with the goal of initiating a pilot Syringe Services Program (SSP) in their community. SSPs are evidence-based, effective and innovative programs that provide access to clean needles and drug preparation equipment for the purpose of preventing the transmission of blood-borne pathogens and related infectious diseases associated with injection drug use. Access to clean syringes has been identified as one of the Centers for Disease Control and Prevention's (CDC) Health Impact in Five Years (HI-5) interventions. HI-5 interventions are community-wide approaches that have demonstrated positive health impacts within

*SSP Infographic: CDC Syringe Services Program [webpage]. Retrieved (2/20/19) from: https://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-services-programs.pdf

[17] CDC, Viral Hepatitis, Hepatitis B Information [webpage]. (Page last reviewed: May 22, 2018). Retrieved (2/20/19) from: https://www.cdc.gov/hepatitis/hbv/bfaq.htm#overview

five years, and are shown to be cost effective and/or produce cost savings.[18]

The four local health departments that received funding were identified using a data-driven approach to ensure efforts were being implemented in high need areas with the state's most marginalized populations. Participating health departments include: Central Michigan District Health Department, Chippewa County Health Department, District Health Department #2, and Marquette County Health Department. In 2018, three of the four funded local health departments were able to successfully provide community members with access to clean syringes and other drug preparation equipment for the prevention of blood-borne and infectious diseases.

In addition, funded local health departments have utilized innovative strategies and approaches to promote health and social equity through their SSPs. This includes use of a mobile unit to provide syringe access, as well as recruiting repeat clients to serve as "secondary exchangers" to reach populations who may be afraid or distrustful of service providers. The Viral Hepatitis Unit also hired a Harm Reduction Analyst with 10 years of experience managing the Grand Rapids Red Project's Clean Works program, a legacy SSP, to provide technical assistance to budding SSPs and increase statewide harm reduction capacity in Michigan. All of these efforts work to advance health and social equity by reaching out to and providing needed services for people who inject drugs, who are often stigmatized and underserved.

To address disparities in hepatitis B due to transmission of the virus to infants of infected mothers, the MDHHS Perinatal Hepatitis B Prevention Program (PHBPP) has created an electronic program manual for all Michigan providers and mothers. The manual include links to the CDC, Immunization Action Coalition (IAC), and to the Asian Liver Center to provide translated PHBPP educational materials and program protocols.

The PHBPP also uses CDC's methodology to estimate births of infants to women with hepatitis B (these estimates are calculated based on maternal residence – U.S. or foreign-born origin – race/ethnicity, and risk of infection), and applies these estimates to local health department jurisdictions. The PHBPP team then works with each jurisdiction to utilize innovative strategies and approaches to promote the identification of hepatitis B surface antigen (HBsAg) positive pregnant women to ensure they are receiving the appropriate care and treatment, and to provide the appropriate care for their infant, household and sexual contacts.

To improve health and social equity, the PHBPP collaborates with the Immunization

[18] CDC, Office of the Associate Director for Policy, Health Impact in 5 Years [webpage]. (Page last reviewed: October 19, 2018). Retrieved (2/20/19) from: https://www.cdc.gov/policy/hst/hi5/index.html

Division Nurse Educators to improve relationships among high-risk groups, migrant health centers, refugee services, and federally qualified health centers to increase the awareness and importance of the hepatitis B vaccine along with all the other vaccine preventable diseases. These providers reach underserved populations within Michigan. The PHBPP also partners with the Hmong Project, the Asian Center and local health department refugee/immigration services to help improve health services and protection through vaccination for those at highest risk of hepatitis B virus infection.

In addition, both the Viral Hepatitis Unit and PHBPP hosted trainings in 2018 to increase the capacity of staff and partners to address health and social equity. In December 2018, the Viral Hepatitis Unit collaborated with the Grand Rapids Red Project to provide two full-day, regional harm reduction training opportunities in Grayling and Warren to raise awareness of harm reduction principles and SSPs; increase diversity of staff, management and leadership; and facilitate a training on overdose response utilizing naloxone. Attendees included staff from MDHHS, local health departments, housing support services, recovery centers, community-based organizations, and Prepaid Inpatient Health Plan (PIHP) entities. Throughout 2018, the PHBPP provided educational seminars to local health departments, private providers and birthing facilities to improve the identification of women of childbearing age to reduce the risk of mother-to-infant perinatal exposures. These educational sessions increased awareness of hepatitis B vaccination programs and services available throughout the state to help facilitate access and reduce barriers that may exist within communities.

Youth Violence and Homicide

Violence is defined as "the intentional use of power or force against oneself or another person."[19] Whether physical, psychological or sexual, violence can lead to mental and physical health problems throughout a person's lifetime. Moreover, violence can result in death, particularly among youth. Homicide is the third leading cause of death for persons aged 10–24 years in the United States.[20] In Michigan, the average annual number of deaths due to homicide is highest for the 15-24 age group and the most frequent injury-related cause of death for children ages 1 to 4 years.[21] While violence can result in negative consequences for all young people, racial and ethnic minority

[19] MDHHS, Safety & Injury Prevention, Injury & Violence Prevention [webpage], (Retrieved 3/1/19) from: https://www.michigan.gov/mdhhs/0,5885,7-339-71548_54879---,00.html
[20] CDC. Preventing Youth Violence (fact sheet). 2018. Retrieved (3/2/19) from: https://www.cdc.gov/violenceprevention/pdf/yv-factsheet508.pdf
[21] MDHHS, Injury & Violence Prevention Section. Injury and Violence in Michigan: Michigan's Core Violence and Injury Prevention Program Burden Report. Lansing, MI: MDHHS. 2018. Retrieved (3/1/19) from: https://www.michigan.gov/documents/mdhhs/Injury_Violence_Michigan_Burden_Report_643869_7.pdf

youth experience a disproportionate burden of violence and homicide.[22] Violence, however, is a learned behavior that can be prevented.

The MDHHS Injury and Violence Prevention Section is committed to preventing violence and violent deaths by working with state and local partners to help communities stop injuries and violence. Overarching efforts include:

- Collecting and interpreting data on injury and violence in Michigan.
- Developing and evaluating prevention programs.
- Providing information, tools and technical assistance to communities and partners.[23]

In particular, the Injury and Violence Prevention Section oversees the Michigan Violent Death Reporting System (MiVDRS). This state-based surveillance system is part of the National Violent Death Reporting System (NVDRS) coordinated by CDC. This innovative and unique surveillance system links data from law enforcement, medical examiners/coroners and vital statistics to help participating states design and implement tailored prevention and intervention efforts. By linking data from multiple sources, a more comprehensive picture of violent death is created. This allows MDHHS to identify trends for specific types of violence, formulate a clearer understanding of the circumstances and factors contributing to violent deaths, as well as provide insight into points for intervention in order to improve prevention efforts.[24]

Specifically, data from MiVDRS is used to:

- Identify high-risk groups and communities.
- Examine factors that contribute to health disparities and violence.
- Bolster efforts to reduce violent deaths.
- Characterize victims and suspects of fatal violence.
- Examine specific subtypes of violent deaths including child abuse-related deaths, intimate partner violence incidents, murder-suicides, and gang-related deaths.
- Provide detailed information on circumstances precipitating violent deaths.[25]

---

[22] David-Ferdon C, Simon TR. Preventing Youth Violence: Opportunities for Action. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. 2014. Retrieved (3/1/19) from: https://www.cdc.gov/violenceprevention/youthviolence/pdf/opportunities-for-action.pdf

[23] MDHHS, Safety & Injury Prevention, Injury & Violence Prevention [webpage]. Retrieved (3/1/19) from: https://www.michigan.gov/mdhhs/0,5885,7-339-71548_54879---,00.html

[24] MDHHS, Safety & Injury Prevention, Injury & Violence Prevention, MiVDRS [webpage]. Retrieved (3/1/19) from: https://www.michigan.gov/mdhhs/0,5885,7-339-71548_54879-279986--,00.html

[25] Daniel A., Ofori-Addo A., Smith PK. Monitoring Violent Deaths in Michigan: The Michigan Violent Death Reporting System (MiVDRS), Michigan Department of Community Health. (Poster presentation, n.d.). Retrieved (3/1/19) from: https://www.michigan.gov/documents/mdch/MiVDRS_MPPHPC_MSIPC_poster_390852_7.pdf

This information helps to inform and support state and local decision-makers, policy-makers, community leaders, and program planners as they seek to better understand violent deaths, develop or support effective prevention strategies, and evaluate efforts.[26] In addition, the Injury and Violence Prevention Section takes added measures to address racial and ethnic disparities and promote equity. For example, the Core Violence and Injury Prevention Program (Core VIPP) convenes an Injury Community Implementation Group that consists of stakeholders from various sectors. Recently, they added a representative with a specific health equity focus to help inform their action plan. They also invited the Michigan Multicultural Network to an Injury Community Implementation Group meeting to discuss working with, and in diverse communities, to address injury and violence prevention.

The section also coordinates a Rape Prevention and Education Program (RPE), which has started development of a packet for new community grantees to ensure they have the knowledge and skills to understand and address health disparities and inequities related to sexual violence. Additionally, a community expert from the Sexual Assault Services for Holistic Healing and Awareness (SASHA) Center was invited to present to stakeholders on community efforts to educate and support African American female rape/sexual assault survivors.

Staff within the section also participate in an ongoing professional development training program on health equity and social justice; and the Core VIPP is conducting shared Risk and Protective Factor trainings to support collaboration and working on cross-cutting factors.

Infant Mortality

Disparities in Michigan's infant mortality rate have persisted over time, with Black, American Indian/Alaska Natives, and Hispanic/Latino populations consistently having higher rates than the White population. As with other health inequities, the reasons for these differences in infant mortality are multifactorial and complex. One contributing factor is the lack of integration between population health and clinical systems that engage families. Building systematic connections among public health, human services and clinical care would strengthen the resources and care being delivered to expecting and new mothers, as well as afford opportunities to address social determinants of health (SDOH).

The MDHHS Bureau of Family Health Services is working to foster these connections

[26] MDHHS, Safety & Injury Prevention, Injury & Violence Prevention, MiVDRS [webpage]. Retrieved (3/1/19) from: https://www.michigan.gov/mdhhs/0,5885,7-339-71548_54879-279986--,00.html

and improve integration, as well as address social and economic injustices that are at the root of disparities in infant mortality. This is being done through the Maternal Infant Health Strategy Group and development of The Mother Infant Health and Equity Improvement Plan. Specifically, the Maternal Infant Health Strategy Group (MISG) was established to create synergy between the varied organizations and providers that are working to improve the health and well-being of Michigan's families. This group of leaders is working to craft a strategic plan to align maternal and infant health goals and strategies, facilitate collaboration among stakeholders, and provide guidance on operationalizing a health equity lens to address SDOH and reduce the racial disparity in maternal and infant outcomes in Michigan.

The Mother Infant Health and Equity Improvement Plan builds upon work already begun in Michigan and seeks to join with others in creating sustainable momentum toward achieving equitable health outcomes. The Improvement Plan is forward-leaning and is an iterative, data-driven, evolving road map that will lead Michigan to not only address disparities, but also achieve true equity by removing road blocks created by systemic, structural injustices often experienced by marginalized populations. Social and economic injustices, predominantly racism and other forms of oppression, are at the root of most disparate health outcomes that mothers and infants face in Michigan and across the nation. Therefore, the Improvement Plan promotes equity and strives to ensure every woman and infant in Michigan has the same opportunity for a healthy pregnancy, birth and first year of life. After all, a healthy beginning is the foundation of a healthy life. Moreover, when everyone is healthy, everyone benefits.

Development of the Improvement Plan has included many professional and community stakeholders, as well as the voices of Michigan families. During 2018, a series of town hall meetings were held throughout the state to introduce the plan and solicit input. Collectively, more than 500 people participated in these gatherings and provided feedback. This grassroots approach has allowed MDHHS and the MISG to formulate a plan that improves health outcomes by aligning evidence-based and promising public health and clinical interventions. It further serves to ensure that communities and individuals most likely to experience disparate outcomes have a say in the process, and are able to shape the preventative services and treatments that will improve their health.

In addition, MDHHS is launching a Mother Infant Health and Equity Improvement Plan Ambassador Program, consisting of community members that have an interest in maternal and infant health in Michigan. The purpose of the Ambassador Program is to engage and empower community members through education about lifesaving maternal and infant health interventions, so they can share this knowledge in their own communities. Ambassadors will provide education about key maternal and infant health issues, such as safe sleep practices, birth spacing and planning, treating chronic conditions before pregnancy, and strategies for reducing preterm birth and low birthweight. Increased awareness of life-saving interventions will allow ambassadors and community members to advocate for their health and improve health outcomes. Additionally, ambassadors will provide important feedback to MDHHS about programs, like home visiting and breastfeeding, as well as any barriers that exist, so the department can improve the effectiveness of its efforts throughout Michigan. This is another way the Improvement Plan initiative is utilizing a grassroots approach by engaging community partners and integrating feedback directly from the communities it aims to serve.

Cross-Cutting, Collaborative Efforts to Promote Equity

In addition to the program specific initiatives described above, MDHHS is engaged in several cross-cutting, collaborative initiatives to further address racial and ethnic minority health and social equity. Three of these efforts came to fruition in 2018. These initiatives, highlighted below, are unique in their approach to advancing equity not only because they involve various partners both within and outside of MDHHS, but also because they are examining issues of inequity at societal, organizational, and individual levels.

MDHHS Diversity, Equity, and Inclusion Plan

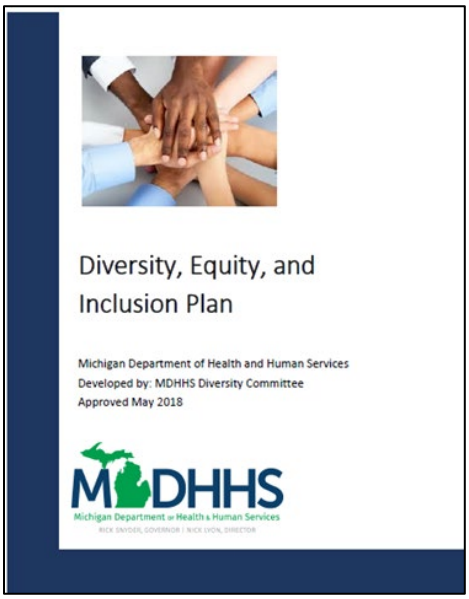
Overview

In 2018, MDHHS released its Diversity, Equity, and Inclusion (DEI) Plan. This plan outlines key actions the department should take toward achieving diversity, equity and inclusion throughout the organization.

The DEI Plan is the culmination of over two years of work, spearheaded by a committee comprised of diverse personnel at all levels – from executive leadership to front-line staff – with representation from each administration within the department. This committee was formed in 2016 and charged with developing a unified diversity plan for the newly merged department that would holistically address the needs of all

organizational units, inclusive of both community health and human services. Given the diverse structures, functions and work environments of the various areas within the department, the DEI committee took a broad, high-level approach and created a plan that allows local offices, state hospitals and other organizational areas within MDHHS to be successful at achieving diversity, equity and inclusion in their unique setting.

The DEI Plan provides a framework that is applicable to all of the administrations, bureaus and divisions within the department and is adaptable to their individual needs. For example, it allows personnel working within foster care to create an environment that is diverse, equitable and inclusive; as well as those working in a state hospital, which has its own particular structure and function, to do the same. This guiding framework is built around five key areas or indicators of success.



- Leadership – Ensuring MDHHS leadership is trained in DEI principles and practices, appoints a DEI Officer to oversee implementation of the plan, prioritizes resources to ensure objectives are met, and is supportive of the department's DEI efforts.

- Culture and Climate – Fostering an environment in which staff are aware and respectful of DEI efforts; are able to provide culturally and linguistically appropriate services; and are supported in their efforts to involve stakeholders, customers and partners in the decision-making and implementation process.

- Recruitment, Hiring and Retention – Increasing diversity of the MDHHS workforce, including leadership, through hiring practices that are inclusive, consistent and transparent; recruiting applicant pools that are reflective of populations served; and ensuring staff working in communities with limited English proficiency are fluent in the language of those served.

- Training and Professional Development – Building capacity of staff to provide culturally and linguistically appropriate services, apply DEI principles to their work, and address implicit bias and systemic inequities.

- Service Delivery – Enhancing services and outcomes by identifying and eliminating systemic bias in departmental policies and procedures; working collaboratively with

vendors, stakeholders and service providers in this effort; and ensuring underserved populations are represented among vendors and service providers.[27]

Since approval of the plan, a structure to support implementation has been established. This consists of a Diversity, Equity and Inclusion (DEI) Council, five Action Teams (one for each key area) with appointed team leads, and designation of two DEI Co-Officers – one being the department's Chief Deputy Director.

DEI Council members, along with Action Team leads, have been appointed by departmental leadership and include representatives from throughout the organization. The Council meets quarterly to discuss how implementation is progressing, create strategies to overcome barriers, and celebrate successes. Action Teams are comprised of staff selected through an application process to ensure diverse, equitable and inclusive participation. These groups meet regularly to identify and implement strategies to achieve the outcomes of their specific issue area. Departmental staff also have the opportunity to be involved in carrying out the DEI Plan by serving as a liaison within their organizational area. The DEI Co-Officers oversee the initiative as a whole, lead the DEI Council, communicate progress and needs to the department's executive leadership, and ensure efforts are moving forward.

This initiative is unique not only in its collaborative, department-wide approach, but also in its effort to ensure staff are included at every level across the department and by providing opportunities for all personnel to be involved in some way. Plans for 2019 include administering a structured, department-wide assessment in order to gather data to further inform the work of Action Teams, including where to focus their efforts. This assessment data will also provide a baseline from which to measure progress and impact of DEI Plan initiatives.

Advancing Equity

As stated in the DEI Plan, the initiative's approach to achieving equity is rooted in principles of racial equity. Though not the exclusive focus, a racial equity approach allows the department to address systemic racism and other forms of oppression and exclusion. It further facilitates the design of policies, practices and strategies that result in fair and equitable opportunities for everyone. This approach includes understanding the historic and current drivers of health and social inequities (e.g., racism, sexism, classism), identifying how MDHHS contributes to and can deconstruct these inequities, and working in partnership with communities served to achieve equity.

[27] MDHHS, Diversity Committee. Diversity, Equity, and Inclusion Plan. Lansing, MI: MDHHS. 2018. Retrieved (1/11/19) from: https://mage.org/docs/MDHHS_Diversity_Equity_and_Inclusion_Plan_Final.pdf

Though the DEI Plan seeks to advance health and social equity in Michigan through all five key areas described above, two of the areas 1) Leadership and 2) Culture and Climate, serve as the foundational pieces of the plan. Advancing equity is a difficult endeavor. Therefore, leadership is needed – both at the top and throughout all levels of the department – that is supportive of implementation of the plan and willing to take on the challenges inherent in this process. The leadership component of the DEI Plan is very intentional in identifying what support is needed from leadership in order to be successful. Leadership that is invested in the plan at all levels of the department is essential to ensuring implementation is effective within the various areas and units of the organization.

> ***Systemic inequities cannot be eliminated by the actions of a few. Our success is dependent on employees and partners of MDHHS taking strong positive action for the culture to change.***
>
> ***~ MDHHS DEI Plan, p.5***

Culture and climate are also vital to ensuring successful implementation. Having a strategic, dynamic plan is not enough. If the culture and climate of an organizational area does not support it, then the plan will not succeed. Therefore, the DEI Council and Action Teams are working diligently to move the needle on the culture and climate piece. This includes fostering involvement and investment in the plan among employees, as well as encouraging a culture of learning and exploration that allows staff to think about and apply equity principles in a deeper and more meaningful way.

Together, these two areas provide the structure and framework to move the other Action Teams forward. Supportive leadership, along with a culture and climate that embraces DEI principles, will facilitate the integration of equity into day-to-day operations, thus leading to changes in how the department does business. It will further ensure that employees and stakeholders are creating environments that are diverse, equitable and inclusive in how they operate and function.

Though still at the beginning stages of implementation, the DEI Plan keeps equity at the forefront of conversations within the department. This includes examining routine practices and procedures through an equity lens – such as how RFPs are formulated, contracts awarded, policies established, etc. – and considering how to improve upon these in order to promote more equitable outcomes. In addition, the plan calls for a core group of DEI subject matter experts to be formed to support training and professional development within the department. The Training and Professional Development Action Team has already adopted a department-wide training curriculum derived from the Health Disparities Reduction and Minority Health Section's Equity and Cultural Competency Program (described next in this report). Additionally, they have drafted a

training policy recommending all MDHHS personnel be required to complete a web-based health equity training and systemic racism module. All of these efforts are necessary in order to identify and address inequities at the systemic level and ultimately improve outcomes for employees, stakeholders, customers, and communities.

Equity and Cultural Competency Program

Overview

In conjunction with the release of the DEI Plan, the MDHHS Health Disparities Reduction and Minority Health Section (HDRMHS) finalized and launched its Equity and Cultural Competency (ECC) Program. The ECC Program is a comprehensive, multi-faceted, collaborative initiative that applies an organizational change lens and systems-based approach. The initiative seeks to advance equity by increasing awareness and understanding, building capacity, and creating a new culture of equity and cultural competency within the department.

The program consists of the following components:

- Training and Workshops – Conducting facilitated workshops geared toward conceptualizing equity, cultural competency and social justice principles in order to change the narrative that has supported the status quo and begin a pathway to action.

- Building the Culture – Offering ongoing facilitated events, discussions and activities geared toward building, reinforcing and normalizing a culture of equity, cultural competency and social justice.

- Technical Assistance – Identifying and addressing technical assistance needs to support active implementation of an equity and cultural competency lens. Technical assistance is available to staff who have attended required trainings and provides guidance on working through personal or program related challenges, identifying next steps, and drafting an action plan for successful implementation.

- Monitoring and Evaluation – Assessing increased knowledge, progress and implementation. This includes ensuring program revisions include participants' feedback and the most current evidence-based subject-matter content and data.[28]

Each of these components has been designed for a diverse public health and human

[28] Murillo Y. Equity and Cultural Competency Program Concept Paper. Lansing, MI: MDHHS, Health Disparities Reduction and Minority Health Section. 2018.

services workforce using evidence-based strategies and best practices from research. As a whole, the ECC Program works to foster a new environment and change the way MDHHS operates in order to advance equity. This includes building internal capacity within the department to engage in and carry out health and social equity work.

Advancing Equity

The ECC Program works to advance equity by changing the culture from within. This inward focus is somewhat different than other HDRMHS and departmental efforts, which typically are directed outward through the implementation of community-based initiatives. However, as a state department, MDHHS leadership and staff have a great deal of leverage and decision-making power when it comes to developing policies, allocating resources, and implementing health and social service programs, all of which impact communities. Therefore, it is essential to increase state personnels' and decision-makers' understanding of equity, oppression and power. Likewise, it is important to equip them with practical skills, tools, frameworks, and the lens necessary to make decisions that are more equitable. By doing so, department leadership and staff can better develop policies, programs, written and unwritten practices, procedures, budgets, etc., that dismantle inequities and close gaps, especially among racial and ethnic minority populations and others that are disadvantaged and oppressed by the system. Having community-based, equity-focused programs and initiatives – though necessary – is not enough. The fact that many of today's disparities also existed 10 or more years ago suggests that the department, and arguably other state institutions, need to act differently. External change must start with internal change. This requires raising awareness and understanding through training, technical assistance and other capacity building activities to ultimately change the culture.

While developed by and housed within the HDRMHS, the ECC Program is a department-wide, collaborative effort. It aligns with many elements of the DEI Plan and certain components have been integrated into the work of DEI Action Teams, particularly the training and culture/climate pieces. For example, the training and workshops component of the ECC Program has been adopted by the DEI's Training and Professional Development Action Team, and will serve as the training curriculum for staff across the entire department. Moreover, the proposed mandatory training policy, mentioned previously, will require all staff to complete the "Introduction to Health Equity" online training as well as the "Systemic Racism" online training, both of which are part of the ECC Program's training and workshop component.

In addition to working across areas of the department, the ECC Program has extended its collaboration to other state agencies, particularly in the development and piloting of ECC trainings and workshops. One example is the work being done on the workshop,

"Inside Our Mind: Hidden Biases," which is part of the ECC training curriculum. MDHHS has partnered with the Michigan Department of Civil Rights (MDCR) and the MDHHS Office of Workforce Development and Training (OWDT) in the design, development and piloting of this training.

This intra- and interagency collaboration is key to ensuring the program is integrated with other state efforts and effectively building the capacity of both leadership and staff to carry out this work. It further increases buy-in, reach and leveraging of resources.

Collaboration with Michigan Department of Civil Rights: Government Alliance on Race and Equity (GARE) and State of Solutions (SOS) Initiatives

Overview

As articulated, in order to advance health and social equity, the systems, policies and procedures that perpetuate institutional racism and discrimination need to be addressed. This goes beyond the public health and human services domains. Therefore, there needs to be a collective effort to foster a culture of equity in the state. MDHHS's collaboration with the Michigan Department of Civil Rights (MDCR) is a unique way state agencies are working together to bring about this cultural shift.

MDCR, as a department, is working to dismantle barriers to inclusion, both internally and externally; and is currently collaborating with several state level organizations on a number of equity initiatives. In addition to MDHHS, this collaboration includes the Michigan Department of Education (MDE), the Michigan Public Health Institute (MPHI), and more recently, the Michigan Department of Environmental Quality (MDEQ).

The collaboration among MDCR, MDHHS, MDE, and MPHI started as an interagency workgroup under the umbrella of GARE. GARE, which stands for the Government Alliance on Race and Equity, is a national network that focuses on bringing together areas of government to work on racial equity and inclusion, as well as expanding on the important role that government plays in creating and sustaining equitable outcomes. Through this network, members have the opportunity to share best practices around diversity, equity and inclusion; and gain access to tools and resources to better understand and identify strategies to dismantle inequities and create inclusion. These resources address a range of topics related to racial equity, including health.

GARE primarily works with city and county governments. However, it also offers opportunities for organizations in all sectors that want to be involved in equity work, including private, nonprofit and state agencies. MDCR has been a member of GARE for several years and in 2017, encouraged MDHHS, MDE, and MPHI to also join the GARE

network. Since joining GARE, this group of agencies has been meeting quarterly to discuss issues related to racial equity, strategize how to maximize the benefits of their GARE membership, and brainstorm ideas for collaboration around topics of diversity, equity, inclusion, health, etc. The group has also had conversations about the need for state agencies to better understand and learn from each other, and develop common language and a framework around equity. Toward this end, they have worked on developing multi-departmental racial equity inventories with the purpose of identifying points of intersectionality among the departments and equity efforts. The goal is to establish a collective template that informs future opportunities for promoting and implementing equity throughout the state.

Another area of collaboration is the State of Solutions (SOS) initiative. SOS is a national effort, somewhat like GARE, but with a specific focus on health equity. Convened by the Institute for Healthcare Improvement (IHI) with support from the Robert Wood Johnson Foundation (RWJF), this effort involves working with collaborative partners to apply an equity lens and develop intentional strategies to improve health, well-being and equity for people of all racial and ethnic backgrounds. Michigan is one of 15 participating states, with MDCR serving as the lead organization of the collaborative in Michigan, of which MDHHS is a part. The SOS initiative provides Michigan with the opportunity to build and expand its unprecedented collaboration with state agencies and other stakeholders in order to minimize isolated efforts and work together to change the dominant narrative and the systems that sustain inequitable outcomes.

As a result of this collaboration, MDCR has been able to expand its initiative, Building Internal Capacity to Create and Sustain Equity Long Term. This one-year training program began in August of 2018 and will continue through June 2019. Though it was originally intended to be an internal process to train a core group of staff from within MDCR, they have extended the training to representatives from state agencies that are part of the interagency collaborative (MDHHS, MPHI, MDE, and MDEQ). By expanding this core group of participants, staff from across several state agencies and departments will gain knowledge and awareness of the root causes of racial discrimination and systemic inequity, build capacity to effectively apply an equity lens to their work, and develop common language and a framework to operationalize and implement equity. The initiative consists of five phases:

1) Train a core team to serve as agents of change with representation from every unit and division of MDCR and select staff from departments that are members of the interagency collaborative.

2) Deliver at least 50 hours of racial equity training to the core team.

3) Develop a capacity building plan and organizational structure to institutionalize equity within and outside of MDCR.

4) Grow a train-the-trainer module centered around advancing racial equity within local jurisdictions and organizations.

5) Provide resources and tools to advance racial equity within local jurisdictions.

The first two phases of this project, which took place in 2018, have focused on raising awareness and racial consciousness. This includes learning how racialized ideologies impact staff, the people they serve and the work that they do. This requires understanding systems, the impact of discrimination, and the difference between discrimination and systemic advantage. The subsequent three phases, taking place from January to June 2019, are designed to assess collective levels of readiness to implement change and explore strategies to operationalize equity. Through this process they intend to create a template that can serve as a replication model for other state agencies and organizations that want to better understand how to implement and operationalize equity. By working with members of the interagency collaborative group in the implementation and operationalization stages, collectively they will be better able to promote a sustained equity approach through policies and practices within and across departments. This will further help in reaching the ultimate goal, which is to institutionalize equity and ensure it is sustained long term.

Advancing Equity

The collaborative partnership among MDCR, MDHHS, and other state agencies advances equity through multiple means. GARE and SOS seek to promote equity by applying a racial equity (GARE) and/or health equity (SOS) lens as participating organizations work to address policy and institutional systems that are driving inequities. GARE specifically approaches equity through a racial equity framework that defines and works to address implicit and explicit bias; along with individual, institutional and structural racism. Strategies include building organizational capacity to achieve sustainable institutional change; using tools to create policies, programs and practices that disrupt and dismantle inequities; applying data to set goals and measure progress; and partnering with communities to achieve meaningful outcomes.[29]

The SOS initiative advances equity by working with state collaboratives to implement

[29] Local and Regional Government Alliance on Race & Equity (GARE), Our Approach [webpage]. Retrieved (1/23/19) from: https://www.racialequityalliance.org/about/our-approach/

improvement strategies and institute sustainable systems change within their organizations. This initiative views states as natural units of innovation and change. Therefore, it enables state agencies and community coalitions and networks to come together to catalyze improvements in health.[30] It moves equity forward by implementing strategic and coordinated actions across sectors and communities to improve health equity.[31]

MDCR's Building Internal Capacity to Create and Sustain Equity Long Term training program is advancing equity by exploring this issue from a personal and interpersonal level as an essential step in pursuing institutional change. While it is important to understand how history, culture, systems, and institutions have led to injustices, it is equally important for people to understand how these have influenced individuals. This includes raising awareness of how people see themselves, how they see others and what shapes those views. Doing so is necessary to build individuals' capacity to become racially conscious. This pursuit involves exploring issues such as racialized messages and ideology, social conditioning and internalize oppression, systemic advantage/disadvantage, personal experiences of discrimination, intergenerational trauma, implicit bias, and dynamics between power and privilege. All of these influences how individuals engage and connect with people, as well as have an impact on health. Becoming aware of the ways in which individuals and their health have been affected by these factors allows health and human service professionals to better understand the people they serve, and even themselves. In turn, this learning provides a foundation for cultivating relationships needed to address racism and other forms of oppression as well as developing, implementing and operationalizing strategies to promote equity. Essentially, it is necessary to understand the ways individuals have been impacted by societal factors in order to create a system that will dismantle inequities.

Cross-Cutting, Collaborative Efforts – Challenges and Opportunities

The collaborative efforts highlighted above bring both challenges and opportunities to advancing health and social equity. One shared challenge has been bringing various partners together and establishing a common understanding and language around equity that is inclusive of all that equity encompasses, such as health, race, class, economics, gender, etc. There has been somewhat of a disconnect when discussions

[30] 100 Million Healthier Lives, Initiatives, States of Solutions [webpage]. Retrieved (2/8/19) from: https://www.100mlives.org/initiatives/#scale2

[31] 100 Million Healthier Lives, convened by the Institute for Healthcare Improvement (IHI). 15 States Striving to Become "States of Solutions" in Addressing Health Equity: Governmental and private groups to partner on population health challenges [Press release]. May 2, 2018. Retrieved (2/8/19) from: http://www.ihi.org/about/news/Documents/States_of_Solutions_Final_050218.pdf

focus exclusively on health equity, particularly with the merger of human services and community health. This challenge has been addressed by broadening the concept of health equity to equity in general, so as to include everyone at the table, while also increasing awareness of the different types of equity that exist and how they intersect. The goal is to help audiences comprehend that health equity is determined by a range of socioeconomic and environmental factors and it is almost impossible to separate one from the other. Building awareness of the connection between social issues and health with different audiences has enabled health equity to become more of an inclusive concept among collaborators both within and outside of MDHHS.

Another challenge has been obtaining the funding, staff and logistical support needed for these initiatives to be fully successful. Limitations in these resources presents significant constraints on what can be done department wide and the reach of these efforts. Though staff have been very supportive of equity initiatives and willing to participate in committees, workgroups, trainings, collaborative planning endeavors, etc., they are restricted by time and other duties such as attending to their day-to-day job responsibilities. Having funding to support dedicated staff time could facilitate greater involvement and success. Additionally, since the rollout of the DEI Plan, the DEI Council has discovered needs that require funding in order for the plan to be implemented properly. Though they are doing their best to leverage existing resources, there is much more that could be done if designated funding was available. This raises the issue of budget priorities and leveraging opportunities. By aligning resources across funding streams and looking for creative ways to leverage existing assets, equity may be advanced more optimally, both within MDHHS and across state government.

People believing that equity is an add-on to their work presents an additional challenge, particularly in light of the time and funding constraints they face. This sometimes creates resistance among personnel to adopt an equity approach. However, by employees keeping equity at the forefront of their minds, and by the department transforming organizational practice in order to make it an integral part of how MDHHS operates, equity will become embedded throughout the department and a seamless part of daily work. This can be accomplished with strong leadership support and continued training and skills development.

Despite these challenges, collaboration has brought opportunities as well. Working with partners within MDHHS, across other state organizations and with a non-profit public health institute brings in additional levels of expertise that are beneficial in raising awareness, clarifying important issues, identifying areas of intersectionality, and guiding strategies. It also brings additional tools and resources to the table that organizations and programs would not have access to otherwise. The potential to leverage resources

that are already in place and capitalize on existing efforts is another benefit of collaboration. Those that are already involved in equity work come to the table with an understanding of the difficulties inherent in advancing equity and have made a commitment to working through these challenges. Furthermore, by working with those who are currently doing equity work, there is the opportunity to accelerate momentum and maximize strategies for change. Uniting with others strengthens efforts through collective impact and could also set a precedence for others to become involved and engaged in this work. Essentially, the equity movement has the potential to grow as a result of these collaborations and partnerships by expanding the venues, opportunities and initiatives organizations and communities are engaged in.

Alignment with Public Act 653

The programmatic efforts and cross-cutting, collaborative initiatives described above align with many PA 653 provisions. These are highlighted in the chart below.

PA 653 Provision	MDHHS Program/Initiative and Activities
(a) Develop and implement a structure to address racial and ethnic health disparities in this state.	**Youth Violence** – The Injury Community Implementation Group convened by the Core VIPP provides a structure for addressing injury and violence prevention in diverse communities. **Infant Mortality** – The Maternal Infant Health Strategy Group (MISG) and the Mother Infant Health and Equity Improvement Plan serve as structures to address racial and ethnic health disparities related to maternal and infant health. **Diversity, Equity, and Inclusion (DEI) Plan** – This initiative provides a plan and implementation structure to promote diversity, equity and inclusion within the department, and thereby advance health and social equity. It further strengthens the structure to elevate health and social equity as a priority, signifying an institutional commitment to making diversity, equity and inclusion an integral part of the department's work. **Equity and Cultural Competency (EEC) Program** – The EEC Program enhances and strengthens existing structures within the department to address health disparities by building the capacity of leadership and staff through the training program, fostering environment and culture changes within the department, and providing a

PA 653 Provision	MDHHS Program/Initiative and Activities
	platform for organizational and systems change to advance health/social equity. **Michigan Department of Civil Rights (MDCR)/ Government Alliance on Race and Equity (GARE)/ State of Solutions (SOS)** – The interagency workgroup is working on developing a collective framework that informs future opportunities for strategically promoting and implementing equity. This includes having a capacity building plan and organizational structure to institutionalize equity.
(b) Monitor minority health progress.	**Youth Violence** – Data collected through the MiVDRS can be analyzed to provide insights into violent deaths that are experienced by racial and ethnic minority populations in Michigan, as well as potential points of intervention to reduce disparities in this area.
(c) Establish minority health policy.	**DEI Plan** – The department is in the final stages of establishing a policy requiring all MDHHS personnel to complete an online training on health equity and systemic racism. • This policy will ensure MDHHS personnel are equipped with the knowledge and skills necessary to address minority health and human service needs. • They are also looking to provide training in, and encourage the use of, an equity assessment tool, which would provide a structured process for examining the potential impact of existing and/or new policies and programs on racial equity. • Additionally, Service Delivery is taking a closer look at the department's administrative policies and processes – including Request for Proposal (RFP) and contracting practices – in order to ensure they support equity. This is in alignment with the Governor's Executive Directive – 08 (encouraging expanded opportunities for geographically-disadvantaged business enterprises in Michigan). **ECC Program** – The DEI Council has adopted the ECC Program and integrated it into the work of the Training and Professional Development Action Team. As mentioned, they are also in the final stages of instituting the department-wide policy requiring MDHHS employees to complete equity-related online training.

PA 653 Provision	MDHHS Program/Initiative and Activities
(d) Develop and implement an effective statewide strategic plan for the reduction of racial and ethnic health disparities.	**Infant Mortality** – As noted, the Mother Infant Health and Equity Improvement Plan serves as a statewide, strategic plan to address racial and ethnic health disparities related to maternal and infant health.
(e) Utilize federal, state, and private resources, as available and within the limits of appropriations, to fund minority health programs, research, and other initiatives.	**Hepatitis B** – The collaborative funding provided to four local health departments to implement SSPs in their community is an example of how resources are being utilized to fund evidence-based programs to address racial and ethnic minority health disparities [this also relates to provision (m) below].
(f) Provide the following through interdepartmental coordination: i. Data and technical assistance to minority health coalitions and any other local entities addressing the elimination of racial and ethnic health disparities. ii. Measurable objectives to minority health coalitions and any other local health entities for the development of interventions that address the elimination of racial and ethnic health disparities.	**Hepatitis B** – Technical assistance is being provided to local entities to reduce disparities through the Harm Reduction Analyst, who assists new SSPs and works to increase statewide harm reduction capacity in Michigan. • Technical assistance is also provided by the PHBPP team to local jurisdictions to implement innovative strategies to reduce infection of infants born to HBsAg-positive women. **Youth Violence** – Through the MiVDRS, data on violent deaths are available to community partners, stakeholders, policy-makers, and other local entities. • In addition, one of the core functions of the Injury and Violence Prevention Section is to provide technical assistance to communities and partners.
(h) Develop and implement recruitment and retention strategies to increase the number of minorities in the health and social services professions.	**Hepatitis B** – The Viral Hepatitis Unit, in collaboration with Grand Rapids Red Project, hosted a training in which issues pertaining to increasing diversity of staff, management, and leadership was among the topics addressed. **Infant Mortality** – The Bureau of Family Health Services is part of an effort, led by the Population Health Administration, to develop a new approach to hiring personnel. The new protocol is designed to increase diversity among the department's leadership and staff. • It includes training for managers involved in the hiring process, revised screening and selection criteria, improved equity questions, and metrics aimed at increasing workforce diversity.

PA 653 Provision	MDHHS Program/Initiative and Activities
	• The effort also involves establishing procedures to ensure the success and retention of racially and ethnically diverse staff. • These strategies are based on efforts within The Office of Workforce Development and Transformation that have been very successful. **DEI Plan** – The Recruiting, Hiring, and Retention Action Team is working to ensure the department has a diverse workforce of health and human service professionals, inclusive of racial and ethnic minorities. Diversity in leadership and staff is essential for developing and providing health and human services that are culturally proficient, and for addressing health and social issues. **ECC Program** – The ECC Program strives to bring about organizational change and build a new culture within the department in order to promote inclusion and equity. While not a direct strategy for increasing the recruitment and retention of minorities in health and social services professions, this could attract more people of color to seek employment at the department and aid in the retention of existing staff.
(i) Develop and implement awareness strategies targeted at health and social service providers in an effort to eliminate the occurrence of racial and ethnic health disparities.	**Hepatitis B** – The Viral Hepatitis Unit and PHBPP provided training and educational seminars for staff and partners to raise awareness of evidence-based strategies, programs, and services to reduce the transmission of hepatitis B. **Youth Violence** – Strategies to raise awareness among health and social service providers about health and social equity issues include development and distribution of materials to inform grantees about health inequities and disparities related to sexual violence, as well as equity-related trainings for partners and staff. **DEI Plan** – Related activities include the following: • The Training and Professional Development Action Team has adopted a department-wide training curriculum (derived from HDRMHS ECC Program described in this report) and created a training policy recommending all MDHHS personnel be required to complete a web-based health equity and systemic racism training. Training efforts are

PA 653 Provision	MDHHS Program/Initiative and Activities
	designed to build staff capacity to apply DEI principles to their work, and increase awareness of and ability to recognize and reduce implicit bias and system inequities contributing to disparities. • The department is developing an intranet page to promote awareness, facilitate communication, and provide a platform for Action Teams to share information. It will also keep staff informed, connected, and involved in DEI efforts. • The DEI Plan also includes strategies to raise awareness among health and social service providers by collaborating with vendors, providers and stakeholders in efforts to address systemic inequities. • It is also working to raise awareness among MDHHS leadership and staff of systemic bias that may exist in departmental policies and procedures so that these can be identified and eliminated. **ECC Program** – The ECC Program works to raise awareness and increase knowledge and understanding among health and social service providers about issues pertaining to cultural competency and equity. • This includes strengthening capacity to examine the underlying causes of inequities and to identify policy, systems and environmental changes that advance equity. • The program is also piloting parts of the training curriculum with external partners and stakeholders. • They plan to extend the program outward and offer trainings to other health and social service providers in the state once internal capacity is built. **MDCR/GARE/SOS** – The collaboration with MDCR aligns with PA 653 in its efforts to explore and better understand how the experience of racial discrimination impacts health. • This encompasses looking at how adverse experiences and trauma, including intergenerational trauma, shape behavioral practices and unhealthy outcomes. • They are also exploring the ways in which a racialized ideology impacts physical, mental, emotional, and social health. • Additionally, through MDCR's Building Internal Capacity to Create and Sustain Equity Long Term

PA 653 Provision	MDHHS Program/Initiative and Activities
	training program, select staff from MDHHS (along with other state departments) are gaining awareness and knowledge of conditions underlying racial and ethnic inequities, which in turn contribute to health disparities. • MDCR is also working with MDHHS to develop a training on implicit bias as part of the ECC Program. This two-day workshop is part of a train-the-trainer program, which will help to build the department's internal training capacity and increase its reach among staff. • These efforts are working toward building awareness among health and social service providers about issues contributing to racial and ethnic health disparities, while simultaneously increasing their ability to identify and implement strategies to ultimately eliminate these disparities.
(j) Identify and assist in the implementation of culturally and linguistically appropriate health promotion and disease prevention programs that would emphasize prevention and incorporate an accessible, affordable, and acceptable early detection and intervention component.	**Hepatitis B** – The PHBPP uses translated educational materials and a language line interpreter service to help reduce barriers with non-English speaking clients. • Additionally, their partnership with various community-based organizations, such as migrant health centers, refugee/immigration services, Hmong project, and the Asian Center helps ensure programs and services are culturally and linguistically appropriate. **Infant Mortality** – The involvement of multiple stakeholders and community members in the development and implementation of the Mother Infant Health and Equity Improvement Plan will help ensure strategies and initiatives are culturally and linguistically appropriate for the populations they intend to serve. • Additionally, cross-sector involvement will facilitate linkages among clinical practice, public health and community resources to improve access to prevention, early detection and treatment measures. **DEI Plan** – The Culture and Climate as well as Training and Professional Development outcomes outlined in the DEI Plan address ensuring the implementation of

PA 653 Provision	MDHHS Program/Initiative and Activities
	programs and services that meet national Culturally and Linguistically Appropriate Services (CLAS) Standards. This will strengthen the implementation of culturally and linguistically appropriate services, both in the health and human services fields. **ECC Program** – Through cultural competency training and skills development, the ECC Program serves to enhance the department's ability to identify and assist in the implementation of culturally and linguistically appropriate programs.
(l) Appoint a department liaison to provide the following services to local minority health coalitions: i. Assist in the development of local prevention and intervention plans. ii. Relay the concerns of local minority health coalitions to the department. iii. Assist in coordinating minority input on state health policies and programs. iv. Serve as the link between the department and local efforts to eliminate racial and ethnic heal	**Infant Mortality** – Though not formally a department liaison, the Mother Infant Health and Equity Improvement Plan Ambassador Program provides linkages to Michigan communities and populations served through participating ambassadors. • These ambassadors will have a working relationship with MDHHS as well as community partners, and will provide input regarding their community's needs. • This will allow MDHHS to seek input on policies and programs, as well as learn about barriers that exist so that efforts can be more meaningful and have a greater impact. **DEI Plan** – Though the DEI Plan does not specifically call for a department liaison to be appointed, it does recommend MDHHS designate an Equity Officer. It also supports soliciting minority input on state policies and programs, and calls for underserved populations to be represented among state vendors and service providers.
(m) Provide funding, within the limits of appropriations, to support evidence-based preventative health, education, and treatment programs that include outcome measures and evaluation plans in minority communities.	**Hepatitis B** – As stated with provision (e) above, funding has been provided to four local health departments to implement evidence-based SSPs in their community in order to reduce transmission of hepatitis B, including among racial and ethnic minorities.

Conclusion

In 2018, MDHHS continued to expand and evolve its health and social equity efforts by not only implementing health equity initiatives in specific program areas, but by also working collaboratively across organizational units and other state agencies to advance equity. Among one of the most noteworthy accomplishments of 2018 was the launch of the department's DEI Plan. This plan affirms the department's commitment to identify and address systemic inequities, and provides a framework for all MDHHS areas to promote diversity, equity and inclusion. The DEI Plan, coupled with the ECC Program (also launched in 2018), has the potential to result in real cultural change within the department; and in turn, effectively impact racial and ethnic minority inequities.

Additionally, the department's collaboration with MDCR, other state agencies and a non-profit public health institute signifies a greater movement to recognize the impact of social inequities and various forms of oppression on health outcomes. This has led to a commitment of participating agencies to work together to identify points of intersectionality and opportunities to apply an equity lens to institutional structures, policies, practices and procedures. Through these efforts, MDHHS is better able to implement strategic and coordinated actions across sectors and communities to improve both health and social equity.

While MDHHS celebrates its accomplishments of 2018, it acknowledges that there is more work to be done. Efforts to advance equity need to be continually woven into the fabric of the department's daily work, and equity principles upheld as the guide posts of initiatives. Moreover, equity efforts need to be further supported through investment of fiscal resources, human capital, time, and prioritization. With these enhancements – and through continued efforts to apply an equity lens to improve departmental structures, practices, workforce diversity, and staff capacity – MDHHS will be able to succeed at achieving the aims of PA 653. Moreover, as public servants accountable to all Michigan citizens, state employees and representatives need to focus on interventions and reforms that will change the systems and policies that drive inequities. With this focus, MDHHS, and indeed the state, will be well positioned to move equity forward.

Acknowledgements

The Health Disparities Reduction and Minority Health Section would like to thank representatives from the Diversity, Equity, and Inclusion Plan initiative, Equity and Cultural Competency Program, and Michigan Department of Civil Rights collaborative equity efforts for taking part in key informant interviews. The section would also like to thank management and staff from the Michigan Department of Health and Human Services Viral Hepatitis Unit, Perinatal Hepatitis B Prevention Program, Bureau of Family Health Services, and the Injury and Violence Prevention Section for providing information on their program efforts. Additional thanks are extended to these organizational areas and partners from the Eastern Michigan University Healthy Asian American Project for reviewing the data briefs.

Attachment A: Public Act (PA) 653

Act No. 653
Public Acts of 2006
Approved by the Governor
January 8, 2007
Filed with the Secretary of State
January 9, 2007
EFFECTIVE DATE: January 9, 2007
STATE OF MICHIGAN
93RD LEGISLATURE
REGULAR SESSION OF 2006

Introduced by Reps. Murphy, Gonzales, Zelenko, Williams, Whitmer, McConico, Leland, Clemente, Condino, Tobocman, Farrah, Lipsey, Alma Smith, Clack, Cushingberry, Plakas, Hopgood, Waters, Anderson, Stewart, Kolb, Meyer, Adamini, Brown, Gaffney, Virgil Smith, Hunter, Kathleen Law, Bieda, Meisner, Wojno, Vagnozzi, Taub, Accavitti, Stakoe, Gleason, Wenke, Ward, Byrum, Sak, Nitz, Moolenaar, Casperson, Dillon, Angerer, Bennett, Byrnes, Caul, Cheeks, Espinoza, Green, Hansen, Rick Jones, Kahn, David Law, Lemmons, Jr., Marleau, Mayes, McDowell, Miller, Polidori, Proos, Sheltrown and Spade

ENROLLED HOUSE BILL No. 4455

AN ACT to amend 1978 PA 368, entitled "An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to provide for the imposition of a regulatory fee; to provide for the levy of taxes against certain health facilities or agencies; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for the implementation of federal law; to provide for penalties and remedies; to provide for sanctions for violations of this act and local ordinances; to provide for an appropriation and supplements; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates," (MCL 333.1101 to 333.25211) by adding section 2227.

The People of the State of Michigan enact:
Sec. 2227. The department shall do all of the following:
(a) Develop and implement a structure to address racial and ethnic health disparities in this state.
(b) Monitor minority health progress.
(c) Establish minority health policy.
(d) Develop and implement an effective statewide strategic plan for the reduction of racial and ethnic health disparities.
(e) Utilize federal, state, and private resources, as available and within the limits of appropriations, to fund minority health programs, research, and other initiatives.

(f) Provide the following through interdepartmental coordination:
(*i*) Data and technical assistance to minority health coalitions and any other local entities addressing the elimination of racial and ethnic health disparities.
(*ii*) Measurable objectives to minority health coalitions and any other local health entities for the development of interventions that address the elimination of racial and ethnic health disparities.
(g) Establish a web page on the department's website, in coordination with the state health disparities reduction and minority health section, that provides information or links to all of the following:
(*i*) Research within minority populations.
(*ii*) A resource directory that can be distributed to local organizations interested in minority health.
(*iii*) Racial and ethnic specific data including, but not limited to, morbidity and mortality.
(h) Develop and implement recruitment and retention strategies to increase the number of minorities in the health and social services professions.
(i) Develop and implement awareness strategies targeted at health and social service providers in an effort to eliminate the occurrence of racial and ethnic health disparities.
(j) Identify and assist in the implementation of culturally and linguistically appropriate health promotion and disease prevention programs that would emphasize prevention and incorporate an accessible, affordable, and acceptable early detection and intervention component.
(k) Promote the development and networking of minority health coalitions.
(*l*) Appoint a department liaison to provide the following services to local minority health coalitions:
(*i*) Assist in the development of local prevention and intervention plans.
(*ii*) Relay the concerns of local minority health coalitions to the department.
(*iii*) Assist in coordinating minority input on state health policies and programs.
(*iv*) Serve as the link between the department and local efforts to eliminate racial and ethnic health disparities.
(m) Provide funding, within the limits of appropriations, to support evidence-based preventative health, education, and treatment programs that include outcome measures and evaluation plans in minority communities.
(n) Provide technical assistance to local communities to obtain funding for the development and implementation of a health care delivery system to meet the needs, gaps, and barriers identified in the statewide strategic plan for eliminating racial and ethnic health disparities.
(o) One year after the effective date of this section and each year thereafter, submit a written report on the status, impact, and effectiveness of the amendatory act that added this section to the standing committees in the senate and house of representatives with jurisdiction over issues pertaining to public health, the senate and house of representatives appropriations subcommittees on community health, and the senate and house fiscal agencies.

This act is ordered to take immediate effect.
Clerk of the House of Representatives
Secretary of the Senate
Approved

For more information about this report, please contact:
Michigan Department of Health and Human Services
Health Disparities Reduction and Minority Health Section
colormehealthy@michigan.gov
Phone: 517-284-4760

MDHHS is an Equal Opportunity Employer, Services and Programs Provider
100 copies printed