

PRIME Health Equity Learning Lab

Project Proposal Summaries

Introduction

The Health Equity Learning Lab is a five-session series designed to help 3-to-7 member public health work teams develop a plan for executing a change in practice within a health equity framework. The total contact time for the five sessions is 16 hours; individual sessions are 2 – 4 hours in length. Sessions are generally 2-3 weeks apart. Participating teams are expected to complete homework assignments between sessions. All sessions are scheduled outside of normal staff meeting time.

The Learning Lab objectives are outlined below. This summary will focus on the final objective. It is through the meeting of this objective that the work teams propose meaningful, sustainable projects to affect specific practice-based changes within their work section.

Learning Objectives for Learning Lab Series

- Articulate in concrete terms the reasons why it is important to adopt a health equity framework for practice within their section
- Articulate in specific terms what it would mean to apply a health equity framework to their day-to-day work
- Assess the degree to which participants' department or work unit currently applies health equity principles in carrying out its responsibilities, and identify changes that need to occur to allow them to apply those principles more fully
- Create realistic scenarios illustrating typical opportunities to apply a health equity framework within the section
- ***Commit, individually and collectively, to actions that will strengthen the application of a health equity framework to the future operation of the section, and identify indicators for evaluating success in honoring these commitments in three months, six months, and twelve months***

It is a prerequisite that all individuals participating in the Learning Labs have had prior health equity training, preferably the Health Equity Social Justice Workshop. PRIME has sponsored several workshops in the past. Some exceptions have been made, mainly for participants from local agencies. Team members who had no prior health equity training were put onto teams with others who did have prior training so that the working definitions of health equity and disparity, and an understanding of a health equity framework would be represented on each team. Additionally, Learning Lab facilitators met with members prior to the sessions to review definitions and concepts and provide background resources.

Learning Lab Project Proposal Timeline:

The following timeline highlights specific activities related to the work-based team projects that constitute one of the Learning Lab outcomes. The agenda for each of the Lab sessions has multiple group activities and learning opportunities that are not shared below.

Meeting 1: Work teams are formed. Participants self-identify into groups that focus on similar aspects or issues of health. Typically groups are comprised of staff within the same work sections of MDHHS, though occasionally there are external partners who participate in the Labs with a collaborating section.

Homework: Complete Health Equity Assessment on Survey Monkey

Meeting 2: Specific work practices are identified along with accompanying opportunities for improvement of health equity practice.

Meeting 3: Groups work to articulate concrete examples of ways that the section could apply a health equity framework in its daily practice. Work teams meet to discuss upcoming homework.

Homework: Consider scenarios presented in Meeting 3 and attempt to generalize what those scenarios indicate about the creation of a health equity framework for participants' particular work within the Division. What actions or changes in policy or practice would prevent the recurrence of these scenarios? Actions or changes should try to meet these criteria: **feasibility** (can it be done?); **impact** (will it make an important difference?); **sustainability** (will it stick, or will things go back to the status quo after the initial application?) Teams summarize their preliminary action plan and send to Facilitator for feedback focusing on feasibility, impact, and sustainability.

Meeting 4: Work on preliminary action plans. Present results of the team homework assignment from Meeting 3 to the larger Learning Lab group and Facilitator for input.

Homework: Prepare a Plan of Action for implementing the principles of health equity within the Division. The Plan should include Objectives, a sequence of Actions to be taken, responsible parties for the identified tasks, timeline, and Indicators of success. Groups are required to meet to develop their plan.

Meeting 5: Final presentation of each group's plans and indicators of success, with input from invited guests and managers from MDHHS.

Three, six, and 12-month technical assistance and consultation follow-up sessions has been recently implemented to gauge progress toward the project goals.

Learning Lab Team Project Summaries

For the purposes of this report, quantitative evaluation of the most recent Learning Labs is problematic due to small numbers of participants in specific labs, and a temporary postponement of a number of the labs' final meeting due to the facilitator's medical leave. The last three labs have had less than 20 participants. Therefore, it was decided that combining pretest and posttest evaluation surveys from the

three labs would provide the most representative evaluation data. Until such time as the final lab meetings have all been completed, and the data is aggregated, a qualitative summary of the work-based projects that have been proposed and implemented at the Department will provide outcomes from each of the Learning Labs.

The proposed projects have been diverse. They have different focus areas and creative process improvements. The one thing they share in common is a vision to include new ways to focus on health equity within the scope of participants' current work. The Learning Lab process has changed and improved over time, due largely to the posttest evaluations completed by participants. In light of this, the later the Lab was completed, the more detail and strategic planning details were available for the following summary.

Included in this summary are equity action plans that have been developed in the following areas within the Michigan Department of Health and Human Services. All Health Equity Learning Labs were sponsored by PRIME except the Chronic Disease and Injury Control Division.

- Child, Adolescent & School Health Section 2016
- Women and Maternal Health Section 2015
- Chronic Disease and Injury Control Division 2015
- Children's Special Health Care Services Division 2014
- Women, Infants and Children's Division 2013

2016

Child, Adolescent & School Health Section (CASH)

Hiring Intentionally for Real Equity (HIRE):

The HIRE work group chose to focus their efforts on ensuring equity in the hiring process within the section as a mechanism to increase diversity and work toward health equity. The group identified that often, job postings, their distribution, and even the interview process excludes qualified candidates who may have a wealth of experience, but may have had limited access to advanced postsecondary education. In order to address these concerns, they proposed the following objectives and goals:

Objective 1: Institute a hiring process that follows written protocols and improves the CASH section's capacity to address health equity

Three-Month Goal: Best practices on equitable hiring practices culled out of research

Six-Month Goal: Draft new written protocols for section manager approval

Twelve-Month Goal: Written protocols are implemented section-wide

Objective 2: Demonstrate a commitment to promoting health equity throughout the application and interviewing process

Three-Month Goal: Research used to re-draft position descriptions to appeal to new and diverse candidate pool

Six-Month Goal: New, inclusive interview questions complete and incorporated into new interviews

Twelve-Month Goal: Complete application will reflect a commitment to hiring and health equity

Objective 3: Develop a recruitment plan that will ensure a diverse applicant pool for all open positions within the CASH section

Three-Month Goal: Research on the efforts of other entities to attract a diverse applicant pool is complete

Six-Month Goal: Postings are widely distributed via people, groups, and organizations on a developed contact list

Twelve-Month Goal: Diverse applicant pool is realized for all CASH position openings

At the time of this report, the team had completed their research, and one job posting within the CASH section had been posted that included language with the position description, interview questions, and job posting announcement that indicated that the promotion of health equity is expected of each staff member and is a priority for the Section. Written protocols for all steps in the hiring process have been drafted, and the new recruitment plan is in the process of being developed.

Health Equity Local Preparedness Team (HELP):

This work group identified that there are varying levels of understanding of health equity principles among their grantees statewide. They see a lack of consistent foundational training on health equity that is necessary to ensure local programming is inclusive and meets the needs of regional participants. In order to address this, they proposed building local capacity to address health equity through developing accessible, targeted health equity trainings to grantees. Their plans include the following objectives and goals:

Objective 1: In collaboration with local partners, develop a process for improving capacity for health equity orientation and training.

Goal 1: Identify existing resources for an online foundational health equity training such as MDHHS Holes in the Mitten for CASH grantees. Local, foundational health equity training at a 101 level would qualify if grantee provides proof of completion.

Goal 2: Provide foundational online health equity training and resources to CASH grantees

Goal 3: Provide ongoing topic-specific health equity training (201 level) and resources as needed to CASH grantees

Group 4: Annually review online health equity training resources to ensure quality, relevance, and availability

Objective 2: Institutionalize health equity training requirement through existing CASH monitoring and reporting processes

Goal 1: Work with program staff to modify the existing site review tool to include foundational health equity programming requirements

Goal 2: Work with program staff to modify program reports to include foundational health equity programming requirements

Objective 3: Ongoing evaluation of health equity and programming efforts

Goal 1: Incorporate standard health equity indicators/questions into all CASH training needs assessments

Goal 2: Needs assessment results will be used to inform health equity training to the field

Goal 3: CASH programs will collect and summarize health equity information gathered from reports and site reviews and share with CASH section and other stakeholders

Goal 4: Utilize the collected health equity information to inform future programming efforts

Broaden Funding Opportunities

These members of the CASH section have observed that the applicant pool for the Request for Proposals (RFPs) they distribute remains mostly the same and traditionally consists of larger organizations with less hands-on experience within the target populations the section hopes to serve. There are many reasons for this—they are perceived as structurally sound and capable; they know where to find the RFPs; they have experience with the reporting requirements, budgets, and fiscal management; they have experienced grant writers who know the language of grant writing, and tend to score higher during the review process; and there tends to be consistency in the pool of grant reviewers.

Because of the trend to award funds to the same groups from one funding cycle to the next, the state grantors are often unaware of smaller, local organizations who may be better connected to the target population. Staff often receive many inquiries for funding after awards are made, and organizations state that they were unaware of where to find the RFPs. This inability of the smaller, community-based organizations (CBOs) to access funding announcements limits their capacity, growth, and sustainability. To address these challenges the work team proposed the following objectives and goals that they hope will result in the funding of new agencies, improve communities, better connect the CASH section to local communities and target populations; and improve everyday practice to increase health equity:

Objective 1: Connect, in an on-going manner, with organizations and programs that are not currently funded but consistently provide services to the target population

Goal 1: Create a CASH system database of names and contact information for CBOs/individuals interested in future funding opportunities

Goal 2: Create and distribute a CASH Section interest contact sheet that staff can take with them when going into the field to populate a “contacts” database

Goal 3: Research existing professional development opportunities related to building program/organizational capacity for writing successful grant applications

Goal 4: Attend at least 2 advisory council/ steering meetings or events

Goal 5: Distribute new RFPs to the contacts housed in the CASH Section contact database

Indicators of Success:

Three Months: Program database and contact sheet are created and details of their intended use are codified and distributed

Six Months: Existing professional development (PD) opportunities related to successful grant writing, competing for grant funds, etc. will be researched; potential collaborative relationships to delivering PD opportunities will be explored within the department and presented to the CASH team

Twelve Months: Database and contact sheet are being utilized; list of PD opportunities is created and disseminated to the CASH team

Objective 2: Revise the content, dissemination, and review structure for the new RFPs to emphasize working with the target population as a core component

Goal 1: Revise wording of the RFPs to emphasize *current* work with target population (e.g. Partnerships with other organizations; agency’s history/experience working with the target population; original letters of support)

Goal 2: Review the weighting of questions and assigned bonus points in the RFP scoring rubric to align with this emphasis

Goal 3: Provide an orientation conference call with all reviewers, providing a detailed review guidance document that makes the process expectations clear

Goal 4: Explore ways of broadening the review panel

Goal 5: Revise Q&A document to make the project emphasis and guidelines clear

Indicators of Success:

Three Months: The RFP that is coming up soonest—the MI-APPP RFP, the past reviewer list, and supporting documentation will be sent to the work team for review.

Six Months: The team will revise the RFP working (Goal 1) and review question weighting (Goal 2). The team will meet to discuss the revisions and any additional edits. Feedback will be gathered from current grantees related to the current funding they were awarded and the RFP process.

Twelve Months: The revised RFP and review process is completed. All changes made to the RFP will be shared with the entire CASH team for feedback, and a list of potential RFP reviewers will be generated.

At the time of this report, the team has held their first meeting to discuss the core information to include in the database and contact sheet, and to assign roles as the team works continues their efforts.

[Data on Childhood Trauma among Teens](#)

Adverse Childhood Experiences (ACEs) and other trauma in early life have profound impacts on health, and the burden of these factors disproportionately burden groups with limited access to resources and associated environmental challenges. The ACEs Study showed the connection between adverse experiences, risk behaviors, and poor health and mental health outcomes. Currently data about risk behaviors is gathered through the Youth Risk Behavior Survey (YRBS) and Michigan Profile for Healthy Youth (MiPHY) surveys administered in Michigan high schools. However, there is no surveillance of ACEs or traumatic events of childhood in these same populations. Understanding the prevalence of this adversities can help schools to track progress toward meeting health and health promotion goals; support modification of school health curricula and programs; support new legislation and policies that promote health; and equip them to seek funding and other support for new initiatives.

Objective 1: Research

Goal 1: Research validated questions related to ACEs or similar trauma

Goal 2: Assess what questions may be being used in other states and measurement tools in other states

Goal 3: Identify the amendment process required to add questions to the YRBS and MiPHY surveys

Goal 4: Identify possible questions for inclusion on the survey(s)

Objective 2: Seek input and support from collaborative partners

Objective 3: Develop proposals/ alternate plans for question amendment and inclusion

Objective 4: Add question(s) for YRBS in June 2016 and MiPHY in fall, 2016.

At the time of this proposal, the team had held a meeting with their partners at the Michigan Department of Education to discuss the process for adding questions to both surveys, and started the research process. The team proposed a four-step plan—on a much more abbreviated timeline than the other teams—as they hoped to have final goals met by the end of 2016 to coincide with the year cycles on the survey instruments in question. At the time of this report, the team has conducted research to: document justification of the proposal; select a question that is predictive of multiple traumatic experiences; and determine if one or more of the existing survey questions can be replaced. They have met with the administrator of the state-wide Behavioral Risk Factor Surveillance System (BRFSS)—which

has included the Adverse Childhood Experiences (ACEs) question module in the past—as well as the MiPHY coordinator to discuss the proposal and determine what steps could be taken to add a questions to the surveys. Their proposal is in process, and they plan to submit it to the survey administrator by July 15, 2016

Health Equity Impact:

Since the burden of adverse experiences fall more heavily on target groups, and the impact of adverse experiences is pervasive and negatively impacts educational achievement and health and mental health outcomes, further limiting opportunities among those they affect, and increasing disparity between groups, attention to cultural, historic, and gender factors is a key component of trauma informed practices which support healing and recovery for those affected by trauma.

2015

Women and Maternal Health Section

Health Equity Communication through a Huddle Model

Members of this team observed that there are limited opportunities to know what their colleagues may be working on that, specifically, may overlap with their own work. They noted that they were uninformed of the current work their colleagues were doing related to health equity, and that they would benefit from the opportunity to briefly inform each other of the current projects they were working on, challenges, and ways to incorporate health equity into their daily work. In order to undo entrenched ideas of “business as usual,” they sought to change to a workplace culture that routinely welcomes challenges to privilege and oppression.

Focusing on intra-Divisional communication, the BAM group planned to create a mechanism for staff to work across programs to share work ideas and strategies, and to challenge the current mechanisms of privilege and oppression. They proposed the implementation of workplace huddles to happen regularly as a way for the colleagues share their work, reduce redundancy, welcome input, and work toward health equity. Huddles are short, time-limited, stand up (if able) meetings that bring staff together at a consistent time and location to share information on individual projects and/or challenges to improve efficiency and productivity in achieving organizational goals. The key agenda items for huddles are:

- Good news
- Metrics
- Focus
- Aha! moments

At the time of this presentation, bi-weekly team huddles continue to be held by the proposal team. Additional team huddles have also been held within the Division, expanding the model. The team has observed that the team huddles are a highly effective method of communication information focusing on health equity in programming and initiatives. The huddles foster relationship building,

communication, and collaboration, with a focus on health equity. The the time-limited nature of the huddles has been problematic for some participants and teams, as they find they have more to discuss than the time allows. They continue to try to implement the huddle model throughout the Division.

Family Planning Program

The state Title X Family Planning Program staff chose to focus on the racial and ethnic disparities that exist in contraceptive use and contraceptive counseling coercion. Recent research on contraceptive use in the United States has demonstrated racial and ethnic disparities in use and method choice with Black women having lower contraceptive use and lower use of highly effective methods. In addition, family planning research has focused on contraceptive counseling approaches to ensure unbiased counseling and assure against unconscious coercion. This research has found that women of color and low-income women are more likely to report being dissatisfied with their family planning provider and report being pressured to use birth control and limit their family size. In one study, 67% of Black women reported race-based discrimination when receiving family planning care, and in another study, providers were more likely to recommend an IUD to low income women of color than to low income white women. Evaluating the clinical encounter within Michigan's Title X clinics will provide the MDHHS with more information on patient- and provider-level factors that may be influencing contraceptive use and counseling for Black or African American women. These findings will provide Michigan's Title X program with the information needed to perform program improvements through training, technical assistance, and programmatic requirements.

Objective 1: By June 2016, the Family Planning Program will assess contraceptive use and counseling coercion through existing literature and available secondary data, focusing on racial and ethnic disparities.

Goal 1: Review patient contraceptive literature, focusing on literature highlighting beliefs and preferences, education and resources, as well as access and use among consumer groups.

Goal 2: Review provider contraceptive counseling literature, focusing on counseling coercion, and specifically examining provider knowledge, attitudes, and biases, as well as best practices for contraceptive counseling that ensures unbiased counseling and assures against unconscious coercion

Goal 3: Review available national and state secondary data sources (e.g. National Survey of Family Growth (NSFG); Youth Risk Behavior Surveillance System (YRBS); Guttmacher; Michigan Primary Care Association (MPCA); Pregnancy Risk Assessment Monitoring System (PRAMS); Medicaid) to learn more about contraceptive needs and services, as well as use, focusing on racial and ethnic disparities

Goal 4: Work with Title X sub-recipient agencies to gather contraceptive use data by race/ethnicity, as well as provider demographic characteristics

Indicators of success:

Three Months: Complete the assessment of literature and available secondary data. Identify contraceptive use and counseling coercion among consumer groups, as well as best practices

Six Months: Identify contraceptive use and counseling needs among consumer groups as well as best practices

Twelve Months: Identify the most critical patient- and provider-level factors that can be evaluated within Michigan's Title X clinic settings

Objective 2: Conduct a formative evaluation of patients' clinical encounters within a Michigan Title X family planning setting(s) to ascertain patient- and provider-related factors that impact contraceptive use and counseling, especially for Black/African American women.

Goal 1: Approach Title X sub-recipient agencies about participating in formative evaluation activities, highlighting the benefits of participation, the survey administration process, and the data collection timeline

Goal 2: Use literature review findings to obtain existing survey instruments on patient- and provider-level factors for contraceptive use and counseling coercion, and refine survey questions to measure only relevant concepts to this evaluation

Goal 3: Send developed instruments and protocols to participating Title X sub-recipient agencies for review and feedback

Goal 4: Train clinic staff on survey protocol procedures

Goal 5: Administer patient and provider surveys within identified Title X sub-recipient agencies

Goal 6: Analyze survey data

Goal 7: Disseminate findings to Title X sub-recipient agencies and other key stakeholders

Indicators of success:

Three Months: Develop a patient and provider survey and protocol; and have at least one Title X sub-recipient agency committed to participating in these formative evaluation activities

Six Months: Implement both the patient and provider surveys within the Title X sub-recipient agency and analyze survey data

Twelve Months: Disseminate key findings from the formative evaluation to Title X sub-recipient agencies and other key stakeholders through infographics, fact sheets, and presentations

Maternal Infant Health Program

The Maternal Infant Health Program (MIHP) is a home visiting intervention that serves women and infants across the state during pregnancy and in the postpartum period through education, referrals, and support. The work group from MIHP program chose to focus their efforts on engaging fathers and male partners in their home visiting process, to provide similar education on healthy pregnancies, safe homes, and healthy babies. Their proposal during the Learning Lab lays the ground work for successful outreach to fathers/partners.

In order to promote the engagement and participation of MIHP fathers, the team identified the need to:

- Determine the best approach to assess current strategies used by MIHP providers
- Solicit input by developing and distributing a survey
- Gather and analyze data
- Conduct focus groups with fathers and male partners to determine experienced barriers to home visiting involvement
- Develop recommendations for male partner engagement strategies

- Develop State MIHP protocol promoting and encouraging male partner involvement to be implemented during the certification cycle 7 to ensure provider participation

The team proposed the development of a 5-7-question, Likert scale survey, to be emailed to MIHP providers, and provided in the registration email for the February 2016 MIHP training. The intention of the survey would be to assess how the local MIHP providers are engaging with fathers, if at all, and what types of services are currently provided to fathers/ male partners, if any. The workgroup also proposed conducting additional literature review research on the involvement of fathers with home visiting programs. From the survey, focus groups, and associated research, the team proposed the development of a revised protocol, focusing additional effort on male partner involvement.

These engagement efforts are viewed as a pilot that could be scaled up to other state-wide home visiting programs within the Division and Bureau, including the programs within the Child, Adolescent, & School Health section, that is already working on similar efforts. These initiatives align with the goals of the State Infant Mortality Reduction Plan, 2016.

At the time of this report, the MIHP work group has conducted literature reviews, and researched previously-implemented national models, successful statewide inclusion methods from other states, as well as articles and books. Research is ongoing. Staff have also registered to attend conferences focusing on fatherhood.

Survey results have been received from 66 MIHP providers across Michigan. Seventy-eight percent of respondents indicated they were unaware of where they could obtain resources for fathers. The vast majority, 86%, of responding providers invite fathers/male partners to participate in home visits from the initiation of services; but only 32% of providers will schedule visits around the male partner's schedule. Respondents stated that current efforts to engage fathers include using mothers as a gatekeeper to provide resources and information to fathers; referring fathers to community programs; providing toolkits with resources that support fathers' involvement; sending appointment reminder cards to both parents; encouraging fathers' participation in childbirth education classes; and engaging fathers in MIHP's "Ages & Stages" questionnaire—an infant development resource tool.

The first provider training that covered male-partner engagement was held at the June 2016 Coordinator Trainings, featuring Mr. Cole Williams as a special speaker who focused on the role of fathers in infant development. Starting in June, fatherhood resources have been included in the Coordinator emails using resources from Fatherhood.org and the National Fatherhood Initiative, and a "Rolling into Fatherhood" developmental wheel for children birth through age 3 has been provided to each MIHP agency. It provides education on developmental stages, as well as activities that fathers can do with children to promote bonding.

Chronic Disease and Injury Control Division

(Learning Labs replicated in this division were not sponsored by PRIME)

WISEWOMAN

The area of focus is to get local BCCCNP/WISEWOMAN agencies to conduct outreach to and provide all services (i.e. health coaching) to targeted populations

Objective 1: Change program requirements to require WISEWOMAN agencies to conduct outreach to and provide services to targeted populations

Goal 1: Update Local Agency Requirements policy to require local WISEWOMAN agencies to conduct outreach to and provide all services to targeted underserved populations

Goal 2: Keep Health Equity and Social Justice (HESJ) in front of agencies at all meetings (Pilot calls, Quality Improvement calls, Annual Meeting, Navigation Networking calls)

Goal 3: Write HESJ focus into agency recruitment materials and future requests for proposal (RFP) so new agencies understand it is part of the program from the beginning

Goal 4: Add a performance measure related to conducting outreach to and providing WISEWOMAN services to targeted underserved populations – Determine consequence of not meeting performance measure

Indicators of success:

Three Months: Local agency requirements updated; Pilot, QI, and Navigation Networking calls have HESJ on the agenda

Six Months: Agency recruitment materials contain HESJ focus; RFP contains HESJ language

Twelve Months: New HESJ performance measure in place; Consequence of not meeting performance measure identified and communicated

Objective 2: Train and mentor local WISEWOMAN agencies in Health Equity and Social Justice; identifying target underserved populations; conducting outreach to targeted populations; and working with the targeted populations

Goal 1: Develop training for local BCCCNP/WISEWOMAN agencies

Goal 2: Add HESJ to currently established trainings (e.g. Community Navigator, BCCCNP Navigator)

Goal 3: Conduct training for local WISEWOMAN agencies. Train on the whole process from identifying target population to providing health coaching.

Goal 4: Work with each agency to identify target population(s) in their geographic service area.

Goal 5: Direct agencies to specific partners who can help with their target population(s)

Work with each agency to identify target population(s) in their geographic service area.

Indicators of success:

Three Months: Training outline developed; Potential arguments from agencies identified and answered

Six Months: Training developed; Local agencies trained by May 2016 (annual meeting)

Twelve Months: Each agency has identified at least one target population and is actively conducting outreach and providing services to that population; Agencies are pursuing HESJ training and activities outside of WISEWOMAN

Objective 3: Partner with state and local organizations outside of public health in order to better reach target populations

Goal 1: Identify potential organizations such as neighborhood centers, MI Municipal League, Charities, LGBT organizations, human rights organizations

Goal 2: Develop presentation template local WISEWOMAN agencies can use to introduce WISEWOMAN to local organizations

Goal 3: State staff make contact with state level organizations to introduce WISEWOMAN and to discuss services available to their clients/members

Goal 4: Facilitate relationships between state level organizations and local WISEWOMAN agency

Goal 5: Discuss progress of agency in connecting with state and local organizations on pilot and QI calls

Indicators of Success:

Three Months: Potential organizations identified (state and local); Presentation template for local agencies developed

Six Months: State level organizations contacted

Nine Months: Relationships between local WISEWOMAN agencies and state and local organizations have been formed

Twelve Months: Each local agency has partnered with at least 2 new agencies that serve targeted populations

Cancer Prevention

Develop a plan to gather data about target groups in order to support health equity and future work with target groups. (1st focus is on Native American Population, others might include Arab population, LGBTQ, Hispanic, persons with disabilities, persons with mental health disorders, those for who English is not their first language.)

Objective 1: Build the case for collecting data on target groups. (internal structure)

Goal 1: Define the problem and detail the “ask,” which includes determining scope and framing

- What are we trying to accomplish?
- There is a data gap as it relates to information on the health status of the Native American populations in Michigan.
 - This is not fair or just.
 - Data gap → incomplete knowledge of how cancer and/or other health concerns impact Native Americans and uncertainty about the types of health initiatives that will most benefit this population.
 - How will collecting data help Native Americans?

Goal 2: Meet with Cancer Prevention and Control Section and Unit managers

- Enlist their support

- Identify a responsible team
- Establish the scope – level of state government participation
- What data are we after?

Goal 3: Managers and staff will identify other MDHHS staff that may be interested in this data project.

- Consider existing relationships
- Define the state’s role in the process

Goal 4: Develop the “ask” of the identified MDHHS staff and an elevator pitch and send invitations.

- Deliver a standardized, consistent message about how and why something should be done.

Goal 5: Establish a broader MDHHS staff team

Objective 2: Work with stakeholders to develop a plan for data collection. (external structure)

Goal 1: Convene newly identified Staff Team to identify partners (organizations that we have a relationship with who represent the interests of the target group) and develop a broader “ask.”

Goal 2: Communicate with partners to:

- Assess interest
- Develop expanded stakeholder list
- Revise the “ask” and elevator pitch for the broader potential stakeholders
- Consideration- must establish trust and meaningful relationships with key groups
- Framing:
 - We have a problem – it impacts your health and solving it will help
 - We want to join alongside you and offer our assistance to solve the problem

Goal 3: Convene partners on a conference call to define the scope of the problem, assess interest in developing a plan, and determine the best process for plan development

- What data are we after?
- What relationships do we need to develop?
- What are the roles of key stakeholders?

Goal 4: Convene partners on a conference call to develop a process for data plan development and identify a list of participants for the planning process.

Goal 5: Recruit additional stakeholders, including community members

Goal 6: Hold 1st meeting with partners and stakeholders on plan development – process to be determined. It might include problem definition, identification of root causes, and identification of potential solutions

Goal 7: Hold 2nd meeting with partners and stakeholders on plan development – process to be determined. It might include determining strategies for solutions, available resources, needed resources, role definition and commitments.

Goal 8: Hold 3rd meeting with partners and stakeholders on plan development (if needed) - process to be determined. The goal will be to have a final data plan that can be implemented in FY 17.

Indicators of Success:

Three Months: By January 2016, identify and communicate with a group of partners about the need for an improved process of data collection and analysis to support public health interventions in specific target populations.

Six Months: By April 2016, convene a broad group of stakeholders to start the process of problem definition, potential strategies, and next steps to develop a plan to gather data on the Native American population.

Twelve Months: By October 2016, have a plan for how to gather and analyze data on the Native American population to support assessment of the effectiveness of public health interventions for the Native American population in Michigan.

Epidemiology & Asthma

Explore ways to analyze and package disparities data for high burden counties.

Objective 1: Complete the Detroit asthma burden report

Goal 1: Finalize data

Goal 2: Find a personal Detroit asthma story to be included in the Detroit asthma burden report

Goal 3: Obtain approval from management for the report to be released

Indicators of Success:

Three Months: Report completed and approved

Six Months: Report disseminated

Objective 2: Identify and reach out to organizations and champions in Detroit who could use asthma disparity information

Goal 1: Talk with the Michigan Asthma Advisory Committee (MAAC) and strategic partners in Detroit about who should be contacted

Goal 2: Set up a meeting in Detroit to present data and engage in dialog about how the data can be used and packaged

Goal 3: Discuss next steps (how to reduce the asthma disparities in Detroit)

Indicators of Success:

Three Months: Feedback from MAAC and strategic partners

Six Months: Detroit meeting is held

Twelve Months: Conversations regarding next steps on how to reduce asthma disparities in Detroit are occurring

Tobacco, Oral Health & Injury Control

Increase participation in the Michigan Dental Program (MDP)

Objective 1: Increase the number of HIV/AIDS clients in the MDP

Goal 1: Finalize MDP Brochure to go out to clients

Goal 2: Present HIV/AIDS information at Case Manager meeting (50-60 Case Managers)

Goal 3: Train Case managers on MDP client enrollment. Also provide them with the MDP application guidelines and At-A-Glance

Goal 4: Survey Case Managers on education of MDP-following presentation. Send Client Satisfaction Survey on the Michigan Dental Program

Goal 5: Reach out to different area networks to have Client Enrollment Days

Goal 6: Review & Compile Case Manager & Client Satisfaction Survey results

Indicators of Success:

Three Months: Have complete MDP Brochure, completed case manager presentation & survey

Six Months: Have results of Client Satisfaction Survey; Established relationships with area HIV/AIDS networks, with scheduled Enrollment Days

Twelve Months: MDP client participation increased by 10%

2014

Children's Special Health Care Services Division

External Policy and Health Equity: Removing Medicaid Barriers for Children's Special Healthcare Services Clients

Children's Special Healthcare Services (CSHCS) strives to enable individuals with special health care needs to have improved health outcomes and an enhanced quality of life through the appropriate use of the CSHCS system of care. For the purposes of this project, the team from CSHCS wanted to focus on one of its primary goals—**remove barriers that prevent individuals with special health care needs from achieving goals of access and utilization**—in the context of its medical food policy. In most instances, standard formulas are not covered for patients; special formulas are generally covered for unusual circumstances such as food allergies, high nutrients or low protein diets, but clients must meet specific criteria for height, weight, caloric and metabolic needs.

The team identified current policy barriers to coverage of medical foods, including:

- Rigid Medicaid policies and procedures
- Lack of consideration of unique special needs
- Limited access to PRD information related to CSHCS clients
- Procedure codes beneficial to CSHCS clients are not currently approved for use
- PRD policies are not in line with CSHCS mission and purpose

One condition where this burden is disproportionately felt is among patients with Phenylketonuria (PKU)—an inherited metabolic disorder that, left untreated, can cause neurological damage, behavior impairment, seizures, cognitive problems, and brain damage. This condition is screened for among infants by the Newborn Screening Program, as immediate intervention is required to prevent these developmental delays. The condition requires patients to have special protein-free foods such as grains, pastas, fresh vegetables and fruits (once old enough), and the lack of food-based protein requires amino acid replacement—phenylalanine-free food. This supplementation is especially important for newborns, but the condition poses lifelong metabolic problems. A strict diet and supplemental formula is the only way to achieve normal quality of life among patients.

Medicaid—and CSHCS by default—did not cover “medical food,” often leaving economically-disadvantaged families of patients challenged to provide the special medical diet required for a patient’s lifetime. As a solution, the PKU work team proposed a multi-stage process to effectively change the CSHCS policy to offer lifetime coverage for PKU disorder, similar to lifelong policies in place for conditions such as cystic fibrosis.

First, the team proposed identifying the healthcare common procedure code (HCPC) numbers for medical foods, followed by creating a modifier to use with billing to identify the coverage as a CSHCS benefit. Finally, they proposed soliciting bids for a single-source contractor to supply medical formula and medical foods to their patients.

Database Improvement

This CSHCS team proposed improving the efficiency and effectiveness of the existing CSHCS database to ensure that families in target groups are treated equitably. To do this, they proposed integration of all aspects of the CSHCS program into the existing database, focusing on identification of under-represented populations to realize a more equitable distribution and delivery of resources and services. An important component of this is the elimination of data access barriers for the local health departments who administer services, allowing them to better assist families in a timely manner. They also proposed the improvement of evaluation strategies for the effectiveness of CSHCS, allowing data gathering on specific municipalities, diagnoses, and populations. They proposed the implementation of ad hoc query functionality and geospatial analysis capabilities.

Implementation of their objectives were proposed along the following timeline:

Three Months:

By the three month mark, they proposed the development of a CSHCS task force to spearhead the database improvements. Stakeholders from MDHHS CSHCS, local health department CSHCS, and the database management contractor—Kunz, Leigh & Associates (KL&A)—would be included. Participants would conduct situation-specific analyses of needs.

By this point they would also identify which data sources are currently used within CSHCS by surveying MDCH and local health department staff to assess:

- What different program elements are needed?
- What different systems are used?
- What is working? What isn’t?
- What information is needed to best serve clients?
- What will be done with the updated information?
- How will staff use the combined/linked system? How will it improve staff’s work?

Six Months:

By this point, the team proposed the identification of a revenue source and the drafting of a budget. This would require looking into the current CSHCS budget to see if any available monies exists, as well as research on grants that may be available to improve technology within state government. Additionally, this would require the assessment of current resources, including the capacities of KL&A and the state Department of Technology, Management, and Budget (DTMB).

Nine Months:

By the nine month mark, the team proposed that a taskforce would identify various levels of access for each user (state-level, local health departments, etc.) after discussions with MDCH and local agencies. This would include a process for user monitoring, similar to the current process in place with *Contacts at a Glance*. Additionally, they proposed discussing applicability of various elements for integrating all areas of CSHCS, exploring feasibility and sustainability.

Eighteen Months:

By 18 months, the team proposed the implementation and testing of the database improvements, while continuing to explore the applicability and sustainability of various elements of inter-organizational integration. Specifically, the team would examine in what ways the changes may improve health access and equity for disadvantaged groups among the CSHCS clientele.

Twenty-Four Months

Within two years, the team proposed an evaluation component to measure the efficiency and effectiveness of the database updates. Recommendations from the evaluation would inform continuing improvements to the system as indicated. Successful implementation would see an ongoing rate of 75% of surveyed families and staff agreeing that the updates were user friendly, that the changes improved workflow, and ultimately, that the changes improved the assistance provided to families.

Children's Special Health Care Services Communications

This team chose to focus on the improvement of communication within Children's Special Health Care Services (CSHCS) by building opportunities to collaboratively build effective partnerships across sections in order to promote a more efficient and seamless system of care for their client population. The group was confident that increasing internal efficiency would translate into increasing service quality and access for underserved populations. They proposed doing this by implementing three action steps.

First, they proposed requiring CSHCS orientation for all newly-hired employees, and offering current employees the opportunity to complete the orientation as well. This would allow new staff to meet with the director and managers from each section. Additionally, they planned to update their "CSHCS 101" document to provide to new and current staff.

Next, they proposed using meetings and/or webinars to promote understanding of the unique work of each section and provide education on various topics that pertain to the CSHCS client population. At Division-level meetings, managers could update the team on current projects within the Division, and allow team members to share tools they use to promote efficiency. Grand Rounds meetings could be used for further education by an expert of a clinical issue relevant to specific patients. Allowing staff to suggest topics and speakers of interest would provide planning resources for the Grand Rounds meetings. Webinars were proposed as a way for managers to share information and provide insights on topics relevant to CSHCS.

Finally, the communication work group proposed forming the Efficiency Discovery Team, with a goal to reduce redundancies, which would provide opportunities to shift staff focus toward more effective outreach opportunities. It was proposed that the group be comprised of staff from each class level of civil service, and their job would be to go through the current procedures and find ways to improve the

workflow. Quarterly meetings would re-evaluate current practices to assess the need for more procedural changes and process improvements.

Children's Special Health Care Services Advisory Committee

A workgroup from the Children's Special Health Care Services (CSHCS) section chose to address the inequities its members observed in the CSHCS Advisory Committee (CAC). They were concerned that the current CAC membership was not a true representation of the CSHCS population based on:

- Diagnosis
- Location
- Race/ethnicity
- Professional affiliation
- Service delivery type
- Family/client age ranges

As an example, the team cited the fact that the CAC members came from groups representing epilepsy, hemophilia, and cleft palate, when the actual CSHCS population was dealing with those conditions, as well as asthma, juvenile diabetes, hearing loss, chronic serous otitis media, esophageal anomaly, cerebral palsy, cystic fibrosis, and 2700 other conditions. Additionally, the team cited evidence of the prevalence of patients, both geospatially and by race/ethnicity—noting that Caucasians made up 62% of clients, African-Americans made up 18% of clients, and Hispanics made up 3% of the clients.

The team proposed the following objectives based on their client data:

Objective 1: Establish committee operations that support a CAC that is effective, responsive, and accountable to the community of children, youth, and some adults with special health care needs.

To accomplish this they proposed to:

- Review existing CAC operations documents, CSN Fund Bylaws and external MDCH examples
- Establish term limits via bylaws recommendations
- Establish membership requirements via bylaws recommendations

Objective 2: To build an inclusive and equitable CAC membership that is diverse in representation geographically, by diagnosis, by race/ethnicity, professionally, by service delivery type, and by family/client age range.

In order to achieve this objective, the following action steps were proposed:

- Make current and incoming CAC aware of travel reimbursement
- Explore the use of video conference technologies
- Conduct a health equity audit/assessment of current CAC members
- Review demographics of clients and partners
- Establish inclusive and equitable recruitment strategies

- Include a health equity screening question in the CAC application or in the interview process
- Set explicit health equity goals in the selection of committee membership
- Establish CAC orientation process that includes a health equity module

It is through the creation of this more culturally-representative Advisory Committee that CSHCS hopes to achieve a more equitable leadership approach that can more effectively advocate for its broad patient base.

2013

Women, Infants, & Children (WIC) Division

Native American Outreach

This WIC team chose to focus on the observed disparity among Native American women and infants as evidenced in the Native American infant mortality rate and WIC utilization among Native populations.

Objective: Identify and implement institutional policies and practices to ensure health equity among 85% of pregnant women who are Medicaid-enrolled and WIC-eligible

In order to accomplish this, they proposed a process of research, engagement and dissemination.

- Identify underserved populations
- Transfer successful strategies to other groups
- Engage Native Americans and local WIC agencies
- Identify and address state and local policies and procedures that impact health equity
- Institutionalize changes to improve health equity statewide

To begin, they proposed the identification of underserved population groups from among their available data, including Native American families, with the goal of improving access and retention for clients from among these populations. Next, they proposed engagement of stakeholders by meeting Native American organizations from across the state to identify strategies that local agencies can use to improve equity for Native families in their communities. The team began a needs assessment that included this outreach and information gathering.

The state-level WIC personnel from the work team also proposed the transfer of the goals of PRIME to their local agencies, while identifying opportunities to evaluation local agencies' current outreach to underserved populations to increase enrollment and retention of clients from these populations.

At the time of this report, the research and engagement efforts yielded a pilot program launched at American Indian Health and Family Services at the WIC clinic of Detroit Department of Health and Wellness Promotion. Enrollment of Native clients increased by 14% in the six months following the implementation of the program in November 2014. The work team has established a PRIME workgroup, including five local agency coordinators and several State WIC Program staff which meets to discuss and

determine best practice/methodologies for sharing health equity information with other local agency Coordinators and their staff. Meetings have been ongoing since 2014.

WIC Data and Systems Management

The Data and Systems Management Section chose to evaluate client and non-client perceptions of WIC in an effort to increase participation and reduce inequities in service, to ensure that referrals are being made to other social service agencies consistently across all WIC clinics statewide; to address inequity within the WIC population by providing additional trainings to local WIC offices in data use and population statistics for the purposes of targeted outreach; and to evaluate the efforts of PRIME across all of the sections in the Michigan WIC Division over a period of time.

The Section chose to use various research and evaluation methods, including literature review, focus groups, and suggestion boxes to evaluate the client and non-client perceptions of WIC. Using available data, WIC identified three target groups—WIC participants; WIC clients who left the program; and WIC eligible women/families who never enrolled in the program. Within those groups, data will be analyzed by race and ethnicity, focusing on Black/African American clients; Hispanic clients; Native American clients; and Arab American clients in an effort to identify disparity and guide programs and policies among its clinics.

Vendor Management and Operations

This work team from WIC chose to address the disparity in access to fresh fruits and vegetables among its clients. The team posed the following questions to guide their efforts:

- In what ways do we disproportionately (albeit unintentionally) put obstacles in the paths of some groups defined by race, class, gender, or history, resulting in their disadvantage?
- In what ways can we provide alternative strategies for people who do not have access to accessible year-round fruit and vegetables?

The group proposed a pilot program to create mobile food markets, leveraging existing policies, infrastructure, and an extended network of existing partners. They identified Tools—including meeting agendas, stakeholders, conferences, trainings, clients, food markets, community engagement, and data reports—that could be used to craft a new policy aimed at increasing fresh produce access for WIC clients. The result is the following five-step plan.

Repair

The team identified the need to repair existing outreach mechanisms, improve clinic-client relationships by giving clients the autonomy to choose when creating their own health goals and making WIC purchases, and to repair existing community-based networking channels.

Restructure

Both internal (state-level) and external restructuring were recommended. At the state level, they proposed the development of a new and appropriate policy to increase access. Externally, the team planned to broker relationships between parties—such as between stakeholder organizations, local WIC

clinics, and farmers markets. At the clinic-client level, the team recommended the restructuring of clients' health goals to include the increased fresh produce access, and to also increase positive perceptions of WIC among their client base, with the goal of less attrition among their clients. Additionally, they proposed introducing the health equity messages of PRIME, and the PRIME initiative specifically, to the local clinic staff, with the goal of decreasing disparities in access to fresh produce.

Remediate

The current advertisement of currently-available options had not been as effective as hoped, so the team recommended providing improvements to the community engagement around the *Double-Up Food Bucks* and *Project Fresh* programs. Additionally they recommended the creation of mobile food markets that could come into WIC clients' neighborhoods, as well as positioning WIC at the state level to function as brokers between communities and the vendors who would come into those communities.

Remove

The team aims for their implemented policy to remove access disadvantage for their clients—both from a geographic and financial perspective. The expected short term outcome would be to minimize nutritional disadvantage for WIC clients, and in the long term, the team anticipates an increase in health equity around fresh produce consumption.

Provide

Finally, the group hopes to provide increased access to knowledge through pre-existing WIC nutritional education experiences, to provide alternative avenues to access fresh produce while alleviating transportation barriers, to increase fresh produce consumption among WIC clients, and ultimately increase the health and wellbeing of the maternal and child client base.

Breastfeeding Awareness and Male Partner Engagement

This work team from the WIC program proposed efforts to increase awareness and support for breastfeeding, focusing on African American and Native American male populations. This was proposed as an element of a larger goal to change the cultural approach to breastfeeding in Michigan, focusing on populations that have historically had disparate breastfeeding outcomes. The team identified barriers to breastfeeding-friendly culture, including media portrayals of breastfeeding, the availability of infant formula, attitudes of family and friends, structural barriers to breastfeeding, and hospital practices. Each contribute to the breastfeeding disparity that exists in Michigan.

Diverse stakeholder groups were identified, as well as the assets of engaging with each group. These included:

Policymakers:

Engaging policy makers is a valuable endeavor due to their ability to make changes, and their access to funding for events such as the proposed breastfeeding walk.

Men:

Men, and young men specifically, were identified as the key audience to whom the proposed efforts would be addressed, as male-partner support is a primary predictor of breastfeeding success. The team proposed the engagement of existing fathers' groups to support their efforts.

Workplaces:

Places of employment play an important role in successful breastfeeding beyond the window of maternity leave, should any exist. Engaging workplaces, and informing them of their obligations under the Affordable Care Act to accommodate lactating women with expanded insurance benefits, is an important step that WIC can take to promote best workplace breastfeeding practices.

Cultural Environment:

The team identified that in order to shift culture to a more breastfeeding-friendly model, there would need to be shifts in cultural norms around breastfeeding.

Addressing all of these audiences through effective messaging will empower the final group—*new mothers*—to make empowered, culturally-normative breastfeeding choices that provide optimal health to their infants.

To augment their efforts, the team proposed engaging specific diverse partners, including the Inter-Tribal Council of Michigan, fathers' groups, faith based organizations, policy makers, breastfeeding coalitions, and academic institutions. Community engagement efforts were proposed that focus on male-partner education and communication campaigns.

As a starting point, the team identified existing skills and resources to facilitate their plans—including networking, existing partnerships/relationships, and influence. They also identified that challenges would include identifying target supports, institutional policies/practices, time constraints, funding needs, and sustainability.

At the time of this report, the breastfeeding walk was successfully implemented, and the team held focus groups of fathers to test messages from breastfeeding educational materials among their population. A second WIC Health Equity work plan objective was to increase awareness and support for breastfeeding from men, focusing on young African American and Native American men. State WIC staff provided assistance to local WIC programs applying for funding from the National Association of County and City Health Officials (NACCHO). The goal of the funding is to reduce disparities in breastfeeding through peer and professional lactation support to serve African American or Native American communities. Three agencies received funding in Oakland County, Benton Harbor and Detroit. Additionally, the Detroit Department of Health and Wellness Promotion contracted to provide breastfeeding peer counseling service through the WIC program at the American Indian Health and Human Services. MDHHS was awarded a W.K. Kellogg grant to increase the number of minority lactation consultants. The grant will provide lactation education, client contact hours and training for three minority women. At the end of the three year grant, the women will meet the requirements to be eligible for the International Board Certified Lactation Consultant examination. Work on the grant began in June 2015. Finally, MDHHS now has an online application that will customize the education module to the race and ethnicity of the mother who is receiving breastfeeding support and education.

In September 2016, all peer counselors and managers will undergo a fatherhood initiative training: Fatherhood Involvement In Systems of Care Training provided by Strong Start Healthy Start (SSHS). SSHS is an initiative of the Health Department to enhance the health of African-American families and improve birth outcomes. Through family support, parent coaching, education and case management,

Healthy Start works to promote health and decrease infant deaths in our community. SSHS provides services which include home visiting for expectant and parenting moms and expectant and parenting dads with a child up to age two. This training provides a deeper perspective on the importance of father involvement, including ways to effectively engage father figures in your community. The effects of father involvement on child outcomes and effective strategies to engage fathers are also discussed.

Additional initiatives to support breastfeeding are being provided through grants from National Association of County and City Health Officials (NACCHO) and W.K. Kellogg Foundation (WKKF). Two local WIC agencies, Kent and Detroit Urban League, applied for and received a grant from NACCHO. The goal of the funding is to reduce disparities in breastfeeding through peer and professional lactation support to serve African American or Native American communities.

Community Partners

This WIC workgroup chose to focus on the equity implications of the consolidation of two of its clinics into one, while creating a structure to engage the community throughout the process. Health equity was a central concern in this process, because there was noted growth and increased diversity among the service population. The team was focused on service access and utilization, as well as building clinic access into the design and location of the new facility.

The highest-need clients in the two clinics—Kentwood and Wyoming—were identified, and the benefits and challenges inherent in the consolidation were assessed for these clients. Benefits included more space in a cleaner and safer environment, as well as the addition of a dental clinic available for mothers and children. However, transportation barriers were identified, as was a relative lack of community input.

To address these barriers, the team proposed community engagement throughout the planning, implementation, and evaluation process through community forums, a town hall meeting, collaboration with existing health service agencies in the area, client feedback and focus groups, and input from WIC staff and county commissioners.

To assess staff readiness, capacity, and adoption of the new clinic plan, the team proposed staff education on the potential benefits of the change, as well as facilitated cross-clinic discussions with representatives from both clinic settings. Additionally, the team proposed repairing past practices when the community and staff input was not included in the planning process; restructuring the consolidation process; and removing the power dynamic by listening to stakeholders.

The team sited county administrative buy-in as a perceived barrier to their engagement and consolidation efforts. However, they were confident that the proposed changes would provide WIC services in a private, culturally sensitive environment, while providing services that were based on the self-identified needs of the community.

Conclusion

The projects proposed by Health Equity Learning Lab participants were creative and diverse, addressing important and varied aspects of the work of MDHHS. From data systems and management, to vendor relationships, to grant funding policies, the teams assessed policies and practices that reinforced inequity, and proposed and made changes. Much of this work is ongoing. Recently, technical assistance and consultation sessions have been designed to take place with work teams at the three, six, and 12 month marks to assess their progress on their goals. The Maternal and Women Health Section and the Division of Chronic Disease and Injury Control have participated in these sessions.