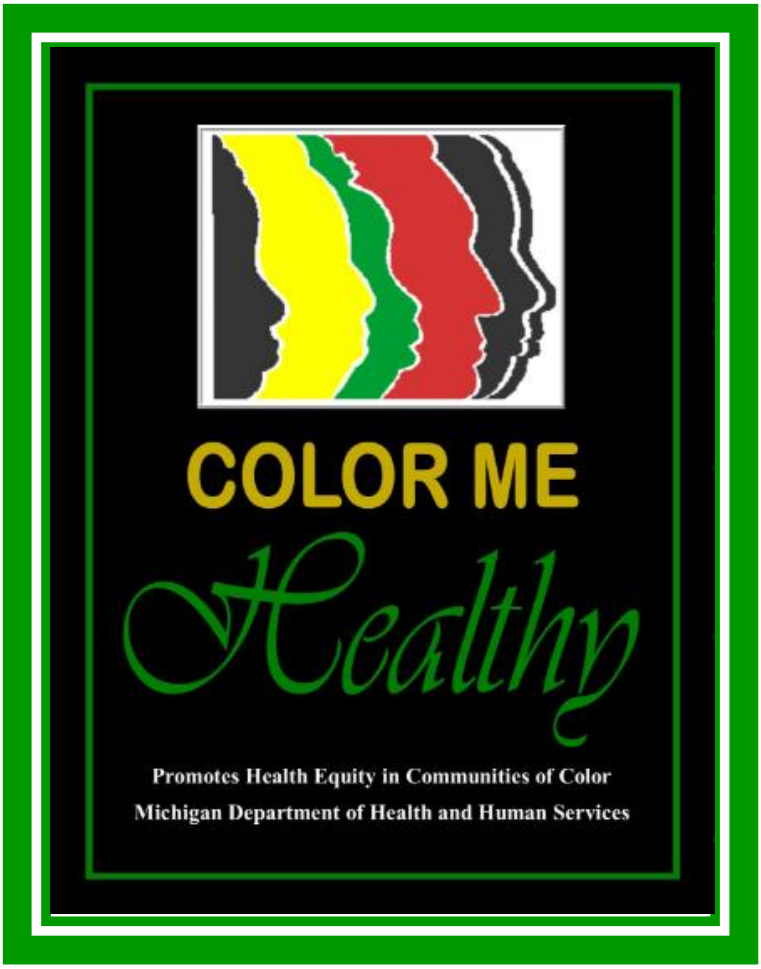
Michigan Department of Health and Human Services

2019 Health Equity Report

Moving Health Equity Forward



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

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

May 2020

Dear Legislator:

On behalf of the Michigan Department of Health and Human Services (MDHHS), I am pleased to present the 2019 MDHHS Health Equity Report, "Moving Health Equity Forward." This report documents the department's efforts to address racial and ethnic health disparities in accordance with Public Act 653. Included with the report are:

- A one-page overview with report highlights.
- A supplemental data brief that looks at changes in health disparities from 2010 to 2017.

This year's report focuses specifically on evidence-based and promising practices that are being implemented throughout the department to address racial and ethnic disparities and promote health and social equity. Evidence-based and promising practices improve our knowledge of:

- Best available research evidence.
- Best practices from the field.
- Community preferences and values.

This results in programs and services that are more likely to meet the needs of marginalized populations and lead to successful outcomes. These efforts are also likely to use public funding and resources more efficiently.

Several examples of evidence-based and promising practices are featured in the report. Such initiatives demonstrate how MDHHS is forging ahead in its endeavor to address disparities and promote equity for all. We are also fully cognizant that more research is needed with racial and ethnic minorities to identify evidence-based and promising practices to improve health outcomes. As we continue this work in 2020 and beyond, we are most appreciative of Michigan legislators and all our community partners. We hope this report will be informative and useful to our collective effort.

Sincerely,

Brenda J. Jegede, MPH, MSW
Manager, Office of Equity and Minority Health
Michigan Department of Health and Human Services

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2019 Health Equity Report
Moving Health Equity Forward

Executive Summary

The Michigan Department of Health and Human Services (MDHHS) 2019 Health Equity Report, "Moving Health Equity Forward," serves as the annual report on the department's efforts to address racial and ethnic health disparities as required by Public Act 653. This legislation was passed by Michigan's 93rd Legislature in 2006 and became effective in January 2007. It amends the Michigan Public Health Code (1978 PA 368; MCL Section 333.2227). (See Attachment A.)

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

The 2019 report presents data on minority health status and disparities including social determinants of health, morbidity, and mortality indicators with the highest Index of Disparity. This measure reflects how much variation or disparity exists in the population for an indicator. The report also includes a supplemental data brief on changes in health disparities from 2010 to 2017 (see data brief attached). Additionally, the report highlights evidence-based and promising practices being implemented throughout the department to address these disparities. Evidence-based and promising practices are based on scientific research and field experience, thus increasing the likelihood of success and more efficient use of resources.

Information was obtained through a department-wide survey along with follow-up communications with select program areas within MDHHS. Of those organizational areas that completed the department-wide survey:

- 50.8 percent implemented evidence-based strategies or promising practices to promote workforce development and diversity.
- 39 percent reported implementing evidence-based programs, activities, services, or promising practices to reduce disparities/advance equity.
- 37.3 percent implemented evidence-based strategies or promising practices

related to the delivery of culturally and linguistically appropriate programs and services.

- 30.5 percent implemented evidence-based programs, activities, services, or promising practices to address social determinants of health.
- 25.4 percent reported implementing evidence-based strategies or promising practices to increase equity awareness among health and social service providers.
- 25.4 percent implemented evidence-based strategies or promising practices related to collecting, analyzing, and reporting race and ethnicity data.
- 17.8 percent reported implementing policies to advance equity based on evidence-based or promising practices.
- 17.8 percent reported that they received, allocated, or redistributed funds to support equity-related evidence-based strategies or promising practices.

Evidence-based and promising practices highlighted in the 2019 report include:

- **Michigan's State Innovation Model (SIM) Community Health Innovation Regions (CHIRs)** – A placed-based, promising practice model for improving the well-being of a region and reducing unnecessary medical costs through collaboration and systems change.
- **Ottawa County's Pathways to Better Health Program** – An initiative based on the research-tested Pathways to Better Health model that facilitates access to preventative care and early treatment by connecting at-risk individuals to services that support care plans and produce positive health outcomes.
- **ERACCE Training and Children's Services Child Welfare Antiracism Team** – A partnership effort between the Office of Workforce Development and Training and the Children's Services Administration to address the overrepresentation of children of color in the child welfare system.
- **Pathways to Potential** – An innovative approach to providing human services which places MDHHS caseworkers, called success coaches, in schools and local venues to assist students and families with removing barriers and connecting them to community services so that they can become self-sufficient and find their pathway to success.
- **Michigan's Women, Infants, and Children (WIC) Program** – A federally-funded, evidence-based initiative that provides nutritious foods, nutrition education, breastfeeding support, and referrals to healthcare and social services for low to moderate income women and children who are at nutritional risk.

These efforts demonstrate how MDHHS is continuing to improve and expand its health and social equity work as it seeks to carry out the provisions of PA 653 and move equity forward in Michigan.

MDHHS 2019 Health Equity Report
Moving Health Equity Forward
Report Highlights

Public Act 653

Requires MDHHS to:

- Develop and implement a structure to address racial and ethnic minority health disparities.
- Establish minority health policy.
- Promote workforce diversity.
- Implement additional actions to advance health equity as specified in the provisions of the act.

Health Disparities in Michigan

Index of Disparity (ID): Reflects how much disparity exists in the population for an indicator. It compares populations prevalence to a reference population prevalence and is expressed as a proportion of the reference population prevalence.

Indicators with the highest ID in Michigan

Indicator	Highest Rate	Overall ID
Poverty rate (population), %	Arab: 28.1% Total pop.: 9.7%	91.8%
Less than high school diploma, %	Hispanic: 27.3% Total pop.: 9.1%	76.7%
Kidney disease mortality per 100,000	Black, NH: 28.3 Total pop.: 15.0	56.4%
COPD prevalence, % (ever told)	Native Am.: 16.3% Total pop.: 7.6%	48.2%
Diabetes mortality per 100,000	Arab: 37.0 Total pop.: 21.9	46.0%
CVD prevalence, % (ever told)	Native Am.: 14.1% Total pop.: 8.5%	29.0%

Evidence–Based and Promising Practices

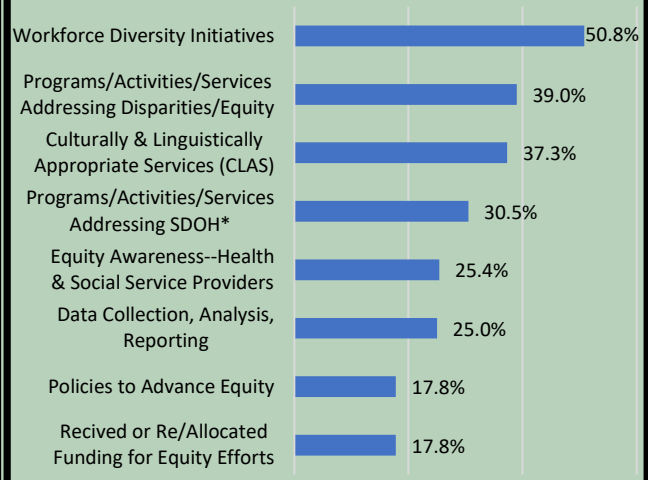
Refers to strategies and efforts that integrate:

- The best available research evidence.
- Best practice and field experience.
- Community preferences and input.

2019 Health Equity Survey

MDHHS organizational areas were surveyed about evidence-based and promising practices they implement to address health disparities & equity.

MDHHS 2019 Health Equity Survey
Percent of Respondents who Reported Implementing Equity-Related Evidence-Based or Promising Practices By Type and Focus of the Practice
(N=118 Respondents)



* Social Determinants of Health

Highlighted Programs

A select number of survey respondents completed a follow-up questionnaire. Highlighted programs include:

- **State Innovation Model (SIM) Community Health Innovation Regions (CHIRs)** – A promising practice that uses a Collective Impact approach and ABLe Change Framework to improve health and reduce medical costs through collaboration and systems change.
- **Ottawa County's Pathways to Better Health** – An initiative based on a research-tested model that uses community health workers to connect at-risk individuals to community services to improve health outcomes.
- **Child Welfare Antiracism Team** – A team, based on the Crossroads Model, formed to address the overrepresentation of children of color in child welfare.
- **Pathways to Potential** – An innovative approach to providing human services in a school setting that helps students and families reach their greatest potential.
- **Women, Infants, and Children (WIC)** – An evidence-based program that provides food benefits, breastfeeding support, and referrals for women and children at nutritional risk.

For more information, contact the MDHHS Office of Equity and Minority Health: Phone: 517-284-4760, colormehealthy@michigan.gov

2019 Health Equity Report
Moving Health Equity Forward

Introduction

The 2019 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 (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 presents data on current minority health status and disparities in Michigan, as well as highlights evidence-based and promising practices being implemented throughout the department to address these disparities. Data on minority health status was obtained through the Michigan Behavioral Risk Factor Surveillance System (BRFSS), vital records, and census data sets. Program information was obtained through a department-wide survey along with a follow-up questionnaire completed by select program areas within MDHHS.

Racial and Ethnic Minority Health and Disparities in Michigan

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 or more populations. In Michigan, as in the United States, racial and ethnic minority populations carry a disproportionately heavy burden of health disparities. Many of these disparities are preventable and constitute what is known as health inequities.

[1] Minority Health and Health Disparities Research and Education Act. *United States Public Law 106-525* (2000), p. 2498. Retrieved (3/10/20) from: https://www.govinfo.gov/content/pkg/PLAW-106publ525/pdf/PLAW-106publ525.pdf

Health inequities 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.[2] Conversely, health equity is the fair and just distribution of social resources and opportunities needed to achieve well-being.[3]

Attaining health equity requires identifying, examining, and addressing the root causes of health inequities. This includes systemic inequities that exist due to racism, sexism, classism, and other forms of discrimination. These structural or systemic inequities are perpetuated when history, cultural knowledge, or community-driven approaches are not taken into account when decisions are made, or when consideration is not given to how a decision may impact one population more than another.[4]

Such decisions often affect the economic and social conditions in which people are born, grow, live, work and age—or social determinants—which influence the health of individuals and communities.[5] Therefore, achieving health equity requires addressing social determinants of health—such as safe and affordable housing, access to transportation, job security, clean water, public safety, social support, quality education, availability of nutritious food, etc.[6]

The tables on pages 3-5 show current data on health indicators for the Michigan population by race and ethnicity. These indicators include social determinants of health, morbidity, and mortality. In particular, the tables display indicators with the highest Index of Disparity (ID). This measure summarizes the disparity between populations' prevalence when compared to a reference population prevalence (in this case, total population) and is expressed as a proportion of the reference population prevalence. For example, an ID of zero percent indicates no disparity in the population, whereas higher values of ID indicate increasing levels of disparity in the population. Therefore, ID reflects how much variation or disparity exists in the population for an indicator.

[2] Whitehead M. The concepts and principles of equity and health. *International Journal of Health services*. 1992;22(3), 429-445.
[3] Ingham County Health Equity Project; Association of State and Territorial Health Officials (ASHTO), 2000.
[4] Minnesota Department of Health. *Advancing Health Equity in Minnesota: Report to the Legislature*. February 2014. Retrieved (4/1/20) from: https://www.health.state.mn.us/communities/equity/reports/index.html.
[5] 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.
[6] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People 2020, Social Determinants of Health [webpage]. Retrieved (3/10/20) from: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Table 1: Social Determinant of Health Prevalence with a High Index of Disparity by Race and Ethnic Background in Michigan[1]								
Social Determinants Indicators	**African American, NH**	**Hispanic/ Latinx[a]**	**A/PI[b], NH**	**Native American**	**Arab**	**White, NH**	**Total**	**Index of Disparity[c] (ID)**
Poverty rate (population) %	23.5%	17.8%	7.1%	17.6%	28.1%	7.1%	9.7%	91.8%
Less than High School diploma %	13.8%	27.3%	10.7%	11.9%	22.0%	7.4%	9.1%	76.7%
Unemployment rate %	13.6%	7.0%	4.2%	11.4%	7.0%	4.5%	5.9%	52.3%
High School dropout rate %	14.28%	12.99%	3.92%	15.18%	8.85%	6.83%	8.85%	51.6%
Households with no vehicle %	18.9%	8.3%	5.1%	13.5%	7.1%	5.5%	7.5%	51.1%
Living in renter housing %	58.2%	40.7%	42.8%	40.8%	39.9%	22.2%	28.7%	49.6%
Percent without health insurance%	6.4%	11.1%	4.9%	8.2%	7.7%	4.5%	5.2%	43.6%

1: Numbers in red are the highest for that indicator and numbers in blue are the second highest.
NH = Non-Hispanic, A/PI = Asian/Pacific Islander
a: Population defined as "Hispanic" in data sources for "Health status and behaviors" and "Morbidity and mortality"
b: Population defined as "Asian" in data sources for "Health status and behaviors" and "Morbidity and mortality"
c: The Overall Population Index of Disparity (ID) is a measure of how much disparity exists in the population. It summarizes how far each group is from the population average. ID=0% indicates no disparity in the population; higher values of ID indicate increasing levels of disparity in the population for that indicator and can be greater than 100%. ID does not reflect health status but reflects how much variation or disparity exists.
Data sources: Social Determinants – American Community Survey/U.S. Census Bureau 2017; Health status and behaviors – 2015-2017 Michigan Behavioral Risk Factor Survey (BRFSS) Prevalence Estimates.

As shown in Table 1, poverty rate and not having a high school diploma have the first and second highest index of disparity (respectively). This indicates that there is a great deal of variation with regard to poverty and educational attainment within the Michigan population. Specifically:

- Poverty disproportionally affects many minority populations. Michigan's Arab American population experienced poverty at 2.9 times the rate of the state average and the African American population experienced poverty at 2.4 times that of the state average.

- Education is a key determinant of social advancement, personal livelihood, and health. However, Hispanic and Latinx Americans older than 25 years of age were three times less likely to attain a high school diploma as the state average. Arab Americans older than 25 years of age were 2.4 times less likely to attain a high school diploma as the state average.

- Employment provides economic stability to individuals. Michigan's African American population has 2.3 times the unemployment rate as the state average.

Michigan's Native Americans have 1.9 times the unemployment rate as the state average.

Table 2: Morbidity Prevalence with a High Index of Disparity by Race and Ethnic Background in Michigan[1]

Morbidity Indicators	African American, NH	Hispanic/ Latinx[a]	A/PI[b], NH	Native American	Arab	White, NH	Total	Index of Disparity[c] (ID)
COPD prevalence % (ever told)	10.1%	5.2%	7.6%	16.3%	3.3%	7.2%	7.6%	48.2%
Any cardiovascular disease prevalence % (ever told)	10.2%	10.3%	3.6%	14.1%	9.0%	8.2%	8.5%	29.0%
Asthma prevalence % (ever told)	19.9%	12.9%	7.3%	24.3%	12.5%	16.2%	16.3%	28.5%
Diabetes prevalence % (ever told)	13.2%	14.2%	12.9%	9.2%	12.1%	8.8%	9.6%	26.4%
Cancer prevalence % (ever told)	6.6%	4.7%	10.7%	11.5%	9.1%	11.6%	10.7%	25.0%
Obese prevalence % (ever told)	40.7%	41.8%	13.7%	36.6%	27.2%	31.0%	32.1%	24.5%

1: Numbers in red are the highest for indicator and numbers in blue are the second highest.
NH = Non-Hispanic, A/PI = Asian/Pacific Islander
a: Population defined as "Hispanic" in data sources for "Health status and behaviors" and "Morbidity and mortality"
b: Population defined as "Asian" in data sources for "Health status and behaviors" and "Morbidity and mortality"
c: The Overall Population Index of Disparity (ID) is a measure of how much disparity exists in the population. It summarizes how far each group is from the population average. ID=0% indicates no disparity in the population; higher values of ID indicate increasing levels of disparity in the population for that indicator and can be greater than 100%. ID does not reflect health status but reflects how much variation or disparity exists.
Data sources: Morbidity – 2015-2017 Michigan Behavioral Risk Factor Survey (BRFSS) Prevalence Estimates.

Table 2 above displays morbidity, or disease prevalence, that have the highest ID in Michigan. As the data reveal, chronic obstructive pulmonary disease (COPD) and cardiovascular disease show the most variation or disparity in the population. In particular:

- The prevalence of COPD in the state's Native American population was 2.1 times the prevalence of the state average. The prevalence of COPD in the state's African American population was 1.3 times that of the state average.

- The prevalence of any form of cardiovascular disease in the Native American population was 1.7 times the prevalence of the state average. The prevalence of any form of cardiovascular disease in the Hispanic and Latinx population was 1.2 times the prevalence of the state average.

- The prevalence of asthma in the Native American population was 1.5 times the prevalence of the state average. The prevalence of asthma in the African American population was 1.2 times the prevalence of the state average.

Table 3: Mortality Rates with a High Index of Disparity by Race and Ethnic Background in Michigan[1]

Mortality Indicators	African American, NH	Hispanic/ Latinx[a]	A/PI[b], NH	Native American	Arab	White, NH	Total	Index of Disparity[c] (ID)
Kidney disease mortality per 100,000	28.3	21.1	***	***	27.7	13.1	15.0	56.4%
Diabetes mortality per 100,000	35.3	26.8	7.8	33.3	37.0	20.2	21.9	46.0%
Chronic lower respiratory disease mortality per 100,000	31.6	17.6	***	65.0	28.8	46.5	44.2	35.2%
Heart disease mortality per 100,000	272.4	120.8	71.2	172.6	267.3	187.2	194.9	32.3%
Accidents mortality per 100,000	64.3	44.8	15.8	73.4	38.6	51.2	52.1	29.3%
Stroke mortality per 100,000	51.8	31.3	26.3	30.0	62.2	38.6	39.9	28.3%
Suicides mortality per 100,000	9.7	12.1	6.5	***	12.8	16.4	15.0	27.1%

1: Numbers in red are the highest for indicator and numbers in blue are the second highest.
*** = Data Not Available
NH = Non-Hispanic, A/PI = Asian/Pacific Islander
a: Population defined as "Hispanic" in data sources for "Health status and behaviors" and "Morbidity and mortality"
b: Population defined as "Asian" in data sources for "Health status and behaviors" and "Morbidity and mortality"
c: The Overall Population Index of Disparity (ID) is a measure of how much disparity exists in the population. It summarizes how far each group is from the population average. ID=0% indicates no disparity in the population; higher values of ID indicate increasing levels of disparity in the population for that indicator and can be greater than 100%. ID does not reflect health status but reflects how much variation or disparity exists.
Data sources: Mortality –2018 Michigan Resident Death Files/Division for Vital Records & Health Statistics. Starting in 1999 disease mortalities are defined with the following ICD-10 codes: Accidents Mortality codes V01-X59,Y85-Y86, AIDS Mortality codes B20-B24, All Cause Mortality all ICD codes, Alzheimer's Mortality codes G30-G30.9, Cancer Mortality Per codes C00-C97, CLRD Mortality codes J40-J47, Diabetes Mortality codes E10-E14, Heart Disease Mortality codes I00-I09.I11.I13.I20-I51, Homicide Mortality codes U01-U02.X85-Y09.Y87.1, Kidney Disease Mortality codes N00-N07.N17-N19.N25-N27, Liver Disease Mortality codes K70.K73-K74, Pneumonia and flu Mortality ICD-10 codes J09-J18, Septicemia Mortality codes A40-A41.9, Stroke Mortality codes I60-I69, Suicides Mortality codes U03.X60-X84.Y87.0.

The data in Table 3 show that the causes of death with the three highest ID in Michigan were kidney, diabetes, and chronic lower respiratory disease mortality (respectively). The populations most affected are African American (non-Hispanic), Arab Americans, and Native Americans:

- The mortality rate for kidney disease in the state's African American population was 1.9 times the rate of the state average. The mortality rate for kidney disease in the Arab American population was 1.8 times the rate of the state average.

- The mortality rate for diabetes in the state's Arab American population was 1.7 times the rate of the state average. The mortality rate for diabetes in the African American population was 1.6 times the rate of the state average.

- The mortality rate for chronic lower respiratory disease (CLDR) in the state's Native American population was 1.5 times the rate of the state average.

Evidence-Based and Promising Practices

> *Eliminating health disparities will require heightened emphasis on translating and disseminating proven interventions…It will also require transcending the confines of academia to reach and influence broader real-world settings.*[7]

The use of evidence-based and promising practices is becoming increasingly important in the health and social services fields, particularly when addressing racial and ethnic disparities. Increasing rates of disease, poor health and social conditions, and limited funding—along with a growing literature on the scientific basis for interventions—calls for implementing proven strategies that have been shown to improve population health.[8] There are also increasing expectations for public health and social service providers to integrate concepts of evidence-based practice into their work. Many federal agencies, as well as other funders, often require the programs they fund to be evidence-based.[9]

Specific definitions of evidence-based practice vary somewhat among disciplines, organizations, and the context in which they are used. However, there seems to be general agreement that ***evidence-based practice*** consists of three key components. These include the integration of:

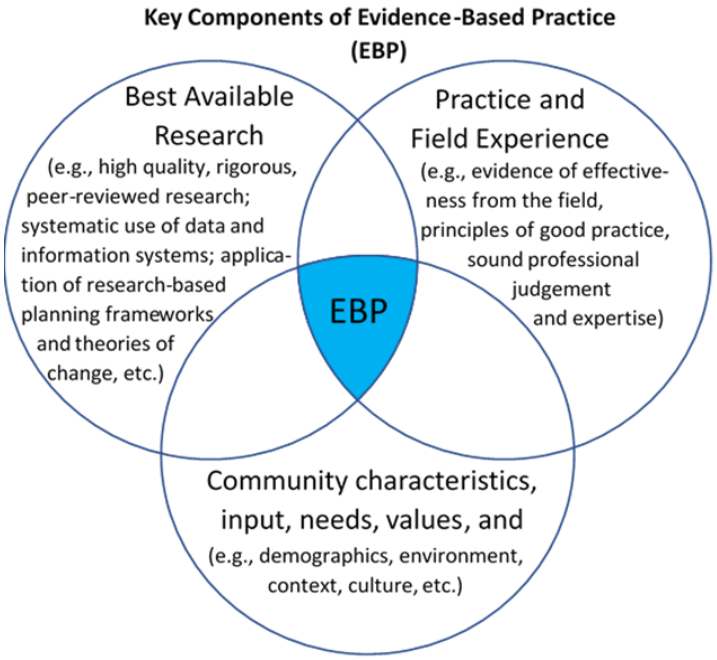
1) The best available research evidence—derived from high quality, rigorous, peer-reviewed research and evaluation; data and information systems; research-based planning frameworks and theories of change/action, etc.;

2) Practice and field experience—including evidence of effectiveness in real-world settings, principles of good practice, sound professional judgement and expertise; and

[7] Koh HK, Oppenheimer SC, Massin-Short SB, Emmons KM, Geller AC, Viswanath K. Translating Research Evidence into Practice to Reduce Health Disparities: A Social Determinants Approach. *American Journal of Public Health*. 2010; 100(S1), S72-S80.
[8] Jacobs JA, Jones E, Gabella BA, Spring B, Brownson RC. Tools for Implementing an Evidence-Based Approach in Public Health Practice. *Preventing Chronic Disease.* 2012;9:110324. DOI: http://dx.doi.org/10.5888
[9] Ibid.

3) Community characteristics, inputs, needs, values, and preferences (Figure 1).[10,11,12,13,14]

Figure 1*



These factors work synergistically to help ensure strategies, programs, services, and policies have the greatest chance for success. Additional considerations in evidence-based practice include drawing from research and field experience in which positive outcomes are clearly linked to the strategy or program being implemented versus other external factors. It is also important to consult a multitude of rigorously conducted research studies to ensure strategies are effective across populations and settings. Finally, community engagement is an essential component given each community's unique culture, values, preferences, and needs.[15,16] Taking these characteristics into consideration, as well as soliciting input and involving communities in the decision-making process, helps to ensure programs, services, and policies will be appropriate for and acceptable to those being served.[17]

A ***promising practice*** shares many of the same attributes of evidence-based practice but needs more research or replication to demonstrate positive outcomes in various settings or populations. Promising practices still have an objective basis for claiming effectiveness—such as evaluation data showing positive outcomes—and the potential to be successful, acceptable, and useful in other settings or populations.[18]

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[10] Ibid.

[11] Vanagas G, Bala M, Lhachimi SK. Evidence-Based Public Health 2017. *BioMed Research International*. Volume 2017, Article ID 2607397, https://doi.org/10.1155/2017/2607397.

[12] The California Evidence-Based Clearinghouse for Child Welfare. *Understanding Evidence-Based Practices*. 2017. Retrieved (2/28/20) from: https://www.cebc4cw.org/files/CEBCUnderstandingEvidence-BasedPractices.pdf

[13] Institute of Medicine (IOM). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academies Press; 2001. DOI: 10.17226/10027

[14] Brownson RC, Fielding JE, Maylahn CM. Evidence-based public health: a fundamental concept for public health practice. *Annu Rev Public Health*. 2009;30:175–201. doi:10.1146/annurev.publhealth.031308.100134

*Figure 1 adapted from citations 8 and 12-14.

[15] Jacobs et al. 2012, op. cit., p. 1.

[16] APHA. Supporting Research and Evidence-Based Public Health Practice in State and Local Health Agencies. Policy Statement, Nov 07, 2017, Policy Number: 20171. Retrieved (2/6/20) from: https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2018/01/18/supporting-research-and-evidence-based-public-health-practice.

[17] Jacobs et al. 2012, op cit., p.1.

[18] Association for Maternal and Child Health Programs (AMCHP). AMCHP's Best Practices [webpage]. Retrieved (3-4-20) from: http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/Pages/Best-Practices-Program.aspx

Evidence-based and promising practices have many benefits. These include a higher likelihood that programs, services, and policies will be successful—leading to improved health and social outcomes, greater workforce productivity, and more efficient use of public and private resources.[19] Challenges include a lack of sufficient evidence for certain strategies and populations, as well as varying criteria regarding the quality and quantity of evidence needed to determine if a strategy or initiative is truly effective.[20]

In 2019, the MDHHS Office of Equity and Minority Health commissioned Public Research and Evaluation Services (PRES) to conduct a systematic review of the existing research literature on evidence-based, evidence-informed, and promising practices to address health disparities for specific racial, ethnic, cultural, and/or linguistic groups. The resulting report, "Strategies to Address Health Disparities for Culturally/ Ethnically/Racially/Linguistically Diverse Communities: A Systematic Review of the Literature," summarizes the findings, including strategies and approaches that are most likely to lead to positive outcomes.

For more information go to: Michigan.gov/MinorityHealth or contact colormehealthy@michigan.gov

It is also important to note that research regarding the effectiveness of evidence-based and promising practices on diverse populations is limited but growing.[21] A recent report commissioned by the MDHHS Office of Equity and Minority Health presents a systematic review of the existing literature on evidence-based and promising practices that address health disparities among racial and ethnic minority populations (see side bar). As this report notes, the National Institutes of Health recommends using evidence-based interventions (EBI) to address health disparities. However, most EBIs have been developed and tested in academic settings for mainstream, highly selected populations. There are fewer EBIs that have been designed for or applied in racial and ethnic minority populations.[22]

As disparities persist, it is increasingly important to have studies on evidence-based practices that specifically involve racial and ethnic communities. Through existing research, it has become clear that prevention efforts must be tailored to the needs of the individuals and their communities in order to be most effective.[23] Therefore, populations of color need to be part of the evidence-based research process. This will not only build the evidence base for strategies that effectively reduce health disparities, but will also build trust and legitimacy with communities of color that such strategies are indeed best suited to address their needs.

[19] Vanagas et. al. 2017; op. cit., p. 1.
[20] Ibid.
[21] The California Evidence-Based Clearinghouse for Child Welfare (CEBC) 2017, op. cit. p. 3.
[22] MDHHS Office of Equity and Minority Health. *Strategies to Address Health Disparities for Culturally/Ethnically/Racially/ Linguistically Diverse Communities: A Systematic Review of the Literature*. Prepared by PRES, 2020 (in press).
[23] Ibid.

Despite these challenges, the benefits of evidence-based and promising practices have led MDHHS to encourage the use of an evidence-based approach. Consequently, the department has incorporated both evidence-based and promising practices into its work. This includes using evidence derived from scientific research studies and systematic reviews, data, evaluation findings, and field experience to inform efforts to address a number of equity-related issues, such as access to healthcare, preventive services, social determinants of health, and economic opportunity among racial and ethnic minority populations in Michigan. A general overview of these efforts, gathered through a department-wide survey, is provided below. This is followed by a more detailed description of select evidence-based programs and promising practices that have been implemented at the state and local level.

MDHHS Evidence-Based and Promising Practices to Achieve Equity: Findings from the Department-Wide Survey

In order to gather information on evidence-based and promising practices within the department, an online survey was administered to MDHHS administrators and bureau directors in January 2020. Directors were encouraged to share the survey with other managers and staff in their organizational area for their completion as well. The survey provided a definition of evidence-based and promising practices (see below) and consisted of a series of questions regarding the implementation of evidence- and practice-based programs, services, activities, procedures, and policies to address various equity-related issues. To maximize the response rate, an email reminder was sent mid-way through the survey response period.

Definitions*

For the purpose of the survey, evidence-based and promising practice were defined as follows:

Evidence-Based Practice refers to a strategy, program, service, activity, initiative, procedure, or policy that is based on evidence from research and practice. It has peer-reviewed, documented empirical evidence of effectiveness for improving health and social outcomes. An evidence-based practice typically:

1) Uses principles of scientific reasoning and rigorous systematic research (e.g., peer-reviewed literature, systematic reviews, randomization/comparison groups, etc.), data and information systems, and/or application of research-based theories of behavior, social change, or action;
2) Integrates scientific evidence with community input, needs, and preferences;
3) Clearly links positive outcomes to the strategy, program, service, activity, initiative, procedure, policy, or practice being evaluated and not to other external factors;
4) Is replicable and produces positive outcomes in various settings and/or populations.

Promising Practice refers to a strategy, program, service, activity, initiative, procedure, or policy that works in one setting or population but needs more research or replication to support positive outcomes in other settings or populations. A promising practice has an objective basis for claiming effectiveness—such as evaluation data showing positive outcomes—and the potential to be successful, acceptable, and useful in other settings or populations.

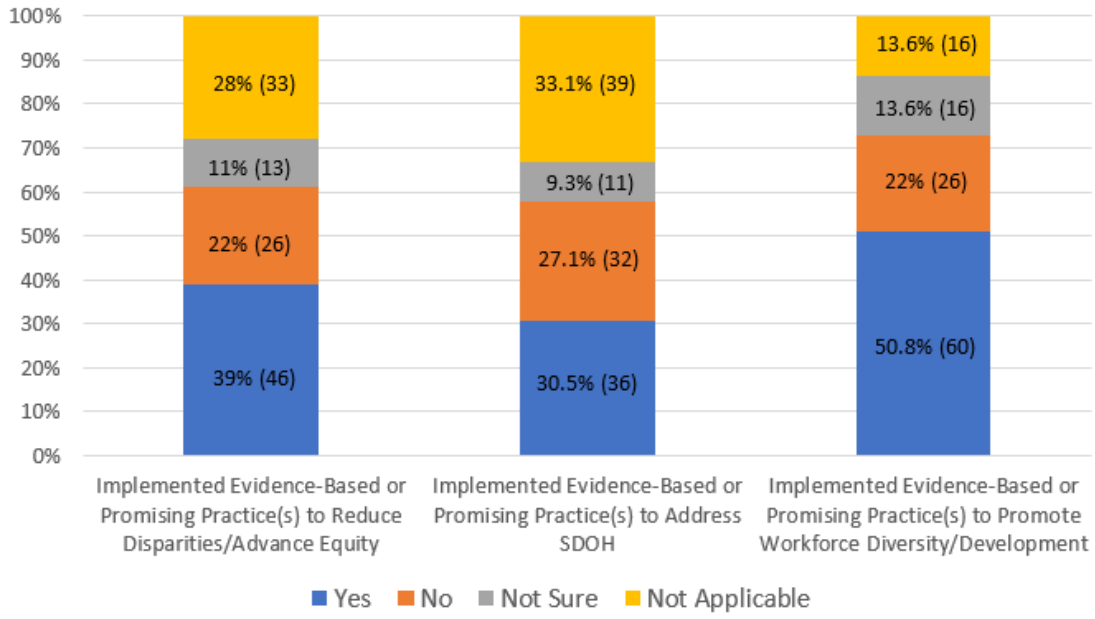
* Adapted from references 8, 12, 13 & 18

A total of 118 unique responses were received, each representing a different specific organizational area within the department. General findings from the survey are summarized below. It is important to note that respondents were asked to indicate if their efforts were an evidence-based or a promising practice based on the definitions provided. Therefore, the findings presented do not represent the total number of initiatives being implemented within the department related to each question, but rather those that respondents considered to be an evidence-based or a promising practice.

Programs, Activities, and Services to Reduce Disparities/Promote Equity, Address Social Determinants of Health (SDOH), and Promote Workforce Diversity and Development

Survey respondents were asked if their organizational area implemented any evidence-based programs, activities, services, or promising practices to reduce racial and ethnic disparities, advance equity, address social determinants of health, and/or promote workforce diversity and development. Findings are shown in Figure 2.

Figure 2
Survey Responses Regarding Implementation of Evidence-Based or Promising Practice(s) to Reduce Disparities/Promote Equity, Address SDOH, and Promote Workforce Diversity/Development
Shown as Percent (Number) Responding, N=118



As shown above, 39 percent of survey respondents reported implementing an evidence-based or promising practice to reduce racial and ethnic minority disparities and advance equity. This included community-based programs funded by their area through grants or contracts, providing support or technical assistance to communities or local entities to address disparities and promote equity, or statewide initiatives managed by their area.

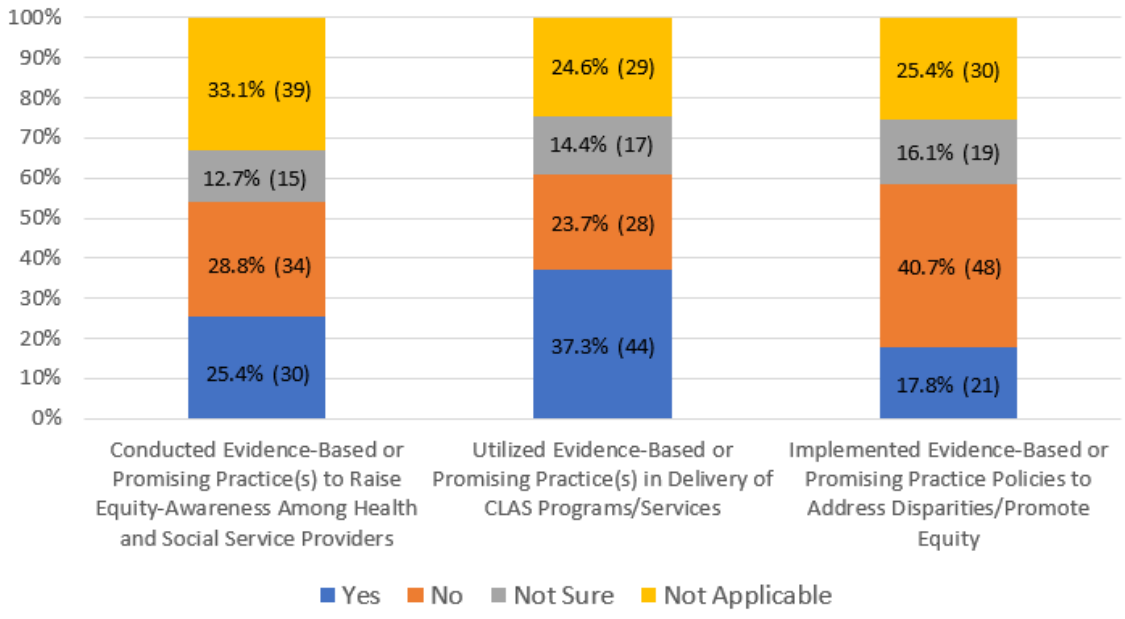
About one-third (30.5%) of respondents noted that their area implemented evidence-based or promising practices to address social determinants of health. Examples included increasing asset limits for major public assistance programs (e.g., food assistance, cash assistance, etc.), providing case management to low-income individuals living with HIV to assist with wrap around services (e.g., transportation, housing, insurance navigation, etc.), and abating lead hazards in eligible households. The majority (50.8%) of survey respondents reported implementing evidence-based or promising practices to promote workforce diversity/development. Efforts included requiring or offering the opportunity for managers and staff to participate in professionally developed equity-related training, having select staff participate in a training series aimed at improving hiring processes to ensure a diverse workforce, and implementing recruitment and hiring protocols designed to increase diversity.

Evidence-Based or Promising Practices to Raise Equity Awareness, Deliver Culturally and Linguistically Appropriate Services (CLAS), and Establish Equity-Promoting Policies

Figure 3 shows the percent (and number) of respondents that reported implementing evidence-based strategies or promising practices to raise awareness about equity issues among health and social service providers, deliver culturally and linguistically appropriate program and services (CLAS), and establish policies to promote equity.

Figure 3

Survey Responses Regarding Implementation of Evidence-Based or Promising Practice(s) to Raise Equity Awareness, Deliver CLAS Programs/Services, and Establish Policies to Address Disparities/Promote Equity
Shown as Percent (Number) Responding, N=118



Of those responding to the survey, one-quarter (25.4%) said that their organizational area conducted evidence-based or promising practices to raise awareness among health and social service providers in an effort to eliminate racial and ethnic disparities and promote equity. Common activities included providing external partners, grantees, contractors, and service providers with professionally developed trainings on various equity-related issues.

Over one-third (37.3%) of respondents reported utilizing evidence-based or promising practices in their delivery of CLAS programs and services. This included providing interpretation services and translated materials, working with community groups to ensure efforts were appropriate for the populations served, and integrating CLAS standards into grant solicitations and provider contracts.

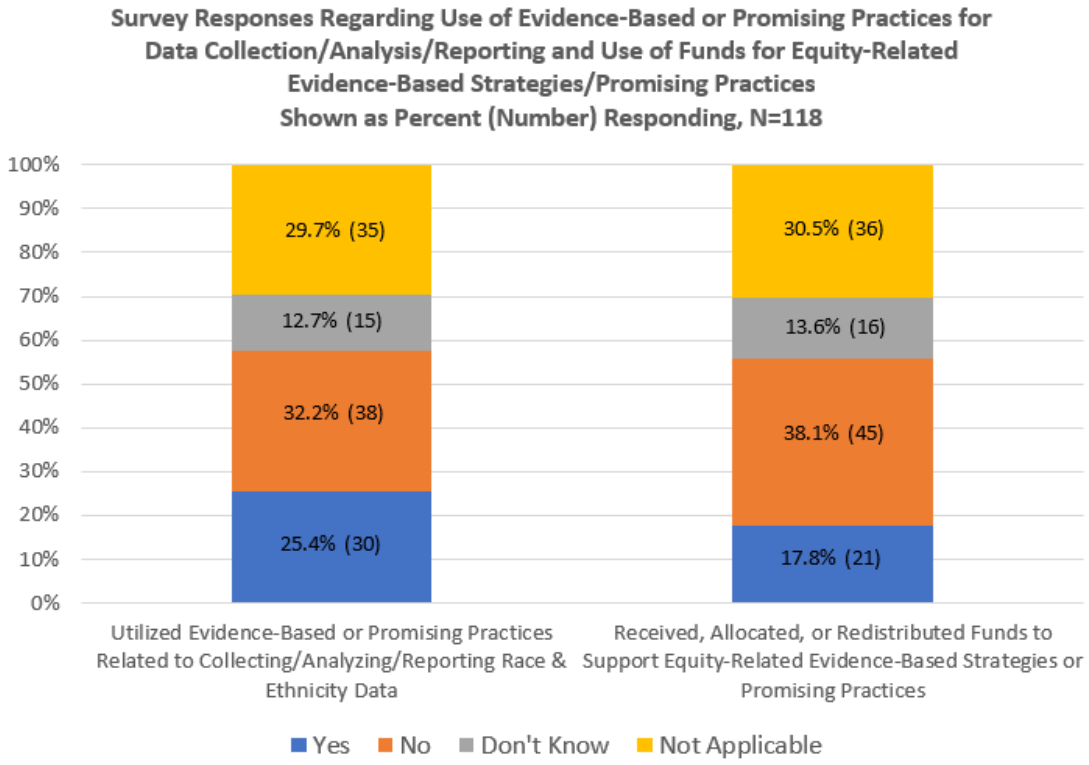
About 18 percent (17.6%) reported that their area had implemented policies based on evidence-based strategies or promising practices to address racial and ethnic disparities and/or promote equity. Policies included mandatory training or implementation of recruitment and hiring policies to promote diversity. Other examples were requiring health equity language and scoring to be part of Requests for Proposals, and instituting a blind removal policy—a promising practice that removes demographic information from a child welfare case when it is under review to determine whether a child needs to be removed from the parental home.

Use of Evidence-Based or Promising Practice for Data Collection/Analysis/ Reporting and Use of Funds for Equity-Related Efforts

According to the 2019 survey, 25 percent of organizational areas responding utilized evidence-based strategies or promising practices related to collecting, analyzing, and reporting race and ethnicity data; and about 18 percent (17.8%) received, allocated, or redistributed funds for equity-related work (Figure 4).

Several areas shared that they collected and used race and ethnicity data to identify priority populations, determine needs, and make program decisions. Funding was used to expand programs to better reach racial and ethnic minority communities, incorporate a health equity lens into a needs assessment process, and build capacity of communities to implement population-based primary prevention initiatives that reduce the burden of violence and create social and physical environments that promote good health for racial ethnic minority populations.

Figure 4



Highlighted Evidence-Based and Promising Practice Initiatives

From the survey responses received, several organizational areas were selected and contacted for additional information. These areas were sent a follow-up questionnaire requesting more details regarding their efforts and the evidence-base supporting their strategies and approaches. Selections were made in order to provide examples of both state and local initiatives as well as reflect different areas within the department. These highlighted programs are described below.

State Innovation Model (SIM) Community Health Innovation Regions (CHIRs)

Overview

The Community Health Innovation Regions or CHIRs (pronounced “shires”) were created as part of Michigan’s State Innovation Model (SIM) initiative, which was funded by the Centers for Medicare and Medicaid Services (CMS) from 2015 to January 31, 2020. The purpose of SIM was to test and implement an innovative model for delivering

and paying for healthcare in the state.[24] CHIRs have served as a key component of the SIM effort by providing a placed-based, promising practice model for improving the well-being of a region and reducing unnecessary medical costs through collaboration and systems change. Though CMS grant funding has ended, state general funds have been secured to continue the work of existing CHIRs through the end of fiscal year (FY) 2020, and additional funds are being sought to continue in FY21 and beyond.[25] The CHIR community systems change efforts are research-based and draw heavily from the Collective Impact approach[26] and the ABLe Change Framework developed by Michigan State University[27] (see side bars on pages 15 and 16).

CHIRs engage a broad group of stakeholders to identify and address various social, economic, and healthcare factors that affect residents' health such as housing, transportation, and food insecurity, as well as access to high-quality medical care. The CHIR model creates a neutral space for partners to unite around a common vision, aligning their objectives and services to meet the needs of the community. The result is a community that is purposeful in its response to residents' needs, creating conditions that meaningfully support an individual's ability to have a higher, more productive quality of life.

The five CHIRs formed during the SIM project include 1) Genesee County (see spotlight, p.18), 2) Jackson County, 3) Muskegon County, 4) Livingston-Washtenaw Counties, and 5) ten counties in the Northwest portion of the Lower Peninsula. Each of these CHIRs is governed by a regional steering committee and is supported by a designated backbone organization, as well as local action teams comprised of CHIR members and partners from many different service sectors. CHIR steering committees provide a clear leadership structure and promote shared accountability among partners for aligning their resources to address priority community health needs. The backbone organization facilitates the development and implementation of key strategies, creating the necessary capacity to sustain progress on stated objectives.

A CHIR has two primary aims:

1. To transform the lives of individuals by screening for social determinants of health and more effectively linking them to clinical and community-based services.

[24] Michigan Department of Health and Human Services. State Innovation Model [webpage]. Retrieved (3/1/20) from: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_64491---,00.html
[25] MDHHS Community Health Innovation Regions, Implementation Manager, Written communication 2/28/20.
[26] Kania J, Kramer M. Collective Impact. *Stanford Social Innovation Review*. Winter 2011. Retrieved (2/28/20) from: https://cdn.ymaws.com/www.lano.org/resource/dynamic/blogs/20131007_093137_25993.pdf
[27] Foster-Fishman PG, Watson ER. The ABLe change framework: A conceptual and methodological tool for promoting systems change. *American Journal of Community Psychology*. 2012;49(3-4), 503-516.

2. To change community conditions that create barriers to health and well-being.

Collective Impact

A Collective Impact approach is defined as the "commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem."* Collective Impact differs from other forms of collaboration by its cross-sector approach and the implementation of five conditions, found to be common among successful collective impact initiatives.

*The Five Conditions of Collective Impact:	
Common Agenda	All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions.
Shared Measurement	Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.
Mutually Reinforcing Activities	Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action.
Continuous Communication	Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and create common motivation.
Backbone Support	Creating and managing collective impact requires a separate organization with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies.

A study conducted by ORS Impact and Spark Policy Institute examined 25 collective impact initiatives and found that 20 led to documented population changes. They also looked at how the initiatives approached equity in their work and identified seven sites that had a strong equity focus. Of these seven, six achieved significant systems changes and five achieved equity-focused population changes.**

*Kania J, Kramer M. Collective Impact. *Stanford Social Innovation Review*. Winter 2011. Retrieved (2/28/20) from https://cdn.ymaws.com/www.lano.org/resource/dynamic/blogs/20131007_093137_25993.pdf

**ORS Impact and Spark Policy Institute. *When Collective Impact Has an Impact: A Cross-Site Study of 25 Collective Impact Initiatives*. 2018. Retrieved (3/8/20) from: https://www.orsimpact.com/DirectoryAttachments/10262018_111513_477_CI_Study_Report_10-26-2018.pdf

To accomplish these aims, each CHIR works to create and strengthen clinical-community linkages. Clinical-community linkages (CCL) are connections between community and clinical sectors to improve population health.[28] The CCL approach used by CHIRs is consistent with the Agency for Healthcare Research and Quality's *Clinical-Community Relationships Evaluation Roadmap*.[29] CHIRs have worked to strengthen these linkages by designing a unique approach to connect residents with services to address issues that prevent them from living a healthy, productive life. For example, healthcare providers, community organizations, and public health agencies have all come together to examine and strengthen the screening and referral processes in their community. Medical

[28] Centers for Disease Control and Prevention. *Community-Clinical Linkages for the Prevention and Control of Chronic Diseases: A Practitioner's Guide.* Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2016.

[29] Agency for Healthcare Research and Quality (AHRQ). *Clinical-Community Evaluation Roadmap*. Publication No. 13-M015-EF, July 2013.

professionals and community service providers can refer patients and clients to a central hub in the community that facilitates connections to appropriate resources and creates a feedback loop so the original referring entity is informed if the referral was successful and, if not, why not. This feedback loop has been critical to effective care coordination for individuals who are served by multiple agencies and systems in the community. Data from these individual interactions are summarized and aggregated to inform future decisions regarding existing services and potential gaps in service that exist in the community.[30]

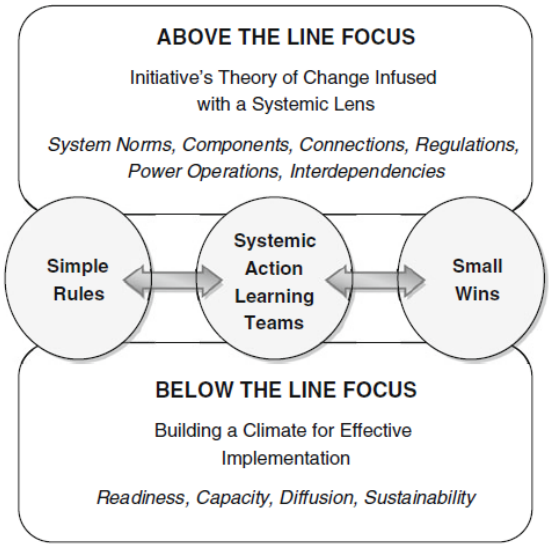
Additionally, policies and practices that inadvertently create barriers or inequities in access to services are reviewed at the community, sector, and organization levels. CHIRs employ a common approach to identifying and understanding root causes of problems impacting the effective delivery of services and designing powerful local strategies to overcome barriers to health at the population level, with the ultimate goal of reducing costs, making services more effective, and providing greater accountability for more efficient use of funds that are coming into the community.[31]

Findings from a comprehensive evaluation of the SIM CHIRs are still being compiled. However, evaluation data analyzed to date strongly suggests that CHIRs have successfully created conditions for increased health and well-being by establishing an aligned system that is more accessible,

Above and Below the Line (ABLe) Change Framework

The ABLe Change Framework is a research-tested approach to the design and implementation of community change efforts that promote systems change. ABLe, which stands for 'Above and Below the Line,' focuses on both the content and process of systems change work to ensure effective implementation. The Above the Line component examines the content of the change by applying a systemic lens to the initiative's theory of change. The Below the Line piece focuses on the process for carrying out an initiative in order to build a climate for effective implementation. The model employs three key strategies to ensure the integration of content and process efforts, and mobilization of broad-scale systems change. These include: systemic action and learning teams, simple rules, and small wins.

The ABLe Change Framework*



For more information, see:
Foster-Fishman, P. G. and Watson, E. R. The ABLe change framework: A conceptual and methodological tool for promoting systems change. *American Journal of Community Psychology*. 2012;49(3-4), 503-516.
*Framework diagram is from the above citation, p. 505.

[30] MDHHS CHIR Implementation Manager 2020, op. cit.
[31] Ibid.

responsive, and effective in addressing needs. According to evaluation data, clinical-community linkages were opened and closed—indicating needs were met—for 73 percent of food-related needs, 71 percent of transportation and safety needs, 64 percent of utility issues, and 63 percent of healthcare affordability needs. Other common needs that CHIRs were able to address included family care, education, employment, housing, and physical and mental health issues.[32] Involvement in CHIRs have also shifted how participants think about health and what is needed to improve health outcomes, as well as led to a stronger focus on social determinants of health. CHIRs have also worked to get people who have not been previously connected to the system linked to the services and supports they need; thus, addressing issues before they become a health care crisis. At the same time, they have provided a lifeline for those who are in crisis, providing support that individuals could not find on their own and increasing the potential to transform lives by improving health and quality of life.[33]

Advancing Equity

The pursuit of equity is one of six critical elements of the community systems change process framework utilized in the CHIRs' work. The focus of CHIRs' equity-related work has been examining systemic causes of local inequities in socioeconomic and health status and working to prioritize changes in policies, practices, and allocation of resources to promote equity in the community. Examples of individual CHIR activities related to equity include revising committee and work group purposes statements to include a focus on equity, creating coaching plans for organizations seeking to pursue equity as a core value, revising membership charters to include equity statements, and creating a resident advisory council in neighborhoods experiencing inequitable access to services.[34] Additionally, evaluation data suggests that because of the CHIRs' efforts, the health care providers and community leaders are more aware and supportive of efforts to improve community conditions and reduce health disparities.[35]

More broadly, the CHIR initiative has the potential to contribute to a structure to address racial and ethnic health disparities in the state. A highly functioning CHIR has the ability to analyze disaggregated data to monitor differences in the ability for racial and ethnic minorities to have their health, social, and economic needs met through community resources. The CHIRs also provide a mechanism for federal and state resources,

[32] MDHHS State Innovation Model and Michigan Public Health Institute (MPHI). *Michigan State Innovation Model Clinical Community Linkages Report – All Community Health Innovation Regions*. January 2020.
[33] Ibid.
[34] MDHHS CHIR Implementation Manager 2020, op. cit.
[35] MDHHS State Innovation Model and Michigan Public Health Institute (MPHI) 2020, op. cit.

policies, and practices regarding minority health to be disseminated to community partner agencies.[36]

Spotlight
Genesee County CHIR Clinical-Community Linkage Initiative

The Greater Flint Health Coalition (GFHC) serves as the backbone organization for the SIM Genesee County CHIR. In this role, GFHC and its multisector partners have worked to align and implement strategies to improve population health in the community. This includes addressing both medical and non-medical factors that affect health—such as housing, transportation, and food insecurity—by supporting linkages between primary care practices and community service providers.[1,2]

To achieve this goal, the Genesee County CHIR implemented the Clinical-Community Linkage Initiative. The focus of the project is "to enhance cross-sector partnerships that impact population health and connect more than 41,000 Genesee County Medicaid beneficiaries with relevant community and social services to address their social determinants of health needs."[2] Another goal is to reduce emergency department utilization and connect clients to a patient-centered medical home[2] (an evidence-based model to improve care coordination and outcomes).[3,4] The county's Clinical-Community Linkage Initiative implemented a community hub model based on the early success of its Genesee Children's Healthcare Access Program—an initiative that addresses health disparities experienced by low-income children enrolled in Medicaid. The GFHC also partnered with a variety of community stakeholders in order to develop a functional and effective clinical-community linkage process.[1,2] Together, the GFHC and its partners have worked to improve the upstream socio-economic factors affecting the health of Genesee County residents.[1] In the project's first two years accomplishments included:

- Created a standardized social determinants of health screening tool, which has been integrated into more than 60 patient medical home practice's electronic health record systems.
- Established four Clinical-Community Linkage Specialty Hubs to provide community-based care coordination and case management services using community health workers, social workers, behavioral health specialists, and peer recovery coaches to support referred individuals.
- Assisted participating patient-centered medical homes in reducing their patients' ED use by over 15 percent.
- Implemented a Community Referral Platform to make, monitor, and track referrals between clinical and community/social service agencies that includes a referral feedback loop that indicates when a need has been met.[2]

[1] Greater Flint Health Coalition (GFHC). State Innovation Model (SIM) [webpage]. Retrieved (3-6-20) from: http://gfhc.org/state-innovation-model-sim/
[2] Flint & Genesee County, Michigan Community Health Needs Assessment 2019 Report. Retrieved (3-6-20) from: http://gfhc.org/wp-content/uploads/2019/06/hc540_comm_hlth_needs_rept2019_final.pdf
[3] Stille C, Turchi RM, Antonelli R, et al. The family-centered medical home: specific considerations for child health research and policy. *Academic Pediatrics.* 2010;10(4):211–217. doi:10.1016/j.acap.2010.05.002
[4] American Academy of Pediatrics Council on Children with Disabilities. Care coordination in the medical home: integrating health and related systems of care for children with special health care needs. *Pediatrics*. 2005;116(5):1238–1244. doi:10.1542/peds.2005-2070

[36] MDHHS CHIR Implementation Manager 2020, op. cit.

Ottawa County – Pathways to Better Health

Overview

The Ottawa County Pathways to Better Health program is an initiative based on the research-tested Pathways to Better Health model developed through the work of doctors Sarah and Mark Redding.[37] The model focuses on prevention and early treatment by connecting at-risk individuals to community services that support care plans and produce positive health outcomes.[38] The Pathways to Better Health model involves care coordination across multiple providers and organizations, serving as a community-wide networking strategy. It also uses community health workers—an evidence-based strategy for improving access to care and health outcomes for vulnerable populations (see side bar). Community Health Workers (CHW) are trained individuals who are trusted members of the community and closely connected to the population served, often sharing characteristics such as race and ethnicity, culture, language, and life experience with their clients.[39,40] CHWs may perform a number of functions, such as providing outreach, advocacy, counseling, and health education to members of their community, as well as links to health and social services.[41]

> Community Health Workers (CHW) have been identified as an effective approach to reaching vulnerable populations, particularly those facing barriers to accessing health and social services. In randomized control trials, CHW have improved health outcomes in diabetes, heart disease, hypertension, cancer screening, mental health, readmission rates, and literacy. Some trials have also shown that CHW programs can reduce acute care utilization and result in cost-savings.
>
> Study citation: Heisler M, Lapidos A, Henderson J, et al. Study protocol for a Community Health Worker (CHW)-led Comprehensive Neighborhood-Focused Program for Medicaid Enrollees in Detroit. *Contemp Clin Trials Commun*. 2019;16:100456. Published 2019 Sep 30. doi:10.1016/j.conctc.2019.100456

The Ottawa County Pathways to Better Health program (OPBH) was launched in 2017 as a three-year pilot project in response to the county's Community Health Improvement Plan (CHIP). The CHIP identified three priority areas—access to care, mental health, and healthy behaviors—that needed the most attention to improve the health and well-being of residents. The Pathways to Better Health model was selected as an effective approach to address these needs.[42]

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[37] Goldman TR. Charting A Pathway to Better Health. *Health Affairs*. December 2018;37(12). doi: 10.1377/hlthaff.2018.05166 Retrieved (3-6-20) from: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05166

[38] Sartorius PJ. Pathways Model Aligns Care, Population Health. *Health Progress*, *The Journal of the Catholic Health Association of the United States*. May-June 2015. Retrieved (3-8-20) from: https://www.chausa.org/publications/health-progress/article/may-june-2015/pathways-model-aligns-care-population-health

[39] Ottawa Pathways to Better Health (OPBH). 2nd Year Progress Report. March 2019. Retrieved (3-7-20) from: https://www.miottawa.org/OPBH/pdf/2018_Pathways_Annual_Report.pdf

[40] Heisler M, Lapidos A, Henderson J, et al. Study protocol for a Community Health Worker (CHW)-led comprehensive neighborhood-focused program for Medicaid enrollees in Detroit. *Contemp Clin Trials Commun*. 2019;16:100456. Published 2019 Sep 30. doi:10.1016/j.conctc.2019.100456

[41] Ibid.

[42] OPBH 2019, op. cit., p.4.

OPBH is a collaborative effort among multiple agencies and organizations including Community Mental Health (CMH), public health, area hospitals, community foundations, and the United Way. Individuals referred to OPBH work with a CHW and receive a comprehensive risk assessment. Each risk factor is then translated into a Pathway. A Pathway is a structured process consisting of an ordered checklist of what needs to be done in order to resolve an issue. CHWs use Pathways to identify, define, and remove barriers for a health or social service problem. Pathways also allow CHWs to track progress from the start to finish; thus, Pathways are monitored to completion.[43,44] The Pathways model includes 20 structured Pathways, which range from behavioral health and medical referral to housing and education. There is also a broad Pathway designated for social services, which contains 25 subcategories such as food stability and phone services.[45] This comprehensive approach and heightened level of accountability leads to improved outcomes and reduced costs.[46]

In order to be eligible for the OPBH program, an individual must be:

- At least 18 years of age or pregnant
- An Ottawa County resident
- Enrolled in or eligible for Medicaid and/or Medicare
- Have two or more chronic health conditions (e.g., diabetes, depression, anxiety, heart disease, arthritis, asthma, hypertension, long-term pain, etc.)[47]

The OPBH intervention addresses the whole person, recognizing that social and environmental factors (i.e. social determinants of health) have a dominant impact on health status, and if not addressed, can become barriers to achieving health and well-being. Data collected by the OPBH shows the top Pathways used by those in the program are medical services (e.g., medical referral, medication assessment and management), with 459 pathways completed; and social services (e.g., education, food assistance, housing, utilities assistance, etc.) with 642 completed pathways.[48] Moreover, clients of the program report a statistically significant increase in their confidence navigating the health care system, decrease in days impacted by poor physical or mental health—including days when poor physical/mental health limited their activities—and improvement in their overall health.[49]

Advancing Equity

OPBH advances health equity and reduces health disparities through the provision of

[43] OPBH Supervisor, Written communication March 6, 2020.
[44] Goldman 2018, op. cit., p.1919.
[45] Ibid.
[46] OPBH Supervisor 2020, op. cit.
[47] OPBH 2019, op. cit., p.5.
[48] Ibid. (Represents data collected between February 2017 and December 2018)
[49] Ibid.

linguistically and culturally diverse support to tackle barriers to health in Ottawa County's underserved communities. In particular, through assistance provided by CHWs, the program is able to address inequities and issues surrounding access to care for the county's most vulnerable populations.

As mentioned, CHWs are trusted by the community, understand its health needs, and seek to promote the community's voice within the health care system.[50] This trusting relationship enables them to serve as a link between health and social services, the community, and the people they serve. OPBH CHWs offer translation services, share culturally appropriate health information, assist with access to health care, give informal counseling on health behaviors, and advocate for individual and community health needs.

In terms of access to care, the CHWs impact the underserved by creating a link to and between medical care, mental health care, and social services. This integration provides the support necessary to address barriers stemming from social determinants of health along with other factors, and promotes confidence in navigating the healthcare system, timely access to affordable care, and better understanding of medical information presented to the patient to improve their health.[51]

ERACCE Training and Children's Services Child Welfare Antiracism Team

Overview

In 2019, the MDHHS Office of Workforce Development and Training (OWDT) within the Economic Stability Administration engaged in two promising practices related to advancing equity. Specifically, OWDT 1) continued to participate in antiracism trainings offered through the ERACCE organization and 2) partnered with the Children's Services Agency (CSA) to co-fund the formation of an antiracism team. Both the training and antiracism team are based on the Crossroads Model developed by Crossroads Antiracism Organizing and Training—a national organization—and is delivered locally by ERACCE, based in Kalamazoo, Michigan. This model has been successfully implemented in other institutions and was specifically used in the Child Welfare System in the State of Illinois, Department of Children and Families. The purpose is to address the overrepresentation of children of color in the child welfare system.[52]

ERACCE, which stands for Eliminating Racism and Creating/Celebrating Equity is a regional community service anti-racism organizing and training resource center that

[50] American Public Health Association. Community Health Workers [webpage]. Retrieved (3-8-20) from: https://www.apha.org/apha-communities/member-sections/community-health-workers
[51] OPBH Supervisor 2020, op. cit.
[52] Office of Workforce Development & Training Director, Written communication March 5, 2020.

works to form, train, and support antiracism teams within institutions.[53] Its mission is to "eliminate systemic racism and build antiracist multicultural diversity within Michigan institutions by providing education, networking, technical assistance, and supportive resources to the region."[54] They seek to achieve this mission by providing antiracism workshops and working with organizations to form Antiracism Transformation Teams. These teams go through additional training that equips them to lead their organizations to identify and dismantle individual, cultural, and institutional racism.[55] Numerous institutions working with ERACCE have come to realize that as they work to dismantle racism internally and transform into systems committed to authentic racial justice, they can more effectively serve their constituents.[56]

One of the foundational workshops offered by ERACCE is Understanding and Analyzing Systemic Racism. This two-and-a-half-day training provides an opportunity for participants to develop a shared language for talking effectively about systemic racism, analyze elements of systemic racism, and examine basic strategies for dismantling racism within their organization in order to blaze a path toward institutional antiracist transformation.[57] OWDT sponsored this workshop in 2019 for MDHHS personnel (as it does at least once a year).

As mentioned, OWDT also worked with CSA to establish their Antiracism Team to address the disproportionality of children of color within Michigan's child welfare system. The formation of the Antiracism Team is a longitudinal process that began with convening a planning and design task force in 2019. Over the course of the year, the team completed a project proposal, obtained administration approval, and select team members—all with technical assistance from ERACCE. The team also started going through a series of training and skill building workshops that is anticipated to conclude in June 2020.[58]

Part of the training includes the development of a strategic plan to address systemic racism in child welfare that contributes to the disproportionality of children of color in care, and inequitable outcomes for children and families of color involved with the system. Upon completion of the training, the team will remain intact and work to implement the strategic plan it has developed. It is expected that the CSA Antiracism Team will remain in place indefinitely; however, the initial group of members have committed to a three-year term. The strategic plan will also outline strategies for those

[53] ERACCE – Eliminating Racism and Creating/Celebrating Equity. Who We Are [webpage]. Retrieved (3/10/20) from: http://www.eracce.org/who-we-are
[54] ERACCE – Eliminating Racism and Creating/Celebrating Equity. Our Focus [webpage]. Retrieved (3/10/20) from: http://www.eracce.org/our-focus
[55] ERACCE, Who We Are webpage, op. cit.
[56] Ibid.
[57] ERACCE – Eliminating Racism and Creating/Celebrating Equity. Training [webpage]. Retrieved (3/10/20) from: http://www.eracce.org/training
[58] Office of Workforce Development & Training Director 2020, op. cit.

first three years. OWDT funded half of the contract for the team formation and training with CSA funding the other half. In addition, several OWDT staff are participating on the team and providing logistical support. It is anticipated that OWDT will implement training-related strategies that result from the strategic plan once it is developed.[59]

Advancing Equity

The ERACCE trainings and formation of the Child Welfare Antiracism Team advance equity by raising awareness and understanding of systemic racism, and providing a structure to address the overrepresentation of children of color in the state's welfare system. Involvement in the child welfare system is linked to diminished child well-being as a whole, with children of color often experiencing disparate outcomes. Therefore, the Child Welfare Antiracism Team is working to examine factors that contribute to this disproportionality, as well as address contributing social determinants of health in order to improve the health and well-being of children within the system. The group is still in the process of developing their strategic plan; therefore, outcome data is not yet available. However, implementation of the strategic plan will further aid in their effort to implement and evaluate evidence-based strategies and promising practices that could contribute to reducing racial and ethnic health disparities and lead to more equitable outcomes.

Pathways to Potential

Overview

The Pathways to Potential program is an innovative approach to providing human services in Michigan. Specifically, the program places MDHHS caseworkers, also referred to a success coaches, in locations where the customer already goes—such as in schools, hospitals, and businesses. Success coaches work one-on-one with families to identify and remove barriers and link them to a network of community services so that they can become self-sufficient. This involves engaging community partners, school personnel, and family members in an effort to help students and families find their pathway to success.[60]

The goal of the Pathways to Potential model is to aid low-income, vulnerable, and disadvantaged residents in finding a path that will help them reach their greatest potential. The model focuses on five outcome areas:

- Health
- Safety
- Self-sufficiency
- Education

[59] Ibid.
[60] Pathways to Potential Program Manager, Written communication March 10, 2020.

- Chronic absenteeism from school[61]

Pathways to Potential was started in 2012, with success coaches placed in 72 schools in four counties.[62] For the current 2019-2020 academic year, Pathways to Potential is located in 306 schools in 42 of Michigan's counties.[63] Schools selected for the program are prioritized in areas where high numbers of families are already receiving assistance through the department,[64] though Pathway to Potential services are available to all families, including those not currently receiving support through MDHHS.

Pathways to Potential Schools*

Success coaches in schools work closely with principals, social workers, attendance agents, and teachers, as well as community organizations to assist students and their families in accessing the resources and support they need.[65] One area of focus is improving student attendance by working with school personnel and families to identify and remove barriers to attendance before they result in truancy and negatively impact learning. Success coaches also work with schools to bring in businesses, faith-based organizations, and community partners to strategize on how to best help students and families. These partnerships ultimately build and strengthen the community as a whole.[66]

The relationships and trust cultivated through the program's approach also helps to enhance communication about challenges and barriers families face so that needs can be addressed before a crisis situation occurs. Additionally, by working on-site in partnership with schools, trust develops between school personnel and parents, leading to reduced absenteeism, greater parental involvement, and improved academic performance.[67]

Outcomes of the program, based on data from the 2016-2017 school year (the most recent, complete data available) include:

- A decrease in chronic absenteeism by more than 20 percent in several counties.

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[61] Ibid.
[62] Michigan Department of Health and Human Services, Pathways to Potential Program. *Annual Report*. August 2018. Retrieved (3/11/20) from: https://www.michigan.gov/documents/mdhhs/P2P_Annual_Report_2018_With_Edits_631124_7.pdf.
[63] Pathways to Potential Program Manager 2020, op. cit.
[64] Michigan Department of Health and Human Services. About: The Pathways to Potential Approach [webpage]. Retrieved (3/11/20) from: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_69890_69988---,00.html
[65] MDHHS Pathways to Potential Program, Annual Report, 2018, op.cit., p.4.
*MDHHS, About: The Pathways to Potential Approach [webpage], op. cit.
[66] MDHHS, Pathways to Potential. Why Pathways to Potential [webpage]. Retrieved (3/11/20) from: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_69890_69989---,00.html
[67] MDHHS Pathways to Potential Program, Annual Report, 2018, op. cit., p.5.

- Assistance interventions provided to over 45,000 students, parents, and others (i.e. siblings of students or other adults in the home).
- More than 20,000 cases in which basic needs such as donated clothing, hygiene items, household and school supplies were provided to students and families.
- More than 49,000 interventions addressing student attendance issues.
- Greater than 19,000 referrals to community resources such as food and nutrition programs, afterschool or childcare programs, parenting support and education courses, job training/employment assistance, rehabilitation services, etc.
- Over 1,700 mental or physical health referrals for students or their families.[68]

Advancing Equity

The Pathways to Potential program works to advance equity by removing barriers to school attendance and assisting students and their families with the resources and support they need to succeed. Research shows that inequities in education contribute to health disparities. In general, individuals with less education are more likely to experience health risks, while higher levels of education are associated with a longer life.[69] Additionally, there is a significant body of research demonstrating a negative impact of chronic absenteeism on academic achievement. Students who are chronically absent miss critical instruction time and are at risk of falling behind and dropping out of school. Chronic absenteeism disproportionately affects low-income students as well as students of color.[70]

With success coaches placed directly in schools, the program is well positioned to improve attendance by working with families and building partnerships to overcome obstacles and remove barriers to attendance. In addition, success coaches assist families in addressing other social determinants of health including housing crises, utility shut-offs, food shortages, and issues in the home that impede learning at school. Ensuring that all eligible clients receive medical insurance is another way the program addresses health disparities and promotes equity.

[68] Ibid.
[69] The Community Guide. What Works Fact Sheet: Promoting Health Equity. November 2017. Retrieved (3/11/20) from: https://www.thecommunityguide.org/sites/default/files/assets/What-Works-Factsheet-HealthEquity.pdf
[70] University of Delaware, Center for Research in Education and Social Policy (CRESP). *Chronic Absenteeism and Its Impact on Achievement*. CRESP Policy Brief Series; #P18-002.5, JUNE 2018. Retrieved (3/11/20) from: https://www.cresp.udel.edu/wp-content/uploads/2018/07/P18-002.5_final.pdf

Women, Infants, and Children (WIC)

Overview

Michigan's Women, Infants, and Children (WIC) program is an evidence-based, federally-funded initiative that provides nutritious foods, nutrition education, breastfeeding support, and referrals to healthcare and social services for low to moderate income women, infants, and children (up to age five), who are at nutritional risk. WIC is part of the Special Supplemental Nutrition Program of the United States Department of Agriculture (USDA). In Michigan, WIC is administered by MDHHS and operates through local health departments and non-profit organizations in all 83 Michigan counties.[71]

In existence for over 40 years, the USDA WIC program is one of the most thoroughly studied federal programs with an extensive body of literature demonstrating its effectiveness at improving the health of mothers and their children. Decades of research shows that WIC participation is associated with healthier birth outcomes, improved birth weight, reduced infant mortality, better infant-feeding practices—including higher initiation and duration of breastfeeding—more nutritious diets, increased access to primary and preventive health care, higher rates of immunization, and improved cognitive development and learning—leading to better academic achievement (see "WIC Works" p. 30).[72]

One of the key functions of WIC is to provide pregnant, breastfeeding, and postpartum women and their young children with nutritious food. Access to healthy food is critical to promote optimal health throughout the life course, particularly during periods of rapid growth and development. Quality nutrition during pregnancy is important to support fetal development and protect mothers from pregnancy-related risks. Good nutrition in early childhood promotes optimal development and fosters healthy behaviors that may be sustained in adulthood.[73] Participants receive food benefits that they can use at approved retail grocery stores and pharmacies. WIC foods are aligned to meet the nutrient needs of mothers and their children during pregnancy, breastfeeding, infancy and early childhood, and supplement household food budgets with the objective to improve food security.[74]

In addition to food benefits, WIC acts as a 'gateway' program connecting families to

[71] MDHHS, Michigan WIC. Facts About WIC. September 2016. Retrieved (3/7/20) from: https://www.michigan.gov/documents/mdhhs/FactsAboutWIC_09_20_16_536532_7.pdf
[72] Carlson S and Neuberger Z. *WIC Works: Addressing the Nutrition and Health Needs of Low-Income Families for 40 Years.* Center on Budget and Policy Priorities; Policy Futures, March 29, 2017.
[73] Ibid.
[74] MDHHS, Facts About WIC, 2016, op. cit.

quality primary and preventive care, as well as social services such as childcare, smoking cessation, substance abuse, and housing referrals. This is facilitated, in part, by a partnership with the MDHHS Integrated Services Delivery (ISD) project, in which clients using the MiBridges website can choose to send their referrals directly to the WIC program to be contacted or enrolled in the WIC program.[75]

WIC Works

In the publication, *WIC Works: Addressing the Nutrition and Health Needs of Low-Income Families for 40 Years*, authors Steven Carlson and Zoë Neuberger examine the evidence supporting the effectiveness of the federal WIC program.[72] From their assessment they conclude:

- Women who participate in WIC give birth to healthier babies who are more likely to survive infancy.
- WIC supports more nutritious diets and better infant feeding practices, including consumption of more fruits, vegetables, whole grains, and low-fat dairy products, and increased breastfeeding.
- Low-income children participating in WIC are just as likely to be immunized as more affluent children and are more likely to receive preventive medical care than other low-income children.
- Children whose mothers participated in WIC while pregnant scored higher on assessments of mental development at age 2 than similar children whose mothers did not participate, and they later performed better on reading assessments while in school.
- Improvements in the WIC food packages over the years have contributed to healthier food environments in low-income neighborhoods, enhancing access to fruits, vegetables, and whole grains for all consumers regardless of their participation in WIC.

Advancing Equity

Michigan's WIC program is advancing equity by providing nutritional support and counseling as well as referrals to social services to a large proportion of Michigan's most vulnerable residents. In addition, the program has implemented policies and evidence-based strategies to address and remove barriers that contribute to racial and ethnic minority inequities. For example, in 2019, Michigan's WIC program completed revisions to a benefits issuance policy and submitted it to USDA for approval. The revised policy was designed to address transportation challenges and other barriers participants encounter with scheduling and attending clinic visits, such as difficulties with housing stability and phone access. The policy was approved in 2020 and will allow the WIC program to relax requirements for food benefit issuance and permit local agencies to provide benefits to clients in three-month intervals (up to six months) for

[75] MDHHS WIC Division, Nutrition and Program Evaluation Section; and Consultation and Nutrition Services Unit, Written communication March 5 & 6, 2020.

clients who have not completed nutrition education and/or missed a scheduled appointment. This will help ensure WIC's most vulnerable clients continue to receive essential benefits.[76]

Michigan's WIC program also works to ensure the cultural and linguistically appropriateness of its services. WIC utilizes a two-step translation process for both Spanish and Arabic printed materials. In addition to external professional translators, the State WIC Division contracts with local WIC agency staff to provide a second level review of translated documents to ensure cultural appropriateness and sensitivity (e.g., topics such as breastfeeding). Michigan's WIC food authorization committee also continually reviews the state's WIC food package to ensure the variety and choice of food options, including cultural and religious considerations.[77]

In addition, the Michigan WIC program has worked to address disparities in breastfeeding among racial and ethnic populations by utilizing an evidence-based strategy of providing peer support to promote breastfeeding (see side bar: "Examining the Evidence - Peer Support for Breastfeeding"). Although breastfeeding provides numerous benefits for both infants and mothers,[78,79] certain racial and ethnic groups have lower rates of breastfeeding initiation than their white counterparts; those that do breastfeed, tend to do so for shorter amounts of time.[80,81] Consequently, the Michigan WIC program implemented a Breastfeeding Community Liaisons (BCL) project.

Examining the Evidence
Peer Support for Breastfeeding*

Peer support programs have been identified as an evidence-based strategy for promoting breastfeeding. Often provided by a trained peer counselor or other lay person, these initiatives have been found by research studies and systematic reviews to significantly increase breastfeeding initiation, duration, and exclusivity. Support is often provided by individuals who are from the same community and have the same or similar sociocultural background as those needing the support, as well as have personal experience with breastfeeding.

Peer support programs have also been identified as a culturally competent way to promote and support breastfeeding for women from different racial and ethnic groups and socioeconomic backgrounds. Given the effectiveness of peer support and counseling programs, many WIC agencies provide this service to their clients.

*Source: Centers for Disease Control and Prevention. Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies. Atlanta: U.S. Department of Health and Human Services; 2013.

[76] Ibid.
[77] Ibid.
[78] Carlson 2017, op. cit., p. 12.
[79] National First Food Racial Equity Cohort. National First Food Cohort Addresses the Value of Peer and Community-based Breastfeeding Support [webpage post]. *Center for Social Inclusion* website. Retrieved (3.6.20) from: https://www.centerforsocialinclusion.org/national-first-food-cohort-addresses-the-value-of-peer-and-community-based-breastfeeding-support/
[80] Ibid.
[81] Pineros-Leano M, Tabb KM, Simonovich SD, Wang Y, Meline B, Huang H. Racial Differences in Breastfeeding Initiation Among Participants in a Midwestern Public Health District. *Health Equity*. 2018;2(1):296–303. Published 2018 Oct 19. doi:10.1089/heq.2018.0016

Peer support programs have been found to be effective for racial and ethnic minority women. A randomized controlled trial of a peer support program among low-income Latina women found that women who received individual peer counseling were more likely to be breastfeeding at one and three months after birth than those who received only routine breastfeeding support.

Study citation: Chapman D, Damio G, Perez-Escamilla R. Differential response to breastfeeding peer counseling within a low-income, predominantly Latina population. *Journal of Human Lactation*. 2004;20(4):389-396.

Specifically, the project placed breastfeeding community liaisons in inner-city Detroit hospitals that have a high number of Medicaid and African American births and poor breastfeeding initiation rates. The effort was developed to determine if early intervention by a breastfeeding community liaison would impact the rates of initiation, exclusivity, and duration of breastfeeding among black women, who might lack breastfeeding role models in their social networks and be more likely to face negative perceptions of breastfeeding among their peers and communities. Breastfeeding community liaisons have previous experience as peer counselors with at least three years of WIC clinic experience. They provide support and education to the mother-baby dyad through the early days of breastfeeding and connect families with continued breastfeeding support through referral to WIC breastfeeding peer counselors and International Board-Certified Lactation Consultants at the local WIC agency. Thus, the project facilitates seamless care between the hospital and home.[82]

Preliminary data has shown that among patients seen by a breastfeeding community liaison, any breastfeeding as well as exclusive breastfeeding has increased. Additionally, women who had contact with a breastfeeding community liaison had increased duration of breastfeeding up to six months. Continued data collection will explore if this relationship continues to impact the duration of breastfeeding.[83]

A study conducted among low-income women at Michigan WIC clinics found that those who received peer support for breastfeeding were 22% more likely to initiate breastfeeding than those who did not. Additionally, peer support recipients breastfed for 2 weeks longer than those who did not receive peer support services.

Study citation: Olson B, Haider S, Vangjel L, Bolton T, Gold J. A quasi-experimental evaluation of a breastfeeding support program for low-income women in Michigan. *Maternal Child Health Journal*. 2010;14(1):86-93.

Finally, to promote growth and diversity in the field of lactation, the MDHHS WIC Division provided scholarships for minority WIC staff to increase lactation knowledge through training and other educational opportunities.[84]

[82] MDHHS WIC Division, Nutrition and Program Evaluation Section, and Consultation and Nutrition Services Unit 2020, op. cit.
[83] Ibid.
[84] Ibid.

This effort is supported by research that has shown that peer support is most effective when a peer has the same or a similar sociocultural background as those whom they support.[85]

Alignment with Public Act 653

The evidence-based and promising practices described above align with many PA 653 provisions. These, along with other relevant efforts of the department, are highlighted in the following chart.

PA 653 Provision	MDHHS Program/Initiative and Activities
(a) Develop and implement a structure to address racial and ethnic health disparities in this state.	Formerly the Health Disparities Reduction and Minority Health Section, the Office of Equity and Minority Health serves as the primary coordinating body within MDHHS to address racial and ethnic health disparities. Additional structures from highlighted programs include: **State Innovation Model (SIM)/Community Health Innovation Regions (CHIRs)** – The CHIR initiative contributes to a structure to address racial and ethnic health disparities in the state by providing data to monitor differences in the ability for racial and ethnic minorities to have their health, social, and economic needs met through community resources. The CHIRs also provide a mechanism for policies and practices regarding minority health to be disseminated to community partner agencies. **Ottawa County Pathways to Better Health (OPBH)** – Provides a structure through the Pathways model, which links vulnerable populations to needed health and social services and tracks progress from the start to finish. **Pathways to Potential** – Has a structure in participating schools to address the needs of students and their families. **OWDT ERACCE Training and Child Welfare Antiracism Team** – The Children's Services Agency Child Welfare Antiracism Team provides a structure for addressing the disproportionality of children of color in Michigan's child welfare system.

[85] Shealy KR, Li R, Benton-Davis S, Grummer-Strawn LM. *The CDC Guide to Breastfeeding Interventions*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2005. (Retrieved 3-6-20) from: https://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf

PA 653 Provision	MDHHS Program/Initiative and Activities
(b) Monitor minority health progress.	Many organizational areas and programs within the department collect data on race and ethnicity for program planning, monitoring, and reporting purposes. These data are also used to demonstrate and monitor disparities in health outcomes. Examples from highlighted programs include: **SIM/CHIRs** – An evaluation of CHIRs' clinical-community linkage efforts has analyzed client demographic information, screening and referral data, and Medicaid claims data to determine the types and severity of client needs, and whether the clinical-community linkage initiatives have reduced the demand for certain types of clinical services. **OPBH** – Collects data on clients and tracks progression through pathways to identify needs and determine when needs are met. **WIC** – Use data collected through the MIS eligibility application as well as PNSS and PedNSS surveillance systems to generate reports on health outcome indicators broken down by race and ethnicity.
(c) Establish minority health policy.	A number of MDHHS areas have a mandatory training policy requiring staff to complete equity-related trainings; and diversity recruitment and hiring policies to ensure diverse candidate pools and promote workforce diversity. Other examples from highlighted programs are: **SIM/CHIRS** – The CHIRs provide a mechanism for developing and disseminating minority health-promoting policies to partner agencies within the state. Additionally, CHIRs have been examining systemic causes of local inequities in socioeconomic and health status and working to prioritize shifts in policies, practices, and allocation of resources to support the pursuit of equity in the community. **WIC** – In order to address client transportation and other barriers, WIC implemented policies to facilitate local agency issuance of food benefits in the absence of client clinic visits.

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.	*The Michigan Health Equity Roadmap: A vision and framework for improving the social and health status of racial and ethnic minority populations in Michigan*, serves as the statewide strategic plan for eliminating health disparities in Michigan. Several organizational areas have also incorporated equity into their strategic plans. Highlighted examples include: **SIM/CHIRS** – Each CHIR developed a plan for addressing non-health issues that will, over time, reduce emergency department costs while improving quality, and design infrastructure necessary to support the effort. **OWDT ERACCE Training and Child Welfare Antiracism Team** – As part of their training, the Child Welfare Antiracism Team is developing a strategic plan to address systemic racism in child welfare that leads to disproportionality of children of color in care and inequitable outcomes for children and families of color involved with the system. **WIC** – Local WIC agencies prepare an annual Nutrition Services Plan that takes into consideration data on racial/ethnic outcomes. Agencies were also requested to select consistent goals statewide, that support the Michigan WIC 2019-2023 Five-Year-Plan Health Outcome Indicators.
(e) Utilize federal, state, and private resources, as available and within the limits of appropriations, to fund minority health programs, research, and other initiatives.	**SIM/CHIRs** – The CHIRs provide a mechanism for federal and state resources to be disseminated to community partner agencies in order to address minority health issues and disparities. **Pathways to Potential** – Funds success coaches in Michigan schools to address the needs of students and families, many of which are in minority communities. **WIC** – WIC disseminates federal funding to local agencies to carry out WIC benefits and services. WIC also received a 3-year grant for the Summer EBT for Children Program. This program provides children well-balanced meals during the summer months when school meals are not readily available. The SEBTC program uses a Bridge Card for electronic benefit transfer (EBT) like the WIC system.

PA 653 Provision	MDHHS Program/Initiative and Activities
(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.	**SIM/CHIRs** – The MDHHS SIM/CHIR initiative works closely with the five CHIR areas, providing technical assistance, program guidance, and evaluation support. **WIC** – As mentioned, WIC generates data reports that provide information on health outcome indicators by race and ethnicity. Local WIC agencies use these reports to make informed decisions about outreach and program planning for the WIC population they serve in order to reduce racial and ethnic disparities. Agencies also set goals that support the Michigan WIC 2019-2023 Five-Year-Plan Health Outcome Indicators.
(g) Establish a web page on the department's website, in coordination with the state health disparities reduction and minority health section.	The Office of Equity and Minority Health continued to maintain its web page (Michigan.gov/MinorityHealth), which provides access to minority health/equity data, reports/documents, training, grant/funding opportunities, tools, resources, and current research.
(h) Develop and implement recruitment and retention strategies to increase the number of minorities in the health and social services professions.	As noted, many organizational areas have diversity recruitment and hiring policies, and provided training to promote workforce diversity (e.g., Hidden Bias, Cultural Awareness for Hiring Managers, Systemic Racism ERACCE trainings, etc.). Additionally: **WIC** – To promote growth and diversity in the field of lactation, WIC provided scholarships for minority WIC staff to increase lactation knowledge through training and other educational opportunities.
(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.	Many MDHHS areas (including those highlighted) provide external partners, grantees, contractors, and service providers with training on various equity-related issues (e.g., implicit bias, equity, social justice, systemic racism, cultural competency, cultural humility, inclusion, SDOH, etc.).

PA 653 Provision	MDHHS Program/Initiative and Activities
(j) Identify and assist in the implementation of culturally and linguistically appropriate health promotion and disease prevention programs that would emphasize prevention and incorporate an accessible, affordable, and acceptable early detection and intervention component.	Efforts related to the delivery of culturally and linguistically appropriate programs and services (CLAS) consisted of staff training, interpretation services, translation of materials, and working with community groups to ensure appropriateness of programs/services. Additionally: **WIC** – The State WIC food authorization committee continually reviews the Michigan WIC Food Package for variety and choice--including cultural and religious considerations--to ensure availability of culturally appropriate foods for clients.
(k) Promote the development and networking of minority health coalitions.	Many programs work with local entities and coalition groups as part of their equity-promoting efforts. For example: **SIM/CHIRs** – CHIRs are governed by a regional steering committee and is supported by a designated backbone organization, as well as local action teams comprised of CHIR members and partners from many different service sectors. Steering committees provide a clear leadership structure and promote shared accountability among partners for aligning their resources to address priority community health needs.
(l) Appoint a department liaison to (i) Assist in the development of local prevention and intervention plans; (ii & iii) Relay the concerns of local minority health coalitions and assist in coordinating minority input; and (iv) Serve as the link between the department and local efforts to eliminate racial and ethnic health.	Many organizational areas have staff that work on equity-related issues. Additionally, several areas work with community groups and solicit participation, input, and feedback from racial and ethnic minority populations served. Examples include: **SIM/CHIRs** – Some CHIRs have created a resident advisory council in neighborhoods experiencing inequitable access to services. These groups provide input and assistance to improve efforts. **OPBH** – The program's CHWs are trusted members of the community that seek to promote the community's voice and serve as a link between health and social services.

PA 653 Provision	MDHHS Program/Initiative and Activities
(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.	**SIM/CHIRs** – MDHHS has provided federal and state (FY2020) funding to support Michigan's 5 CHIRs, which facilitate linkages to essential preventative health, education, and treatment services. Additional funds are being sought for FY21 and beyond. **Pathways to Potential** – Funds MDHHS success coaches (i.e. caseworkers) in local schools to assist students and families with accessing needed care and resources. **WIC** – Disseminates federal funds to local agencies for the delivery of WIC services.
(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.	As described, many programs within MDHHS partner with and fund local communities to address needs, gaps, and barriers related to health care access and delivery along with receipt of social services (e.g. SIM/CHIRs, Pathways to Better Health, Pathways to Potential, WIC). In particular, CHIRs and the Pathways to Better Health program facilitate clinical-community linkages and improved access to care.

Conclusion

In 2019, MDHHS continued its work to address racial and ethnic minority inequities through a number of programs, services, policies, and procedures implemented at the state and local level. Several of these efforts utilized evidence-based and promising practices. Based on the integration of scientific research, rigorous evaluation, application of data, successful practices from the field, and community input, evidence-based efforts and promising practices have an increased likelihood of improving health and social outcomes. They may also result in a more efficient use of limited resources.

Given these benefits, MDHHS is committed to using evidence and data, whenever possible, to inform its efforts and improve its services. This includes adopting best practices when evidence points to effectiveness, using data to identify those who have

the greatest needs, setting measurable goals that can be tracked over time, looking at performance metrics to determine if a program is working as intended, and rigorously evaluating initiatives. At the same time, the department recognizes that an effective model may need to be tailored to certain populations and contexts. This is especially true for racial and ethnic minority communities for which there is less research on effective interventions. Even so, by taking an evidence-based and promising practice approach, MDHHS is better positioned to reduce health disparities and achieve the aims of Public Act 653.

Acknowledgements

The Office of Equity and Minority Health would like to thank all MDHHS personnel that completed the 2019 Health Equity Survey. The section would also like to thank representatives from the State Innovation Model's Community Health Innovation Regions Office (State and Genesee County), Ottawa County's Pathways to Better Health Program, the Office of Workforce Development and Training (ERACCE training and Child Welfare Antiracism Team efforts), Pathways to Potential, and Women Infants and Children (WIC) for providing additional information on their programming efforts, which are highlighted in this report.

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

Summary Data Brief of the Changes in Health Disparities Between 2010-2017

Introduction

This summary data brief focuses on health disparities and how they change in Michigan's populations over time. Group-level data for five racial and ethnic groups in Michigan compared to Michigan's White population are analyzed for two time periods (2008-2010) and (2015-2017). This brief describes how populations compare to one another in terms of population prevalence for several social determinants of health and health outcomes. These comparisons describe populations relative to each other and if the gap is narrowing (less disparate) or widening (more disparate) over time. The purpose of these data tables is to allow for routine monitoring of health disparities in Michigan and to evaluate their progress over time.

Health Indicators

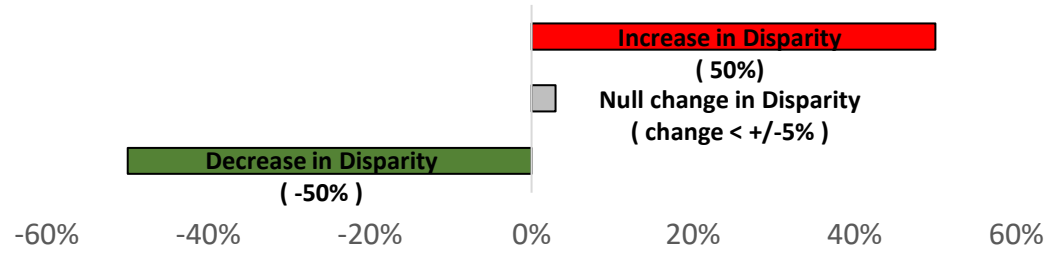
Each of the tables contains two sets of indicators with data for each minority racial and ethnic population. The first set of indicators include social, economic, and environmental determinants for individual and community health. The second set of indicators include health outcomes represented by mortality and morbidity rates and prevalence for several diseases. Monitoring social determinants along with health outcomes is optimal for evaluating success in achieving sustainable health equity for racial and ethnic minority populations in Michigan.

Health Equity Measures

Change in Pairwise Disparity Over Time: The change in pairwise disparity over time describes whether the index population (racial/ethnic minority) prevalence has gotten closer to or farther from the White population prevalence from one time period to another.

The above listed health disparity measure is shown in tabular form with the population prevalence for both the Indexed and White population listed by each of the time periods followed by the **Percent (%) Change in Pairwise Disparity Over Time**. The percent change in pairwise disparity over time for each health indicator is then shown graphically in order from greatest increase in disparity (positive percent and by a red bar graphically) to greatest decrease in disparity (negative percent and by a green bar graphically).

Example chart of change in health disparity



Key: The above figure gives a graphical example of change in pairwise disparity over time. The percent change in pairwise disparity over time for each health indicator is shown graphically in order from greatest increase in disparity (positive percent and by a red bar graphically) to greatest decrease in disparity (negative percent and by a green bar graphically). Percent changes less than (+/-) 5% are represented by a grey bar.

Change in Health Disparity: African American and White Community

- Within the African American community several decreases in disparity between the African American and White American communities have occurred such as a 19% reduction in the disparity of high school dropout rate.
- These reductions have mainly been due to improvements in the prevalence of these social determinants of health for African Americans.
- However, some of the biggest reductions in disparity have been due to a worsening of prevalence in the White community such as rise in the prevalence of female-headed households (3.60% in 2010 to 22.7% in 2017) and individuals with no personal health care provider (12% in 2010 to 15% in 2017).

Indicators	2008-2010		2015-2017		
	African American	White	African American	White	Change in Pairwise Disparity, %
Social Determinants[a]					
Female-headed households, %	31.20%	9.60%	33.50%	22.70%	-55%
No personal health care provider, %	18%	12%	18%	15%	-20%
Living in different house than last year, %	21.90%	12.60%	17.30%	12.50%	-20%
High school dropout rate, %	20%	8%	14%	7%	-19%
No health care access due to cost, %	19%	12%	16%	12%	-15%
Population ≥ 3 years in preschool, %	4.90%	5.40%	5.60%	5.80%	-6%
Living in renter-occupied housing, %	53.30%	21.40%	58.20%	22.20%	5%
Poverty rate children <18 years, %	45.00%	15.90%	41.10%	13.40%	8%
Owner's mortgage cost >30% income, %	48.60%	35.00%	33.70%	21.80%	11%
Median housing value, $	84,100	142,600	73,300	161,900	23%
Unemployment rate, %	13.70%	7.20%	13.60%	5%	59%
Mortality and Morbidity Indicators[b]					
Diabetes prevalence, %	14%	8%	13%	9%	-20%
Septicemia mortality per 100,000	19.7	7.3	18.8	8.6	-19%
Pneumonia and flu mortality per 100,000	19.2	12.9	17.6	14	-16%
Suicides mortality per 100,000	7.2	13.8	9.7	16.4	-13%
Diabetes mortality per 100,000	36.2	22.3	35.3	20.2	8%
Kidney disease mortality per 100,000	24.9	14.1	28.3	13.1	22%
Accidents mortality per 100,000	34.6	36.6	64.3	51.2	33%

Key: Positive percentages represent an increase in disparity (difference) between the population of interest and the White population, while negative percentages represent a decrease in disparity. Percentages less than (+/-) 5% show no change in disparity. For ratios less than 1.00 these values are inverse.

a. Data Source: American Community Survey, population profile 3-year estimate 2008-2010; 1-year estimate 2017. For these indicators Asian estimate does not include Pacific Islanders and all races are non-Hispanic. For Indicators of Hispanic estimates, Hispanics include combination with one or more races.

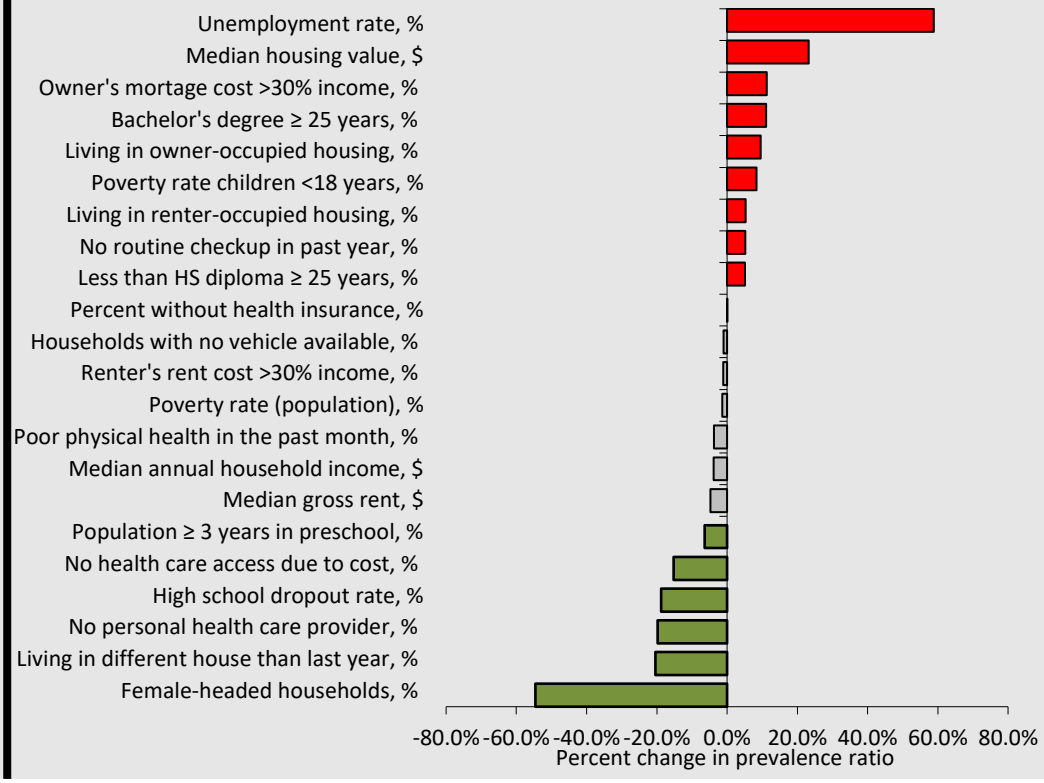
b. Data Source: Michigan Behavioral Risk Factor Survey, 3-year estimates 2008-2010; 2015-2017. For these indicators all race and ethnicities are non-Hispanic.

Calculations for change in pairwise disparity for disparity comparisons to White populations can be found in the Michigan Health Equity Data Project's Michigan Health Equity Data Tables and Related Technical Documents 2000-2009. https://www.michigan.gov/documents/mdch/MI_Health_Equity_Data_Tables_-_May_2011_361639_7.pdf

Change in Health Disparity: African American and White Community

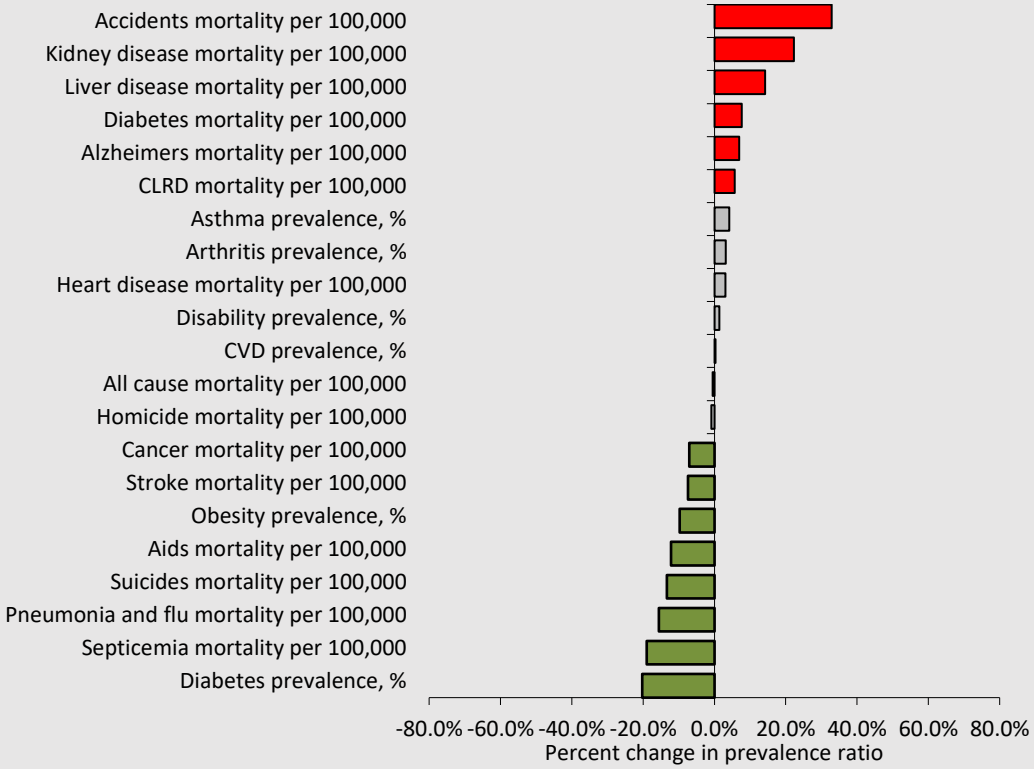
- The gap between African American and White American unemployment rates increased by 58.8% between 2010 and 2017.
- The unemployment rate of White Americans was higher in 2010 than in 2017 while African American unemployment stayed the same.
- In contrast, the gap in the percent of single-parent households decreased between White and African Americans by 54.6%.
- Overall, between 2010 and 2017 the disparity in many SDOH indicators decreased between African Americans and White Americans.

Change in Health Disparities between African American and White Americans: Social Determinants of Health (2010-2017)



Key: The percent change in pairwise disparity over time for each health indicator is shown graphically in order from greatest increase in disparity (positive percent and by a red bar graphically) to greatest decrease in disparity (negative percent and by a green bar graphically). Percent changes less than (+/-) 5% are represented by a grey bar.

Change in Health Disparities between African American and White American: Mortality/Morbidity Indicators (2010-2018)



- Overall preventable causes of mortality such as pneumonia, Septicemia, and AIDS and many chronic diseases like cardiovascular disease have decreased in the disparity between African American and White Americans.
- The reduction in disparity is mainly due to improvements in the prevalence of these health indicators in the African American community.
- However, there is still a great amount of absolute disparity between these populations.

Change in Health Disparity: Hispanic American and White Community

- Between the Hispanic American and White American communities there is a 29% reduction in the disparity in enrollment of children in preschool.
- However, in terms of mortality and morbidity indicators the disparity between the Hispanic American and White American communities has increased.
- In some cases, increases in disparity have been due to the Hispanic American community having greater improvements in mortality than the White American community like in chronic lower respiratory disease (CLRD) mortality rates. In other cases the increase in disparity is due to a worsening of health indicator prevalence in the Hispanic community such as in obesity prevalence.

Indicators	2008-2010		2015-2017		
	Hispanic American	White	Hispanic American	White	Change in Pairwise Disparity, %
Social Determinants[a]					
Population ≥ 3 years in preschool, %	7.10%	5.40%	5.40%	5.80%	-29%
High school dropout rate, %	20%	8%	13%	7%	-25%
Living in different house than last year, %	21.00%	12.60%	16.50%	12.50%	-21%
Female-headed households, %	19.60%	9.60%	38.60%	22.70%	-17%
Poverty rate (population), %	24.20%	8.40%	18%	7%	-13%
Less than HS diploma ≥ 25 years, %	33.00%	10.20%	27.30%	7.40%	14%
Percent without health insurance, %	22.20%	10.70%	11.10%	4.50%	19%
Poor physical health in the past month, %	11%	10%	11%	9%	20%
Mortality and Morbidity Indicators[b]					
Arthritis prevalence, %	21%	30%	26%	28%	-31%
Suicides mortality per 100,000	8.1	13.8	12.1	16.4	-26%
Diabetes mortality per 100,000	36.3	22.3	26.8	20.2	-18%
Stroke mortality per 100,000	34.6	37.6	31.3	38.6	12%
Obesity prevalence,%	34%	29%	42%	31%	15%
Pneumonia and flu mortality per 100,000	12.3	12.9	15.6	14	17%
Heart disease mortality per 100,000	157.4	196.4	120.8	187.2	19%
CLRD mortality per 100,000	30.1	47.2	17.6	46.5	41%

Key: Positive percentages represent an increase in disparity (difference) between the population of interest and the White population, while negative percentages represent a decrease in disparity. Percentages less than (+/-) 5% show no change in disparity. For ratios less than 1.00 these values are inverse.

a. Data Source: American Community Survey, population profile 3-year estimate 2008-2010; 1-year estimate 2017. For these indicators Asian estimate does not include Pacific Islanders and all races are non-Hispanic. For Indicators of Hispanic estimates, Hispanics include combination with one or more races.

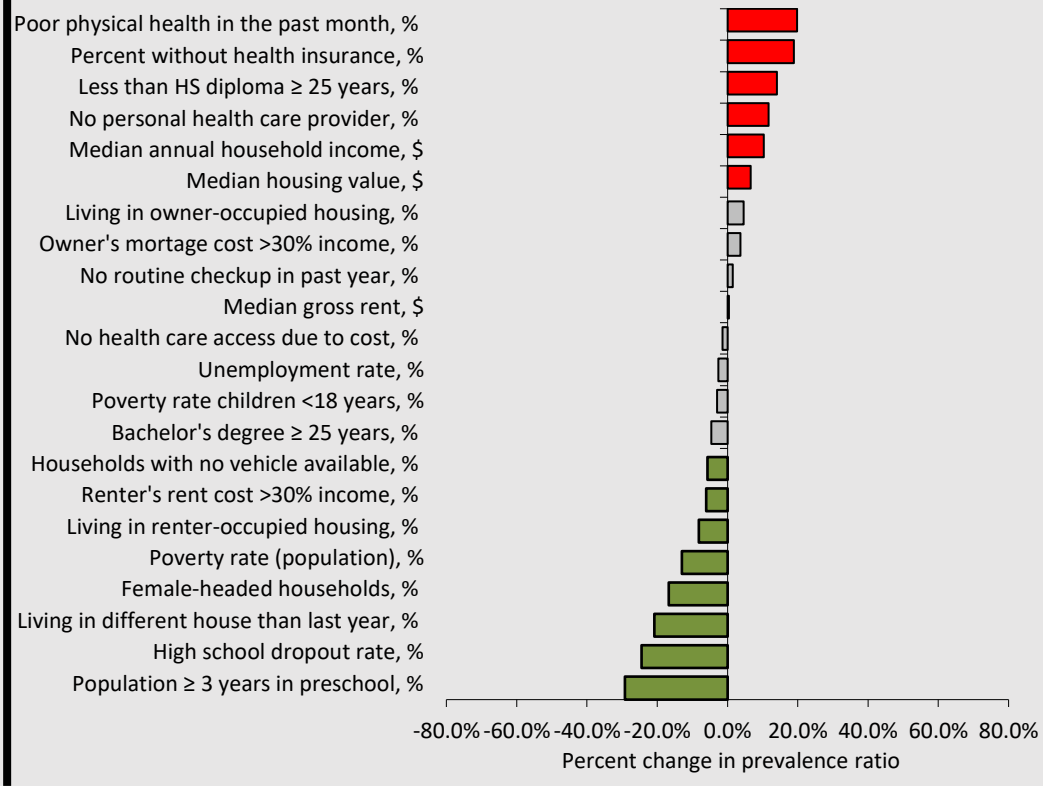
b. Data Source: Michigan Behavioral Risk Factor Survey, 3-year estimates 2008-2010; 2015-2017. For these indicators all race and ethnicities are non-Hispanic.

Calculations for change in pairwise disparity for disparity comparisons to White populations can be found in the Michigan Health Equity Data Project's Michigan Health Equity Data Tables and Related Technical Documents 2000-2009. https://www.michigan.gov/documents/mdch/MI_Health_Equity_Data_Tables_-_May_2011_361639_7.pdf

Change in Health Disparity: Hispanic American and White Community

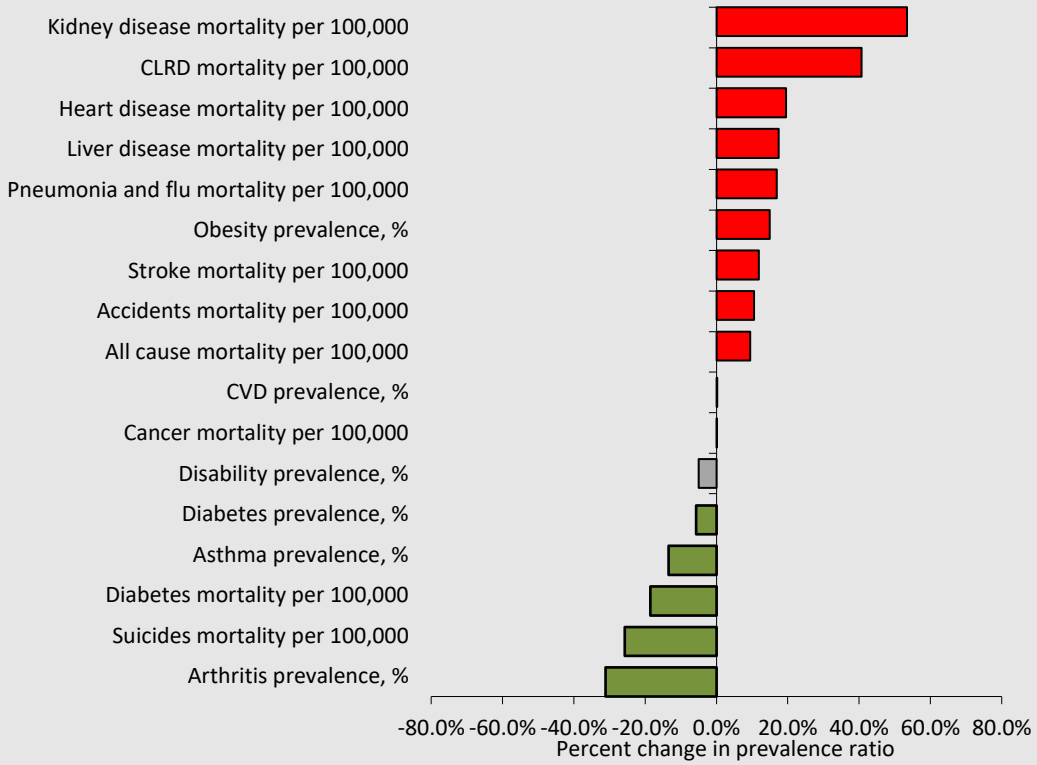
- The disparity between Hispanic and White Americans in many of the key SDOH indicators such as household income, poverty rate, and high school dropout rates have reduced.
- This reduction in disparity is mainly due to improvements within the Hispanic community for many of these indicators.
- Such as an increase in household income and a reduction in the poverty rate within the Hispanic community.

Change in Health Disparities between Hispanic American and White Americans: Social Determinants of Health (2010-2017)



Key: The percent change in pairwise disparity over time for each health indicator is shown graphically in order from greatest increase in disparity (positive percent and by a red bar graphically) to greatest decrease in disparity (negative percent and by a green bar graphically). Percent changes less than (+/-) 5% are represented by a grey bar.

Change in Health Disparities between Hispanic American and White American: Mortality/Morbidity Indicators (2010-2018)



- The disparity in chronic disease mortality between the Hispanic and White communities has increased for several key health issues like chronic lower respiratory disease and heart disease.
- Some of these increases are due to the health indicators prevalence for Hispanic Americans improving more than White Americans, but many are due to a worsening in prevalence.
- The Hispanic community has seen a reduction in disparities for chronic diseases like a 31% reduction in arthritis.

Change in Health Disparity: Asian American and White Community

- Within the Asian American community, the prevalence of many social determinants of health are better than that of the White Americans.
- Some improvements in disparity are due to a worsening of prevalence in the Asian American community or improvement in the White community.
- For example, there is a 433% reduction in the disparity between Asian and White communities for poor physical health prevalence due to Asian American prevalence increasing from 2% in 2010 to 9% in 2017.
- Another example is the reduction in unemployment disparity due to White American unemployment decreasing from 7.2% in 2010 to 5% in 2017 gaining more parity with the Asian American unemployment rate.

Indicators	2008-2010		2015-2017		
	Asian American	White	Asian American	White	Change in Pairwise Disparity, %
Social Determinants[a]					
Poor physical health in the past month, %	2%	10%	9%	9%	-433%
No health care access due to cost, %	15%	12%	11%	12%	-27%
Unemployment rate, %	5.60%	7.20%	4.20%	5%	-20%
Households with no vehicle available, %	6.40%	5.50%	5.10%	5.50%	-20%
No routine checkup in past year, %	36%	35%	27%	31%	-16%
No personal health care provider, %	12%	12%	16%	15%	8%
Median housing value, $	208,300	142,600	261,500	161,900	11%
Median gross rent, $	799	713	1,044	828	13%
Population ≥ 3 years in preschool, %	5.40%	5.40%	4.50%	5.80%	22%
Less than HS diploma ≥ 25 years, %	12.00%	10.20%	10.70%	7.40%	23%
Female-headed households, %	6.50%	9.60%	11.10%	22.70%	28%
High school dropout rate, %	6%	8%	4%	7%	30%
Mortality and Morbidity Indicators[b]					
Obesity prevalence,%	6%	29%	14%	31%	-98.90%
Disability prevalence, %	6%	22%	11%	24%	-65.10%
CVD prevalence, %	10%	8%	4%	8%	-64%
Asthma prevalence, %	6%	15%	7%	16%	-12%
Stroke mortality per 100,000	32.2	37.6	26.3	38.6	20.40%
Accidents mortality per 100,000	16.4	36.6	15.8	51.2	31%

Key: Positive percentages represent an increase in disparity (difference) between the population of interest and the White population, while negative percentages represent a decrease in disparity. Percentages less than (+/-) 5% show no change in disparity. For ratios less than 1.00 these values are inverse.

a. Data Source: American Community Survey, population profile 3-year estimate 2008-2010; 1-year estimate 2017. For these indicators Asian estimate does not include Pacific Islanders and all races are non-Hispanic. For Indicators of Hispanic estimates, Hispanics include combination with one or more races.

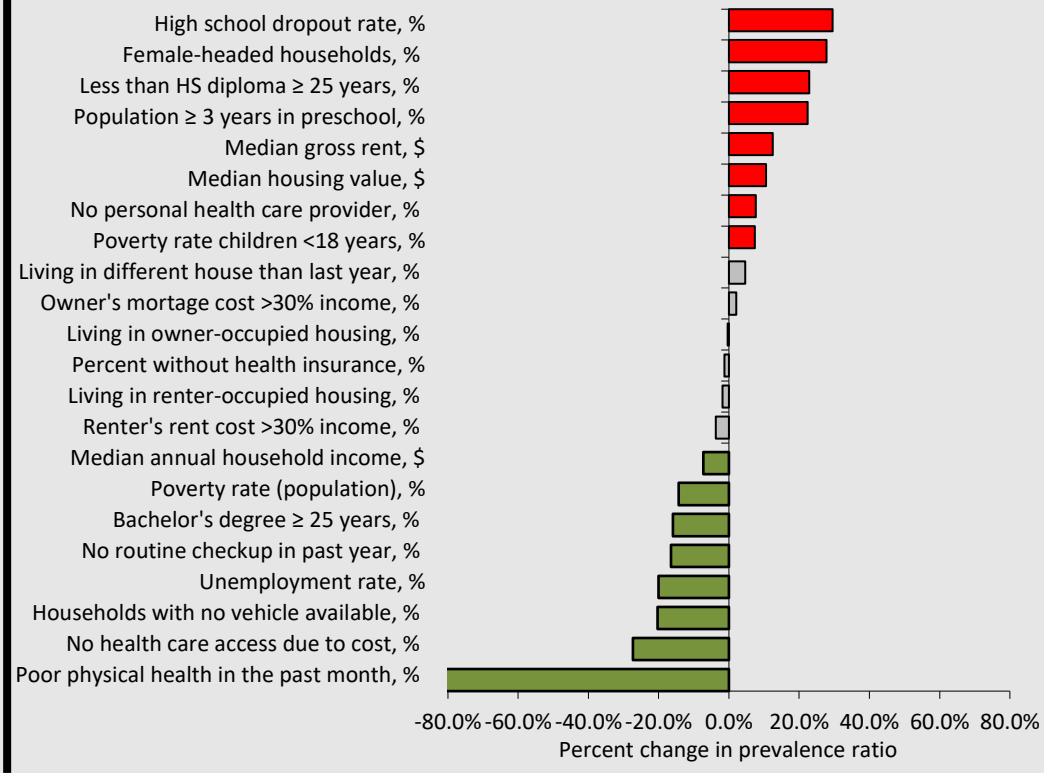
b. Data Source: Michigan Behavioral Risk Factor Survey, 3-year estimates 2008-2010; 2015-2017. For these indicators all race and ethnicities are non-Hispanic.

Calculations for change in pairwise disparity for disparity comparisons to White populations can be found in the Michigan Health Equity Data Project's Michigan Health Equity Data Tables and Related Technical Documents 2000-2009. https://www.michigan.gov/documents/mdch/MI_Health_Equity_Data_Tables_-_May_2011_361639_7.pdf

Change in Health Disparity: Asian American and White Community

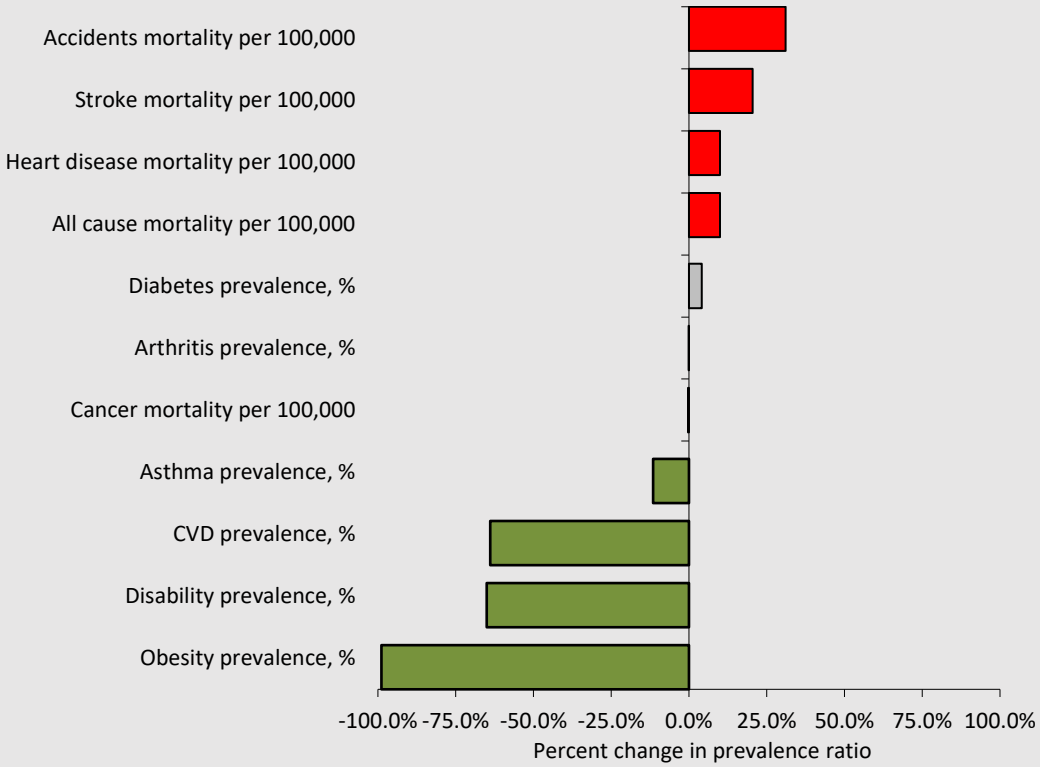
- The prevalence of many social determinant indicators in the Asian American community are lower than the White American community.
- The increase in disparity for high school dropout rates of 29.5%, for example, is due to a worsening of prevalence in the White community.
- However the reduction in disparities for social determinant indicators is due largely to improvements in prevalence in the Asian American community.

Change in Health Disparities between Asian American and White Americans: Social Determinants of Health (2010-2017)



Key: The percent change in pairwise disparity over time for each health indicator is shown graphically in order from greatest increase in disparity (positive percent and by a red bar graphically) to greatest decrease in disparity (negative percent and by a green bar graphically). Percent changes less than (+/-) 5% are represented by a grey bar.

Change in Health Disparities between Asian American and White American: Mortality/Morbidity Indicators (2010-2018)



- Many of the reductions in disparity for health indicators between the White and Asian communities are due to the increase of prevalence in the Asian American community over time.
- For example, the prevalence of obesity among Asian Americans increased from 6% in 2010 to 14% in 2017 approaching White obesity prevalence.
- Additionally, the increases in disparities are due to the lowering of Asian American prevalence and an increase in the White American prevalence.

Change in Health Disparity: Native American and White Community

- The disparity between the Native American and White communities increased across most social determinants of health due in most part to worsening prevalence in the Native American community.
- Native Americans had increases in prevalence such as the proportion of renter's whose rent cost exceeded more than 30% of their income (50.90% in 2010 to 54.40% in 2017).
- However Native Americans have had a reduction in disparity for many morbidity and mortality indicators due to improvements in Native American prevalence for indicators like diabetes and cardiovascular disease mortality.

Indicators	2008-2010		2015-2017		
	Native American	White	Native American	White	Change in Pairwise Disparity, %
Social Determinants[a]					
Poverty rate (population), %	24.20%	8.40%	17.60%	7%	-14%
Less than HS diploma ≥ 25 years, %	18.90%	10.20%	11.90%	7.40%	-13%
Poverty rate children <18 years, %	34.70%	15.90%	25%	13.40%	-13%
No health care access due to cost, %	18%	12%	21%	12%	17%
High school dropout rate, %	15%	8%	15%	7%	19%
Renter's rent cost >30% income, %	50.90%	52.20%	54.40%	45.90%	22%
No routine checkup in past year, %	30%	35%	33%	31%	24%
Population ≥ 3 years in preschool, %	4.90%	5.40%	6.60%	5.80%	25%
Bachelor's degree ≥ 25 years, %	7.50%	16.20%	12.60%	18.80%	45%
Unemployment rate, %	10.50%	7.20%	11.40%	5%	74%
Mortality and Morbidity Indicators[b]					
Diabetes prevalence, %	13%	8%	9%	9%	-39%
CVD prevalence, %	17%	8%	14%	8%	-20%
Obesity prevalence, %	41%	29%	37%	31%	-16%
Cancer mortality per 100,000	205.5	180.3	160.9	160.7	-12%
Diabetes mortality per 100,000	41.4	22.3	33.3	20.2	-11%
All cause mortality per 100,000	875.4	763.6	818.4	763.5	-6%
Asthma prevalence, %	19%	15%	24%	16%	22%
Disability prevalence, %	25%	22%	38%	24%	38%

Key: Positive percentages represent an increase in disparity (difference) between the population of interest and the White population, while negative percentages represent a decrease in disparity. Percentages less than (+/-) 5% show no change in disparity. For ratios less than 1.00 these values are inverse.

a. Data Source: American Community Survey, population profile 3-year estimate 2008-2010; 1-year estimate 2017. For these indicators Asian estimate does not include Pacific Islanders and all races are non-Hispanic. For Indicators of Hispanic estimates, Hispanics include combination with one or more races.

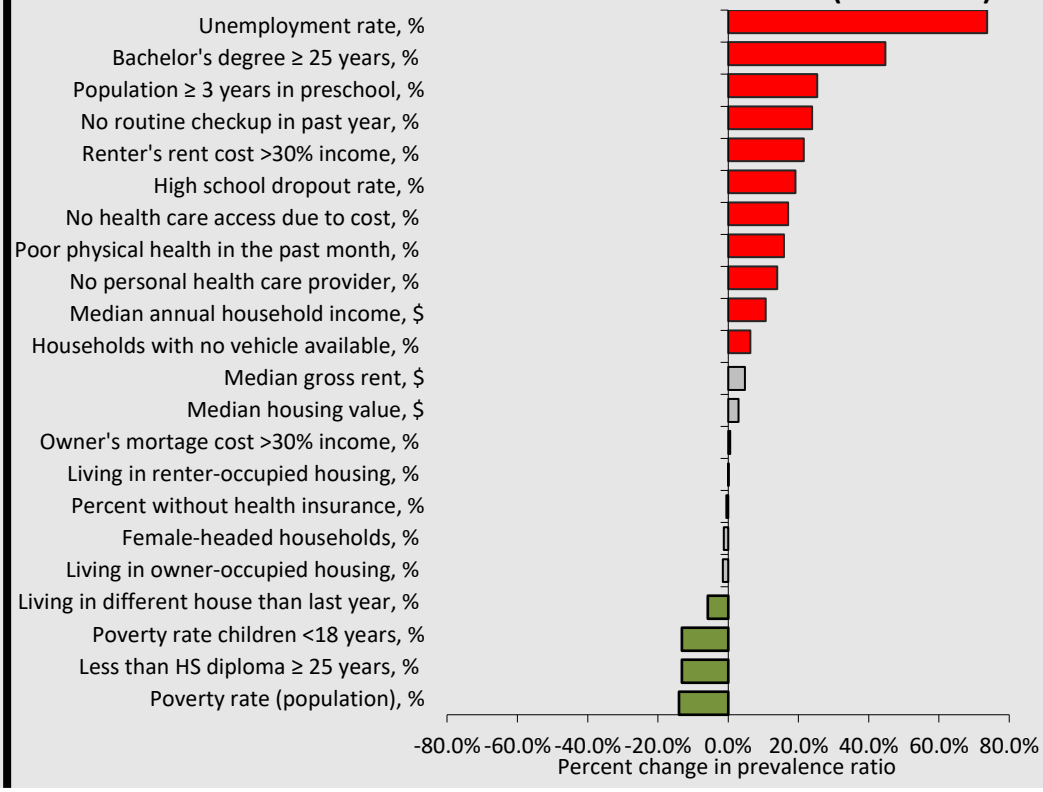
b. Data Source: Michigan Behavioral Risk Factor Survey, 3-year estimates 2008-2010; 2015-2017. For these indicators all race and ethnicities are non-Hispanic.

Calculations for change in pairwise disparity for disparity comparisons to White Populations can be found in the Michigan Health Equity Data Project's Michigan Health Equity Data Tables and Related Technical Documents 2000-2009. https://www.michigan.gov/documents/mdch/MI_Health_Equity_Data_Tables_-_May_2011_361639_7.pdf

Change in Health Disparity: Native American and White Community

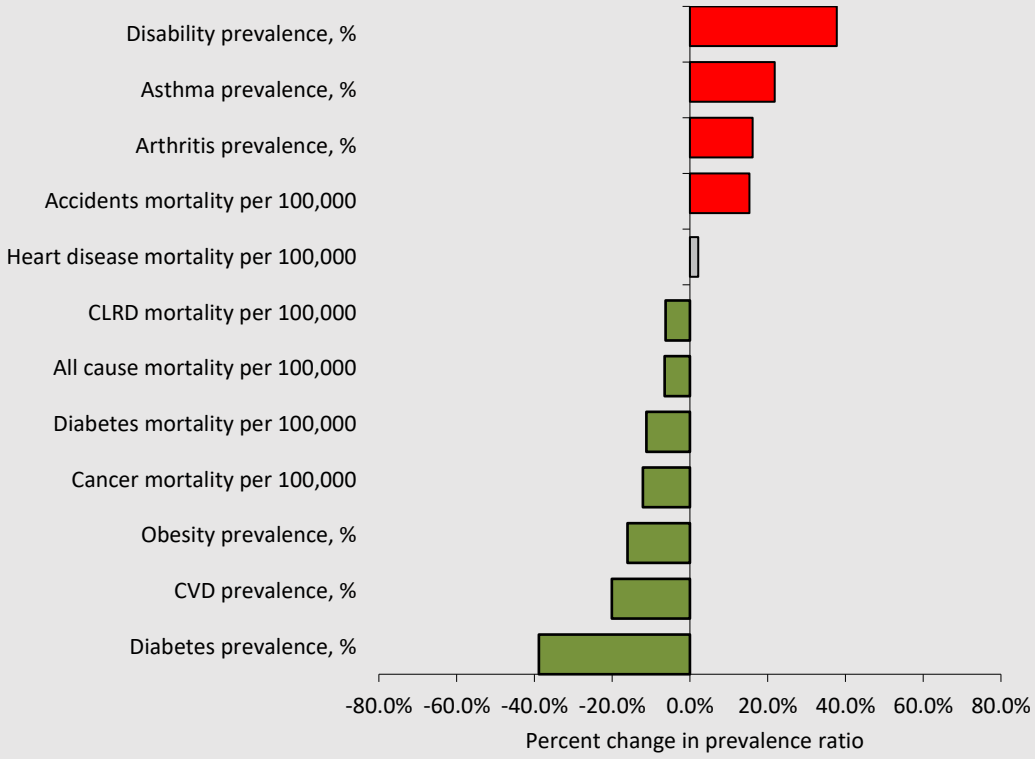
- Many of the social determinants of health indicators saw an increase in disparity for the Native American community.
- The largest increases were in the unemployment rate (73.7% increase), attainment of bachelor's degrees (44.8% increase), and children enrolled in preschool (25.4%).
- The increases in disparity are due to the worsening of prevalence in the Native American community and improving prevalence in the White community.

Change in Health Disparities between Native American and White Americans: Social Determinants of Health (2010-2017)



Key: The percent change in pairwise disparity over time for each health indicator is shown graphically in order from greatest increase in disparity (positive percent and by a red bar graphically) to greatest decrease in disparity (negative percent and by a green bar graphically). Percent changes less than (+/-) 5% are represented by a grey bar.

Change in Health Disparities between Native American and White American: Mortality/Morbidity Indicators (2010-2018)



- Reductions in the disparity between the Native American and White American communities were seen across many chronic disease indicators.
- These included all-cause, diabetes, and cancer mortalities which had disparities reductions due to improvements in the rates of mortality and morbidity for Native Americans.
- There were increases in disparity for disability and asthma morbidity due to a worsening in prevalence in the Native American community.

Change in Health Disparity: Arab American and White Community

- The Arab American community saw decreases in disparity for poor physical health (35% reduction), children enrolled in preschool (29% reduction) and no access to health care due to cost (25% reduction).
- Many of these reductions were due to improvements in the Arab American prevalence for these social determinants.
- However many indicators for mortality and morbidity saw increases in disparity in the Arab American community such as stroke mortality (68% increase) and diabetes mortality (44% increase) which were due to worsening rates for mortality and morbidity in Arab Americans.

Indicators	2008-2010		2015-2017		
	Arab American	White	Arab American	White	Change in Pairwise Disparity, %
Social Determinants[a]					
Poor physical health in the past month, %	14%	10%	8%	9%	-35%
Population ≥ 3 years in preschool, %	5.90%	5.40%	4.50%	5.80%	-29%
No health care access due to cost, %	25%	12%	19%	12%	-25%
No personal health care provider, %	14%	12%	16%	15%	-9%
Living in owner-occupied housing, %	65%	78.60%	60.10%	77.80%	7%
Poverty rate (population), %	25.40%	8.40%	28%	7%	31%
Median annual household income, $	42,288	50,009	43,058	74,581	32%
Less than HS diploma ≥ 25 years, %	22.70%	10.20%	22.00%	7.40%	34%
Poverty rate children <18 years, %	36.50%	15.90%	41.10%	13.40%	34%
Unemployment rate, %	7.50%	7.20%	7.00%	5%	49%
Mortality and Morbidity Indicators[b]					
Obesity prevalence, %	31%	29%	27%	31%	-18%
Cancer mortality per 100,000	221.77	180.3	239.44	160.7	21%
Asthma prevalence, %	15%	15%	13%	16%	22%
Arthritis prevalence, %	25%	30%	18%	28%	24%
Kidney disease mortality per 100,000	22.8	14.1	27.72	13.1	31%
Diabetes mortality per 100,000	28.39	22.3	37	20.2	44%
Stroke mortality per 100,000	35.98	37.6	62.23	38.6	68%

Key: Positive percentages represent an increase in disparity (difference) between the population of interest and the White population, while negative percentages represent a decrease in disparity. Percentages less than (+/-) 5% show no change in disparity. For ratios less than 1.00 these values are inverse.

a. Data Source: American Community Survey, population profile 3-year estimate 2008-2010; 1-year estimate 2017. For these indicators Asian estimate does not include Pacific Islanders and all races are non-Hispanic. For Indicators of Hispanic estimates, Hispanics include combination with one or more races.

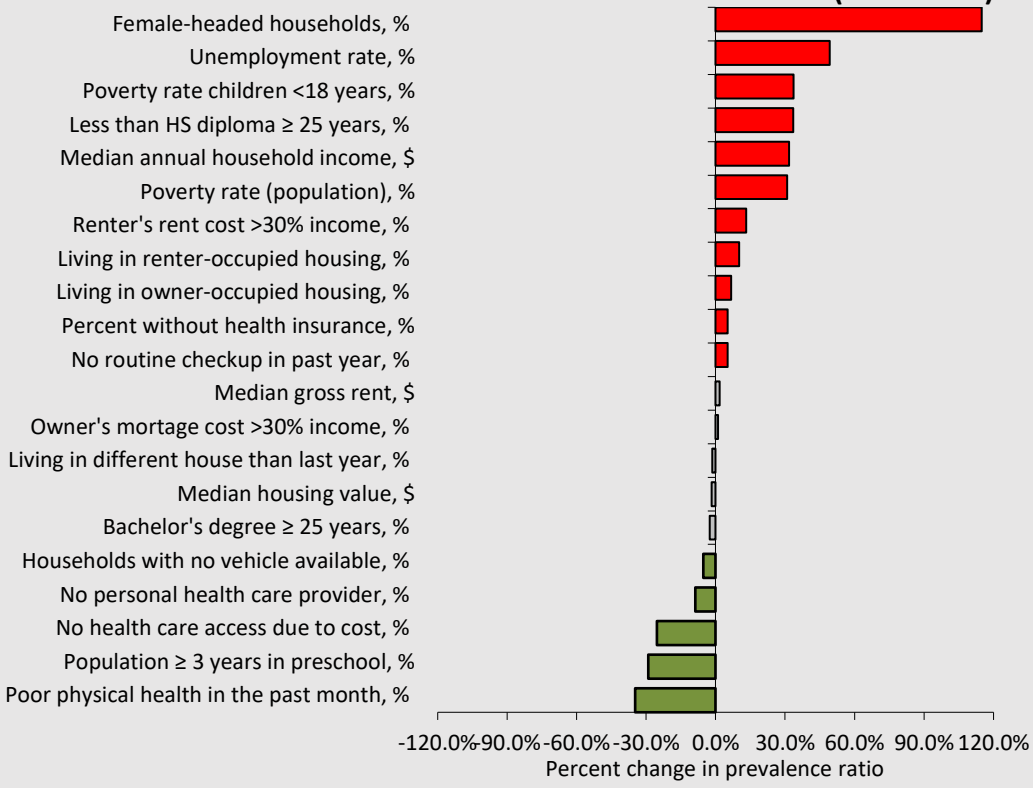
b. Data Source: Michigan Behavioral Risk Factor Survey, 3-year estimates 2008-2010; 2015-2017. For these indicators all race and ethnicities are non-Hispanic.

Calculations for change in pairwise disparity for disparity comparisons to White populations can be found in the Michigan Health Equity Data Project's Michigan Health Equity Data Tables and Related Technical Documents 2000-2009. https://www.michigan.gov/documents/mdch/MI_Health_Equity_Data_Tables_-_May_2011_361639_7.pdf

Change in Health Disparity: Arab American and White Community

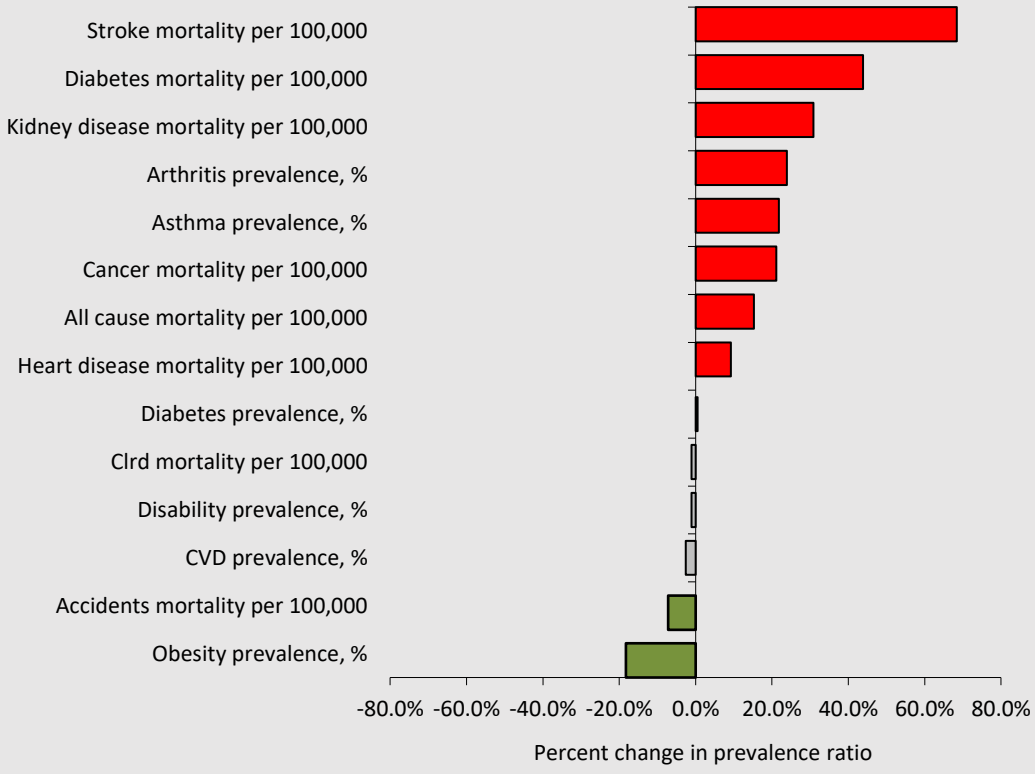
- While several social determinants of health indicators related to income saw increases in disparity, like renter cost burden (13.2% increase), several indicators did decrease in disparity.
- Among them was the disparity in individuals having poor physical health with a 34.7% decrease.
- However, many of the greatest changes in disparity for Arab Americans were increases in disparity.

Change in Health Disparities between Arab American and White Americans: Social Determinants of Health (2010-2017)



Key: The percent change in pairwise disparity over time for each health indicator is shown graphically in order from greatest increase in disparity (positive percent and by a red bar graphically) to greatest decrease in disparity (negative percent and by a green bar graphically). Percent changes less than (+/-) 5% are represented by a grey bar.

Change in Health Disparities between Arab and White American: Mortality/Morbidity Indicators (2010-2018)



- Most morbidity and mortality indicators for chronic diseases saw increases in disparity for Arab Americans.
- This is reflected in the 15.3% increase in disparity for all-cause mortality which was mainly due to rises in the mortality rates of Arab Americans across most indicators.
- However, reductions in disparity for morbidity indicators were seen in obesity prevalence and accident prevalence.

For more information about this report, please contact:
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