Michigan Coronavirus Racial Disparities Task Force

Recommendations for Collaborative Policy, Programming and Systemic Change

Year Two

State of Michigan's final progress report on findings and recommendations for collaborative policy and programming.

MDHHS
Michigan Department of Health & Human Services

EXECUTIVE SUMMARY

Introduction

The COVID-19 pandemic brought into sharp focus tremendous disparities in health and health care, with people of color, particularly Black and African American people, bearing the heaviest burden of negative impacts on health and well-being, as well as socioeconomic impacts. These profound, unfair and avoidable inequities prompted Governor Gretchen Whitmer to create the Michigan Coronavirus Task Force on Racial Disparities (Task Force) through Executive Order 2020-55 to monitor and guide the state's response to the pandemic. The Task Force was developed to focus on:

- Promoting accuracy and transparency in data collection and reporting.
- Removing barriers to health care.
- Reducing the impact of racial bias in medical testing and treatment.
- Mitigating environmental and infrastructural factors contributing to increased exposure.
- Developing and improving systems to support long-term economic recovery and physical and mental health care.

This report reviews the data on the overall trajectory of COVID-19's disparate impact on Michigan populations, in comparison to the national experience, and on Michigan's progress in reaching minority and historically underserved communities in response to the pandemic. It concludes with the Task Force's recommendations for the future.

Overall, the Task Force – strongly supporting the Michigan Department of Health and Human Services (MDHHS) and the Executive Office of the Governor (EOG) – was influential in ensuring that data on disparities was kept in the public eye, that racial bias as an underlying and systemic cause was named and addressed, and that the state government built public trust by working with community-based and faith-based organizations to provide services to those most vulnerable to COVID-19. Moreover, the response focused on immediate, acute needs, while evolving to build towards sustainable, community-centered programs to address the underlying systemic racism that created the disparities in COVID-19 impact.

Disparities in COVID-19 Cases and Deaths

Disparities between Black/African American and white populations were highly pronounced between March and June 2020, and then reduced significantly from 2020 to 2022 across all major indicators, including COVID-19 case and death rates. The report focuses on mortality or death rates as the most reliable indicator of trends in harm caused by COVID-19 over time (e.g., García-Basteiro et al, 2020). State data showed that the reduction in death rates from 2020 to 2022 for Blacks/African Americans was significantly greater compared to the corresponding reduction in

deaths for whites. Importantly, the observed reduction in death rates for Blacks/African Americans in Michigan was greater compared to the corresponding reduction in deaths for Blacks/African Americans nationally (Appendix I). Disparities in death rates between American Indian/Alaska Native and white populations were less pronounced initially but were quite marked between December 2020 and June 2021. The subsequent reduction in death rates for American Indian/Alaska Natives in Michigan after the peak in early 2021 was also significantly greater compared to the corresponding reduction for whites. Moreover, the observed reduction was greater compared to the corresponding reduction in deaths for American Indian/Alaska Natives nationally. Thus, the stark racial disparities in death rates detected during the early COVID-19 waves, and specifically targeted by the Task Force, were virtually eliminated during the omicron and subsequent smaller waves, an outcome that compares favorably with the national experience.

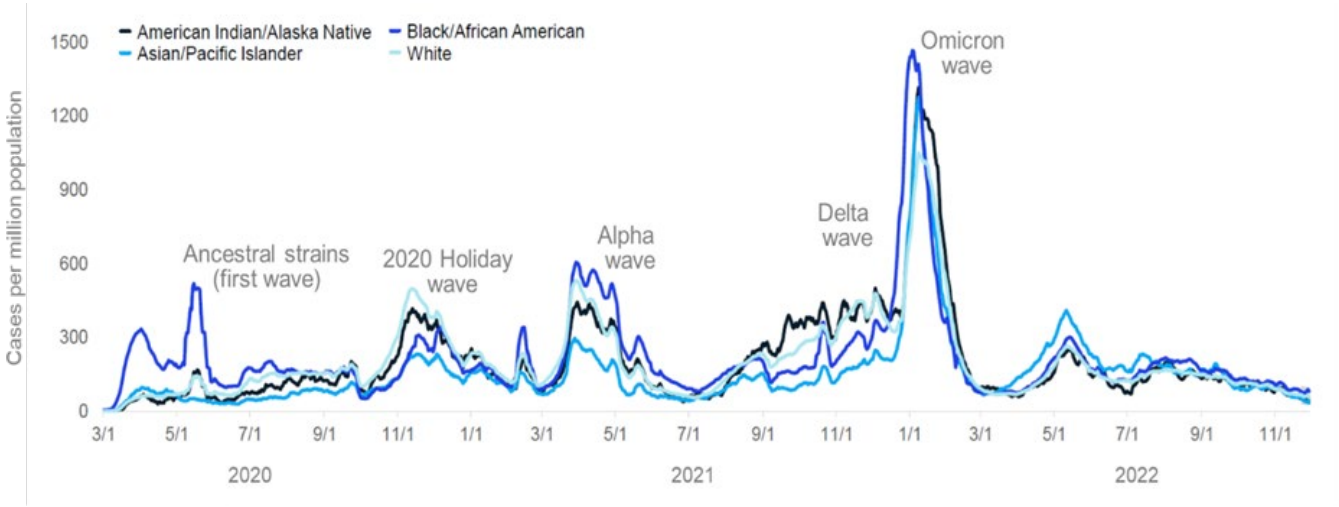


Figure: Seven-day rolling average daily COVID-19 cases per million by race.

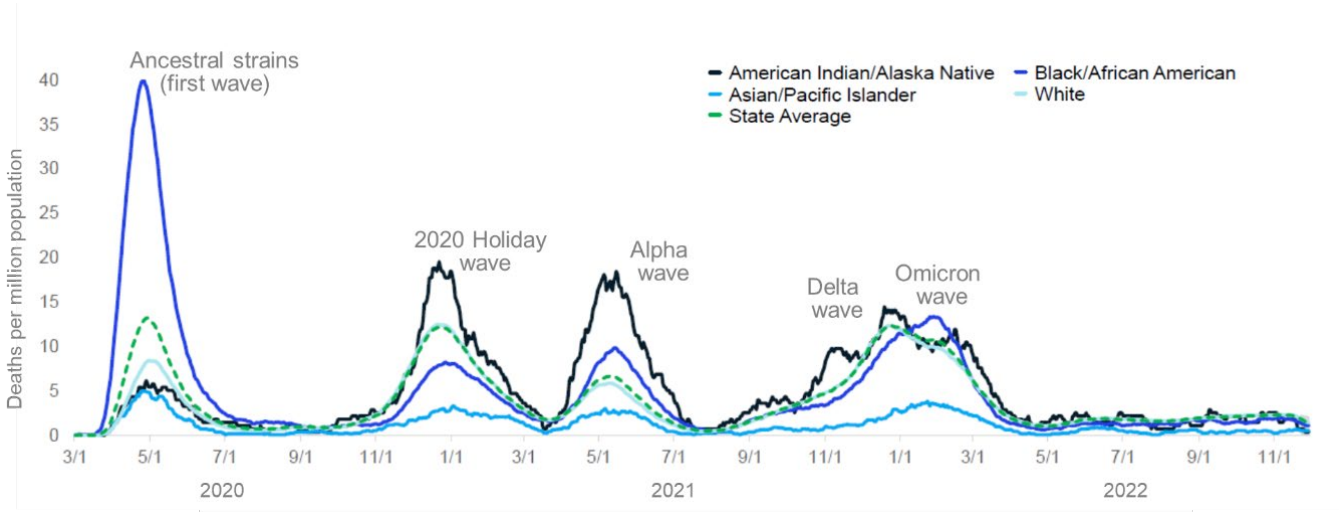


Figure: Thirty-day rolling average daily COVID-19 deaths per million by race.

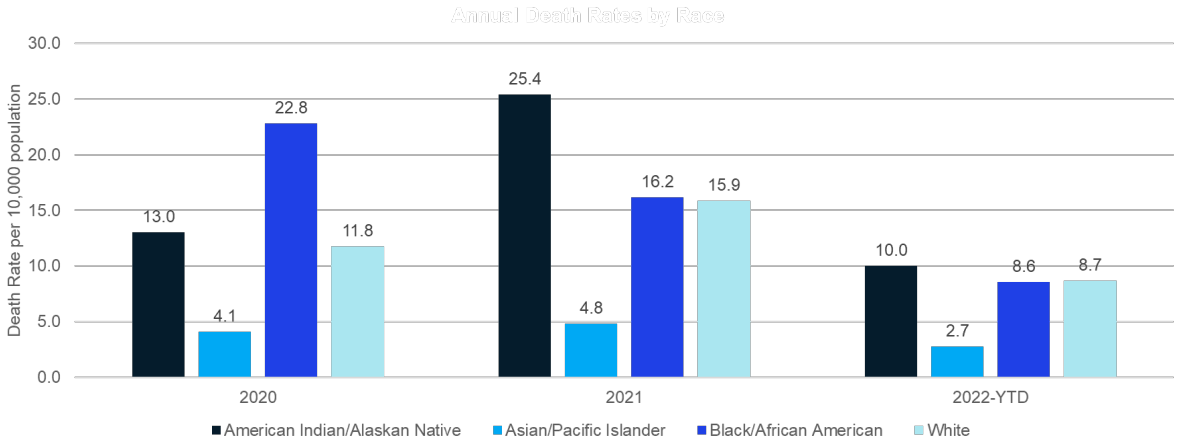


Figure: Year-over-year COVID-19 death rates by race in Michigan.

Initial Response

The Task Force was formed with a diverse membership, including community leaders, health care professionals, and members of affected communities. Staff and leaders from MDHHS and the academic community lent their subject matter expertise to the Task Force as well, creating a positive feedback loop in the initial response. Initial work by the Task Force, in collaboration with MDHHS, involved quickly identifying and submitting recommendations to achieve the following:

- Reducing barriers to COVID-19 testing in communities of color and expanding testing to include and prioritize those at the highest risk for serious illness.
- Providing masks and other personal protective equipment (PPE).
- Developing culturally competent messaging for best practices of COVID-19 mitigation.
- Improving data collection on racial and ethnic demographic information, and greatly enhancing the sharing and analysis capabilities of equity-related data.
- Improving access to health care for marginalized populations.
- Engaging 32 community organizations through the Rapid Response Initiative (RRI) to implement community-based interventions aimed at addressing critical service gaps focusing on racial and ethnic minorities and other marginalized populations.

Partnering with Communities to Address the Pandemic

Workgroups were formed within the Task Force to monitor and provide continuous consultation and feedback on strategies recommended by the Task Force. They also worked closely with MDHHS and other state departments, as well as community partners, to oversee and provide input on their essential work during the pandemic. This work included:

- Establishing neighborhood testing sites, test to treat sites, and mobile health units in communities of color and others at risk for COVID-19 morbidity and mortality.
- Providing testing and vaccinations for vulnerable populations, such as migrant workers and homebound senior citizens.
- Launching public health education messaging and social media campaigns.

In addition, the Task Force solicited feedback and insights from impacted communities and community leaders to improve effectiveness in strategy deployment. Throughout the response to COVID-19, the Social Vulnerability Index (SVI) and census tract data were used to assess community needs and inform strategic site locations and optimize resource allocation by prioritizing interventions to benefit the most vulnerable populations. Such efforts included public health campaigns by the MDHHS Communications Team and Vaccine Equity Project, specifically tailored to the needs and concerns of communities of color, which often meant co-creating and co-designing messaging and strategies with these communities.

Successes in these strategies are demonstrated by findings such as one from a large-scale survey conducted at the height of the pandemic which showed that after initially polling as the least likely, Blacks/African Americans were 12% more likely to always wear a mask compared to the rest of the population (Task Force's Second Year Report, p.18). In addition, recent findings from the monthly Vaccine

WORKGROUPS OF THE RACIAL DISPARITIES TASK FORCE

Strategic Infrastructure
Advancing infrastructure for testing and vaccination, and addressing social determinants of health.

Primary Care Connections
Increasing access and linkages to primary care and exploring the role of telehealth services.

Centering Equity
Addressing the causes of racial disparities in COVID-19 impact through policy and practice.

Mobile Health
Building sustainability for mobile health services within health care system.

Environmental Justice
Addressing the systemic challenges underlying the intersection of climate change, air quality, and COVID-19.

Strategic Communications
Improving media campaigns and messaging targeted to communities of color and young people.

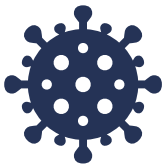
Confidence Survey conducted by the Centers for Disease Control and Prevention (Trends in COVID-19 Vaccine Confidence) suggest that the percentage of Black/African American adults in Michigan with no intention of getting vaccinated has been greatly reduced and may be as low as 1.2%. However, a multitude of data sources indicates that Black/African American parents may justifiably be more hesitant to vaccinate their children due to historical reasons that make them distrustful of government and health agencies. Vaccine hesitancy is a complex and context-specific issue, and the Task Force recognized that it requires targeted understanding and further efforts to address. Recently completed efforts by the Task Force include a research study with Detroit parents of school-aged children (JFM Consulting Group, 2022) and learning table discussions with local and state government leaders from Michigan and many other states (The Barthwell Group, 2022). Each of these projects provided valuable insights that are already incorporated in ongoing campaigns to further reduce vaccine hesitancy in priority communities.

Reducing Longstanding Disparities in Health Care and Addressing Underlying Causes

In addition to seeking to meet more immediate needs, the Task Force began focusing on reducing the stark disparities in health care access and utilization among racial and ethnic groups that have historically faced barriers to accessing and engaging with the health care system. Besides working to decrease the uninsured population across racial and ethnic groups, this work included extending access to health care for people with sickle cell disease, 90% of whom are Black/African American (Lee et al., 2019), as well as Black mothers and other women of color who are more likely to die from pregnancy-related causes than white women, and whose infants are more likely to die before they reach their first birthday. Additionally, the Task Force supported work to incorporate health care and immunization access for Black and Brown children in schools.

The Task Force prioritized putting policies, programs, and practices in place that have the potential to counteract the harms of systemic racism as a key driver of health inequities. This included advocating for the implementation of Executive Directive 2020-7, which directed the Department of Licensing and Regulatory Affairs (LARA) to develop rules to require implicit bias training for health care professionals as part of the knowledge and skills necessary for their work. These new requirements are now in place for all new applicants and those renewing existing licenses or registrations in the state. A similar effort included advocating for a section of Governor Whitmer's declaration of racism as a public health crisis (Executive Directive 2020-9), which required the implementation of implicit bias training as an entry requirement for all new state employees, and for continued employment for existing employees. Executive Directive 2020-9 also directed MDHHS to work with other state departments to examine data, develop and plan policies, and engage, communicate, and advocate for communities of color. In response to this, the Task Force helped launch the Racial Equity Impact Assessment (EIA) initiative within the state government. MDHHS began implementing an EIA demonstration project, with initial results showing that participating staff have improved their capacity at work to address long-standing inequities experienced by marginalized and vulnerable populations.

- Six million surgical masks and 10 million KN95 masks distributed.
- Food, hygiene products and home goods provided to quarantined individuals.
- Rapid Response Initiative grant funded 32 community and faith-based organizations to make 1.2 million contacts with community members, providing PPE, health services, COVID-19 testing, contact tracing, education, food, housing, financial assistance, adult education, and employment services, among other resources.



- Twenty-two neighborhood sites in areas of high vulnerability hosted 7,365 events, administering >364,104 COVID-19 tests; 57% reported as Black or African American, with substantial numbers of Hispanic and Arab ethnicity also served.
- Over-the-counter testing program distributed 5,000+ home test kits.
- Test-to-Treat program administered 3,757 tests and treated 82 patients.

- Twenty-two neighborhood sites hosted 2,364 vaccination events, administering 6,815 shots in arms; over 67% of those served were Black or African American, and significant populations of those with disabilities (8%) and seniors over 60 (37%)
- Completed pilot to supply vaccinations to 300 homebound seniors in two days; more than 21,000 homebound seniors vaccinated across the state.
- Vaccine hesitancy study conducted to document and address concerns of Detroit parents of school-aged children.
- Pilot offered school-based vaccinations to children and parents in Detroit.

- Nine mobile health units administered 52,460 COVID-19 tests and 28,308 COVID-19 vaccinations, as well as an array of other wraparound services.
- Mobile health units provided COVID-19 testing, vaccination, linkage to primary care and Medicaid insurance, health screenings, education, and resource referrals and assistance in Genesee, Ingham, Kent, Muskegon, Wayne Counties.

- Learning tables conducted with leaders in local and state government from Michigan and many other states to discuss and share strategies, tactics, methodologies, successes, and challenges for reducing vaccine hesitancy and increasing vaccination rates in communities of color.
- Vaccine equity project worked with community leaders in areas of high social vulnerability to develop data-driven strategies to address vaccine hesitancy.

- Executive Orders required implicit bias training for State of Michigan employees and contractors, and licensed health care professionals.
- 45,663 state employees (97%) completed implicit bias training.
- 4,789 contractors (85%) completed implicit bias training.
- 60,784 individual health professionals attested to completing training, and 18,559 completed training when applying for new licenses (98%).
- Full-time equity officers across state government prioritize equity initiatives in departments, including language access and implementation of implicit bias training.

- Policy changes to expand the Children with Special Health Care Services program to include health care coverage for adults living with sickle cell disease, invest in clinical treatment and testing capacity building, and provision of non-clinical services.
- State facilitated increased Medicaid and federal marketplace enrollment for people who lost jobs during the pandemic.
- Infrastructure created for state government to meet federally mandated language access requirements.

- Equity impact assessment demonstration project tested in three MDHHS departments.
- Engagement of stakeholders in Climate Solutions Plan to consider disparate racial impacts in environmental justice issues.
- Long-term energy and utility planning to include economic justice analysis.
- HVAC air quality assessments and recommendations provided to 109 schools.

Impacts of the Task Force

While the long-term impact of the work spearheaded by the Task Force will require a longer timeframe to be evaluated, data presented in this report show that grossly disproportionate disparities in health outcomes were virtually eliminated through the course of the pandemic, and the documented improvements in communities of color were greater compared to corresponding national data. The report also outlines all the strategies and activities designed and implemented with clear objectives and specific metrics to monitor progress towards the targeted outcomes. In addition, the work of the Task Force has clearly laid the groundwork for continued progress toward dismantling racial health disparities in Michigan.

More broadly, the successful implementation of a data-driven and community-centered framework, based on cross-sectoral collaboration and diversity, could serve as a comprehensive, field-tested model for how government could effectively respond to the needs of individuals and communities.

Recommendations

The COVID-19 pandemic revealed health disparities centuries in the making. The Task Force brought the necessary focus to address disparities most directly related to the current pandemic, and it promoted programming to address broader inequities in access to care, implicit racial bias, and environmental justice. Disparities remain across many indicators that will continue to make communities of color vulnerable to future pandemics and other stressors. As the Task Force concludes its work, it puts forth the following recommendations to continue the work of dismantling systemic racism, engaging communities of color, and advancing health equity to prepare us for future pandemics and a more inclusive, effective health care system for all Michiganders.

TASK FORCE RECOMMENDATIONS

1. Continue commitment and funding for collection and public reporting of racial disparities associated with COVID-19 and other infectious diseases toward maintaining effective problem identification, problem solving and decision making.

2. Continue investment in use of survey data and comprehensive communications strategies toward influencing and addressing racial disparities in social determinates of health.

3. Sustain investment in and enhance awareness of mobile health units to increase portable access to health care in underserved communities and link people to health and social services.

4. Maintain and expand Neighborhood Testing Sites and school-based health centers into comprehensive community hubs, providing enhanced services, public health programs, referral to resources, and educational offerings; incorporate metrics of success and community satisfaction surveys to demonstrate value and support quality improvement of programs to meet community needs.

5. Expand the use of the Equity Impact Assessment model (EIA) across State of Michigan departments and implement an organizational change model developed by the Office of Race, Equity, Diversity and Inclusion (REDI); measure short-, medium, and long-term outcomes in reductions of racial disparities.

6. Support Sickle Cell Comprehensive Care Act legislation to fund services for sickle cell anemia patients to increase access to value-based services.

7. Explore and implement digital data collection solutions for Black and Brown maternal health patients to report discrimination they face in the health care system.

8. Develop enterprise-wide language access, establish consistent standards, policies and procedures, and provide needed resources throughout the state government.

9. Implement policies and practices to reduce uninsurance and maximize Medicaid and federal marketplace health care insurance enrollment.

10. Define additional infrastructure and funding to address disparities in health and resource access for special populations including migrant and agricultural workers, homebound seniors, and Middle Eastern and North African (MENA) residents.

11. Prioritize funding for HVAC ventilation system air quality improvements and upgrades in public schools to reduce COVID-19 infection rates and impacts on asthma in environmental justice communities.

12. Pilot "Healthy Zone" strategies to improve access to healthy foods and campaigns supporting healthy choices and fitness in targeted communities to reduce chronic disease .

In order to maintain momentum on these recommendations, the Task Force requests that the Executive Office of the Governor's Policy Division establish responsibility for follow-up with the appropriate departments and the expectation that the Governor's Black Leadership Council (BLAC) be briefed on next steps and progress.

Contents

INTRODUCTION

COVID-19 and the Genesis of the Racial Disparities Task Force

While racial disparities in health outcomes have affected generations of Americans, COVID-19 brought the starkness of these disparities to the public eye in a powerful manner, with Michigan at the forefront of noticing significant disparities in COVID-19 cases and deaths. During the first few months of the pandemic, Black and African American people were dying from COVID-19 at several times the rate of white people. Also of concern were disparities in the downstream effects of the pandemic such as unemployment, risk of eviction and foreclosure.

In April 2020, Governor Gretchen Whitmer established the Michigan Coronavirus Task Force on Racial Disparities (Task Force) by Executive Order 2020-55 to oversee, in coordination with the Michigan Department of Health and Human Services (MDHHS) and other stakeholders, the state's efforts to address the disproportionate burden of the COVID-19 pandemic on Black and African American residents and other minorities in health care and health outcomes and recommended actions to reduce historical and systemic inequities. The Task Force was chaired by Lieutenant Governor Garlin Gilchrist and led by the Honorable Thomas Stallworth III, and was comprised of state and federal legislators, leaders of community organizations, university partners, state government officials, and members of affected communities.

Initial Response to Disturbing Racial Disparities

The state made a series of critically important decisions early on that facilitated the overall response to the health care crisis, and the task of addressing racial disparities. Recognizing the need to understand how COVID-19 affects each population differently, state leaders acted immediately at the beginning of the pandemic—more than one month before the first confirmed case in Michigan—to prioritize the tracking of race and ethnicity in COVID-19 demographic data and statistics. As the pandemic evolved, data evolved along with it, revealing clear patterns of disparities between race and ethnicity categories.

The state ensured that labs complied with federal requirements (e.g., CARES Act) when reporting COVID-19 test results, such as providing critical data such as the race of individuals who are tested. This has allowed the state to monitor how the virus has spread in different populations over time. In addition, by regularly matching COVID-19 data with vital records data to validate deaths, the state has been able to track COVID-related mortality by race.

Another critically important decision made by the state was the establishment of the Task Force. The initial approach that the Task Force took to responding to the COVID-19 pandemic was to make a series of urgent recommendations to address immediate, short-term needs and build capacity within communities of color as the pandemic evolved. Some of these initial efforts supported by the Task Force in 2020 included distributing essential personal protective equipment (PPE), supporting community-based organizations in responding to immediate needs, and establishing COVID-19 testing sites in neighborhoods with high need.

PPE and Other Critical Resources

The Task Force supported the most immediate and acute response to the pandemic in 2020, including PPE distribution and education. This included the distribution of 6 million masks at no cost to communities of color. In addition, resources were provided for quarantined individuals, which included food boxes, hygiene products, and home goods in addition to PPE. Other efforts supported by the Task Force included the addition of navigator services to neighborhood testing sites in Detroit to connect community members with public health programs and human services, a utility assistance program and water shutoff moratorium, an initial moratorium on foreclosures and evictions followed by $50 million of funding through the Eviction Diversion Program, and re-eligibility for SNAP benefits of residents formerly convicted of drug felonies.

The Task Force also helped support the state to take policy actions such as issuing guidance letters to health care providers to avoid implicit bias and to law enforcement to avoid discriminatory behavior towards Black residents wearing masks. The state also expanded testing protocols to

include asymptomatic family members. Various communications campaigns about mask wearing were also deployed.

Rapid Response Initiative

In 2020, the Task Force was provided with almost $20 million by the State of Michigan to support rapid response initiatives (RRIs). An RRI was defined as a program that would target immediate gaps in services and urgent needs associated with the disparate impacts of the COVID-19 pandemic that could be addressed within 120 days. The Task Force conducted a grant application process, through which 32 community-based organizations were awarded an RRI grant in August 2020. The purpose of this grant was to support "shovel ready" projects with a broad reach, which could be implemented, funded and delivered by the end of the year and easily scaled to other communities.

Funded RRI projects used a health equity lens and were community-driven. The type of assistance provided, and the number of people assisted, is presented in Table 1. Health services were provided directly by some organizations while other organizations enabled access to health services and health monitoring. Some of these efforts were specific to COVID-19, such as providing testing to marginalized communities while others were focused on broader health care needs, including physical, mental and dental health. Several efforts were focused on expanding access to telehealth services by distributing hotspot devices to help underserved communities acquire internet access for health care provision. Non-medical resources addressed social determinants of health (SDOH) underlying the disproportionate impact of COVID-19, including food security, financial and housing stability, and emergency shelter. Resources were provided directly by most organizations while some programs also helped individuals and families with benefits assessment and provided referrals to community services.

Several organizations specifically addressed education and livelihood crises. Such efforts specifically focused on at-risk communities, in which parents were less likely to work remotely, be able to afford tutors or childcare, or have access to high-speed broadband internet. To address these challenges, organizations provided educational support, including the development of virtual curriculums, distribution of electronic devices, and provision of internet access. Other programs focused on supporting the livelihoods of people in these communities by providing them technological resources, giving guidance to those returning home from incarceration during the pandemic and offering support for small businesses. Across all 32 organizations, almost 1.2 million contacts with community members were made.

Table 1. Type of assistance provided by rapid response community initiatives and the number of individuals reached.

Assistance	Number of Individuals Reached
Health Services	
PPE/Disinfectants	118,343
Telehealth/In-Person Care	221,996
COVID-Testing/Tracing	69,237
COVID-Related Education/Health/Fitness	26,799
Non-Medical Resources	
Food	504,407
Housing/Shelter	2,464
Financial Assistance	7,407
Utilities	4,933
Clothing, Transportation, Lead Filters	2,785
Education and Livelihoods	
E-learning/Adult/Special Ed	223,796
Long Distance Learning	1,484
Employment Services	560
State Benefits Assessment/ID/driver's license	4,942

In addition, the Task Force provided support through the RRI grant for public health data improvements and monitoring by funding several programs, including efforts to develop data systems and processes to better understand the factors underlying racial disparities and identifying communities at heightened risk. For example, one of the RRI-funded initiatives was to help disaggregate COVID-19 data for individuals with an ethnic background from the Middle East and North Africa (MENA). This was done so that the impact of COVID-19 on Arab American populations in Michigan could be more accurately assessed and community needs could be better met. All these efforts provided important information to facilitate a more equitable allocation of MDHHS resources and better public awareness of how the pandemic affected each community in Michigan.

Workgroups

The Task Force established the following workgroups to monitor progress on recommendations and provide support to implementation efforts by MDHHS and other departments via continuous consultations and feedback.

Centering Equity Workgroup: COVID-19 disproportionately impacted communities of color throughout its evolution. This workgroup focused on studying the systemic causes of COVID-19 racial disparities and recommending immediate policies and practices as well as more sustainable changes to promote race equity, diversity, inclusion, and cultural change, thus contributing to the reduction in the negative impacts of systemic racism. This workgroup supported efforts within

MDHHS and other departments of the State of Michigan to reduce the short-, medium-, and long-term impacts of racial disparities, and provided direction for how to respond to and combat racial disparities in potential future public health emergencies. Finally, this workgroup advocated for and secured the implementation of an executive order to advance health equity through implicit bias training for health professionals and the state's workforce and recommended and supported efforts to reduce health and racial disparities by implementing organizational changes aimed at embedding health equity in MDHHS policies and service delivery.

Strategic Infrastructure Workgroup: The objective of this workgroup was to support development of the COVID-19 testing infrastructure needed to effectively meet the needs of Black and African American and other vulnerable communities. This workgroup also supported concurrent delivery of COVID-19 vaccines while improving flu vaccine delivery, with the intention of decreasing vulnerability to COVID-19. Finally, this workgroup provided support for long-term efforts to improve social determinants of health and increase treatment for underlying health conditions within communities of color.

Primary Provider Connections Workgroup: Black and African Americans and other communities of color are disproportionately affected by a shortage of doctors and primary care services, as well as a higher prevalence of uninsured and underinsured people. This exacerbated underlying chronic health conditions in the Black and African American community during the pandemic, increasing the risk of severe COVID-19 cases and death. This workgroup's priorities included short- and long-term efforts to connect those in vulnerable communities to primary care providers and help them navigate the health care system. This workgroup also focused on increasing access to high-speed internet to deliver telemedicine services, and other forms of remote medical care, as well as reducing obstacles to care such as transportation and shortages of all types of health care providers (including physicians, physician's assistants, nurse practitioners, registered nurses and community health workers).

Mobile Health Workgroup: During the pandemic, Michigan created a mobile health unit (MHU) program that filled important gaps in access and care delivery that contribute to rural and urban health inequities. This workgroup was created to identify sustainable solutions for ongoing funding of statewide MHU programs. This included defining the range of services that could reasonably and reliably be delivered using MHUs and aligning these services with a barrier-free payment model. Additionally, this workgroup worked to define alternative payment models for public health and prevention care delivered through MHUs, leverage existing partnerships with local health departments, community-based organizations, and other clinical resources to reach the most vulnerable populations and identify gaps, and develop a coordinated statewide deployment of mobile health services to fill gaps and meet community needs.

Environmental Justice Workgroup: Environmental issues play a significant role in the health and welfare of communities of color as they are disproportionately exposed to air and water pollution and suffer from associated chronic health conditions. Task Force members functioned as representatives in the already assembled Michigan Advisory Council on Environmental Justice

(MAC-EJ) to drive integration of the impact of COVID-19 racial disparities in the environmental justice and climate change problem solving process. This workgroup also served to support air quality monitoring and assessment efforts spearheaded by the Michigan Department of Environment, Great Lakes, and Energy (EGLE), to mitigate the impact of air quality issues on COVID-19 spread in communities of color. Creating avenues for efficient, equitable utility and energy planning as well as supporting the equitable transition of those who work at old polluting factories were other major priorities for this workgroup.

Strategic Communication Workgroup: While not an active workgroup with ongoing meetings and members, strategic communication was a major priority in every area of work of the Task Force. This workgroup supported various educational media campaigns by MDHHS and the State of Michigan regarding COVID-19 prevention, testing, and vaccination, targeted specifically towards communities of color and young people. In addition, members of the Task Force were encouraged periodically to share this work within their own professional and personal networks.

The members of each workgroup, as of January 2023, are listed in Appendix III (page 65).

Purpose, Methods and Key Issues Addressed

This report first details the existing evidence regarding the reduction of racial disparities in COVID-19 outcomes in Michigan between the start of the pandemic in 2020 and the end of 2022. Statistical analyses were conducted using binomial tests to determine the extent to which racial disparities on death rates were significantly reduced over the course of the pandemic. Probability values of <0.05 were considered statistically significant.

Compared to case rates, mortality rates are considered a more accurate indicator to monitor the evolution of the pandemic, as they are the least affected by changing testing practices and inconsistent testing standards across jurisdictions (e.g., García-Basteiro et al, 2020). In addition, structural racism has been shown to be a robust predictor of racial disparities in COVID-19 mortality rates (Siegel et al., 2021). Unadjusted death rates are employed reflecting the total probability of death from COVID-19 and the combined influence of all factors affecting death from this disease. Although some evidence exists to suggest that unadjusted death rates may underestimate the magnitude of disparities, recent research on racial/ethnic disparities in COVID-19 hospitalizations and mortality indicates that when adjusting for age, Blacks/African Americans tend to have a higher prevalence of disease and other health risk factors than whites. These differences, however, are too small to explain disparities in COVID-19 outcomes (Selden & Berdahl., 2020). In addition, a University of Michigan study found that the bulk of disparities in death rates between Blacks/African Americans and whites early in the pandemic was driven by differences in infection rates across all age groups rather than age-specific variation in case-death rates (Zelner et al., 2021). Thus, the main data analysis of this report involves comparing unadjusted death rates across race groups over time, with a focus on year-over-year changes in

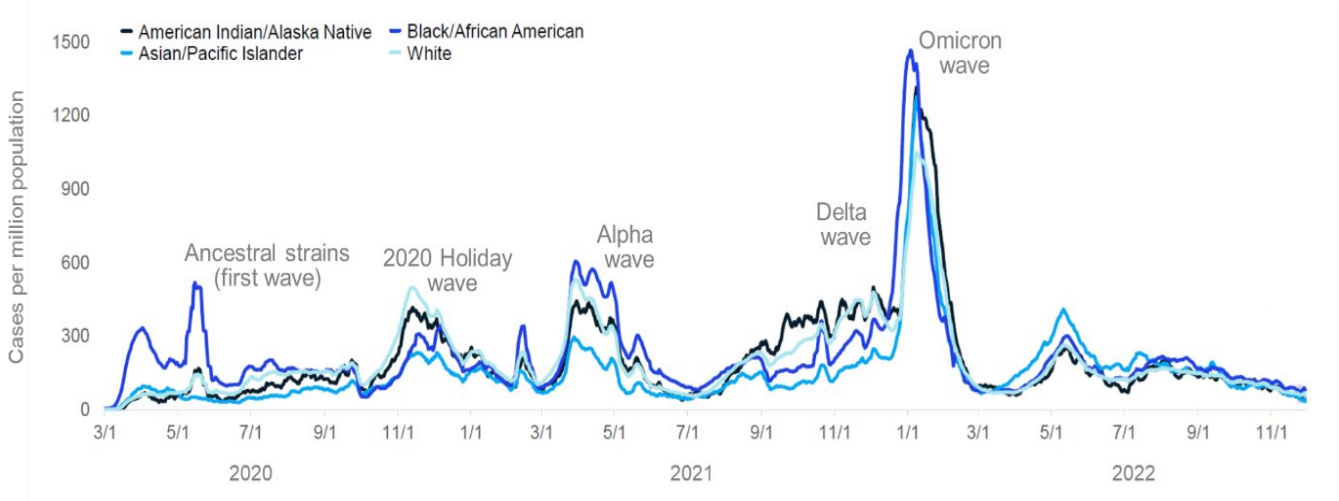
disparities and contrasting observed changes in disparities with corresponding national data. Further methodological details are provided in Appendix II.

Next, the report provides qualitative and quantitative data about the various efforts by the state and other stakeholders that were supported by the Task Force, as well as the Task Force's own work in compiling lessons learned and best practices, to show that these efforts, in total, contributed greatly to the observed reductions in disparities. Finally, the report lists the short- and long-term recommendations provided by the Task Force to sustain the work done so far, as well as the projected impact of implementing these recommendations for continued progress towards eliminating disparities.

FINDINGS

Race Disparities in Mortality Rates Over the Course of the Pandemic from 2020 to 2022

The initial data in the spring of 2020 revealed that the COVID-19 pandemic had an immediate, disproportionate impact on Black and African American persons. This was evident in the number of confirmed or probable COVID-19 cases in the early spring of 2020 with the first wave (Figure 1). Disparities were also evident in following waves, with the pandemic affecting Black/African American, Indigenous and other people of color the most. However, data also shows that such disparities were subsequently reduced, particularly with omicron and subsequent smaller waves.



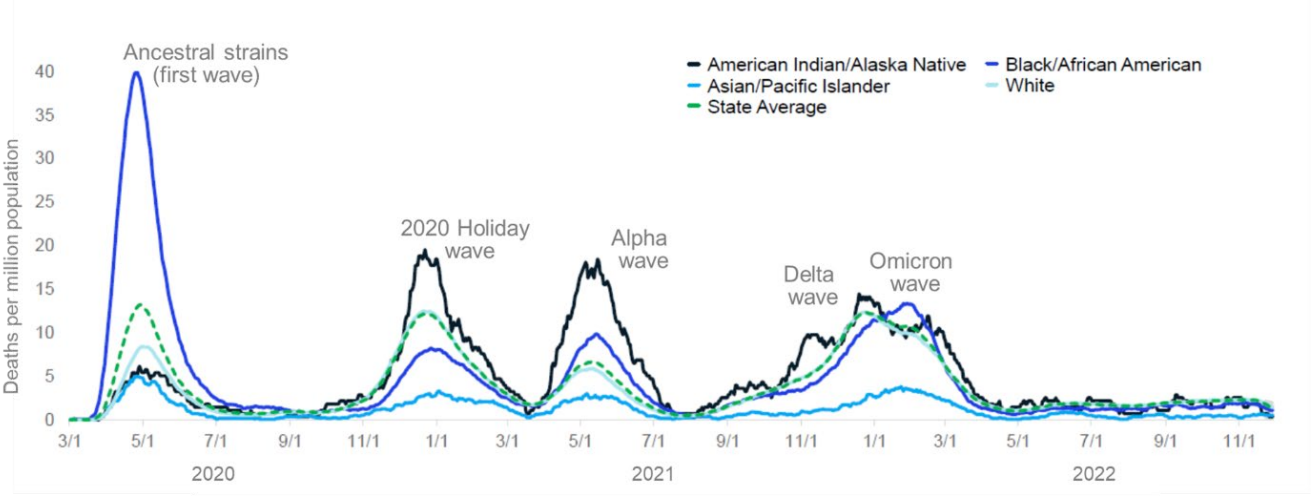
Note: Sourced from MDHHS – Michigan Disease Surveillance System: Data accessed November 2, 2022.

Figure 1. Seven-day rolling average daily COVID-19 cases per million by race in Michigan (Corresponding data by ethnicity are presented in Supplementary Figure 1, Appendix I).

Although case numbers have been a critically important surveillance measure, for the purpose of evaluating the impact of the Task Force, such data is not the most reliable indicator, particularly as

race category information is based on self-report, often resulting in a substantial amount of missing data. Further, testing availability shifted considerably over time. For example, during the first wave, the most reliable testing method, the polymerase chain reaction (PCR), was only reserved for most severe cases. Then, about nine months later, the at-home antigen rapid tests were made available and they were less validated by PCR. Furthermore, contact tracing was scaled back, which would have been a way for individuals to get tested, with the results being reported to local health departments (LHDs).

Figure 2 presents the unadjusted 30-day rolling average daily number of deaths by race.



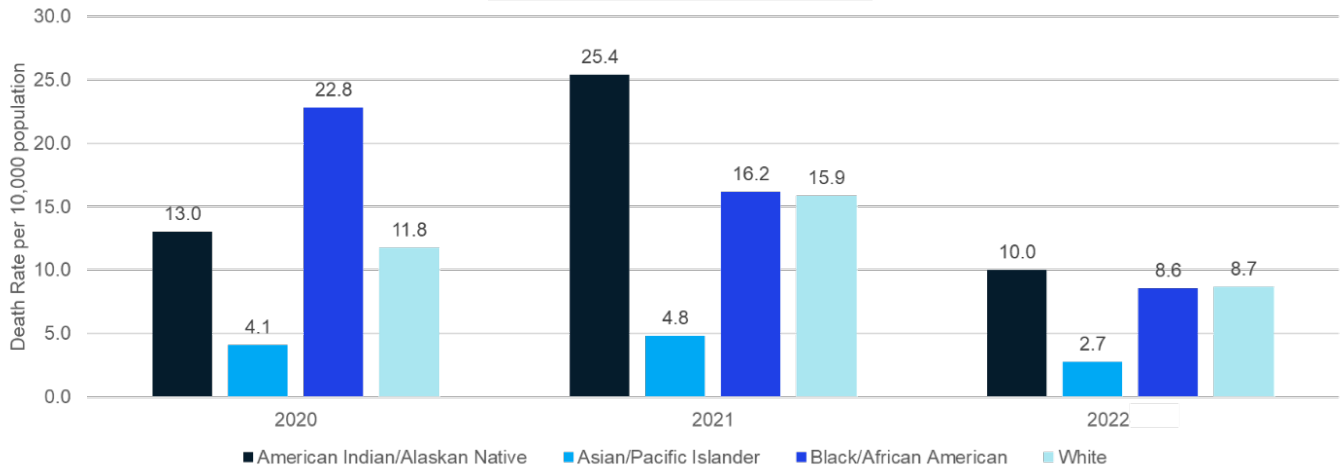
Note: Sourced from MDHHS – Michigan Disease Surveillance System; Data accessed November 2, 2022.

Figure 2. Thirty-day rolling average daily COVID-19 deaths per million by race in Michigan (Corresponding data by ethnicity are presented in Supplementary Figure 2, Appendix I).

Following the Task Force's inception in the spring of 2020, the State of Michigan sought to urgently address observed COVID-related disparities. To assess the impact of the state's efforts to reduce these disparities, we focus on death rates as the most reliable type of surveillance data for the purpose of evaluating *trends over time* (e.g., García-Basteiro et al, 2020). Data presented in Figure 2 shows the year-over-year provisional death rates by race. Overall, the data shows that death rates were highest for Blacks/African Americans in 2020 and American Indian/Alaska Native in 2021. However, racial disparities were greatly reduced across races by 2022.

Consistent with the initial reports of a dramatically greater relative COVID-related burden among Blacks/African Americans (e.g., Zelner et al., 2021), year-over-year data presented in Figure 3 show a large disparity, in 2020, between the death rate for Blacks/African Americans (22.8 deaths per 10,000 population) and the corresponding rate for whites (11.8). However, the data also show a gradually decreased death rate for Blacks/African Americans in 2021 (16.2) and a further decrease so far in 2022 (8.6). The observed reduction in death rate for Blacks/African Americans in Michigan from the high in 2020 to the low in 2022 (difference of 14.2) is significantly greater compared to

the corresponding reduction (difference of 3.1) for whites. Importantly, the observed reduction for Blacks/African Americans in Michigan is also greater compared to the corresponding reduction (difference of 8.9), across the same time frame, for Blacks/African Americans nationally (see Supplementary Figure 3, Appendix I). Similar results were obtained when comparisons were based on between-population differences in reductions for daily death rates from the initial surge peak rate to the peak rate during the omicron surge (Figure 2).



Note: Sourced from MDHHS – Michigan Disease Surveillance System. Data reflect the date of death of confirmed and probable cases; 2022 data are inclusive of dates of death through October only; Data accessed November 2, 2022.

Figure 3. Year-over-year COVID-19 death rates by race in Michigan (additional year-over-year data are presented in Appendix I, including case rates by race, in Supplementary Figure 4, case rates by ethnicity, in Supplementary Figure 5, and death rates by ethnicity in Supplementary Figure 6).

For American Indian/Alaska Natives, year-over-year data presented in Figure 3 shows the largest disparity between the death rate for this population (25.4 deaths per 10,000 population) and the corresponding rate for whites (15.9) in 2021. The reduction (difference of 15.4) in death rates over the next year for American Indian/Alaska Natives in Michigan is significantly greater compared to the corresponding reduction for whites, and it is also greater compared to the corresponding reduction for American Indian/Alaska Natives nationally (see Supplementary Figure 3, Appendix I). Similar results were obtained when comparisons were based on between-population differences in reductions for daily death rates from the second wave peak rate to the peak rate during the omicron surge (Figure 2).

Evolving Response to the COVID-19 Pandemic Using a Community Capacity-Building Approach

As the COVID-19 pandemic evolved from late 2020 through 2022, the Task Force supported a series of efforts intended to support community needs as they too evolved. This included building capacity within communities through increased testing and vaccination outreach efforts, expanding neighborhood testing sites, deploying mobile health units to address primary care linkage gaps, and addressing vaccine equity and hesitancy concerns in communities of color.

Neighborhood Testing Sites

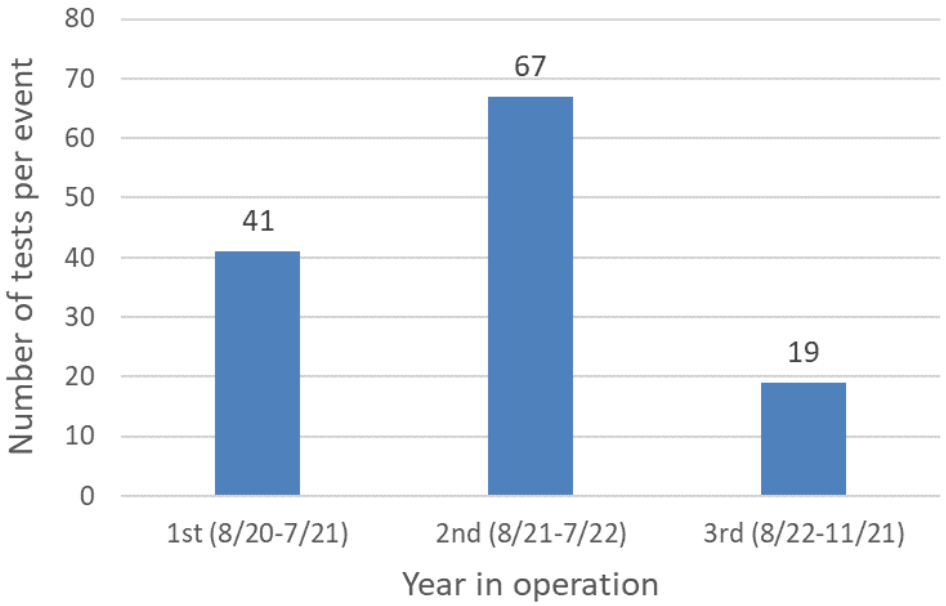
In August 2020, the Task Force supported the MDHHS COVID-19 Testing Collection and Coordination (TCC) Team in the onboarding of 22 neighborhood testing sites in multiple counties across Michigan, concentrated in Metro Detroit and Flint. Neighborhood testing sites were selected using a data-driven strategy based on social vulnerability index (SVI), COVID-19 mortality and census tract data. Selected sites were community-embedded, easy to travel to, and were already considered staples in their communities. Testing site partners included faith-based and educational institutions. Throughout the program's history, the neighborhood testing sites maintained strong community partnerships.

Testing

The testing sites began administering COVID-19 tests in August 2020, hosting frequent events where PCR and Antigen tests were administered to community members. Additionally, sites added over-the-counter (OTC) test kit resources in May 2022. All services were offered to community members at no cost. Sites ensured accommodations for senior populations as well as those with disabilities. Language access and translation services were also provided.

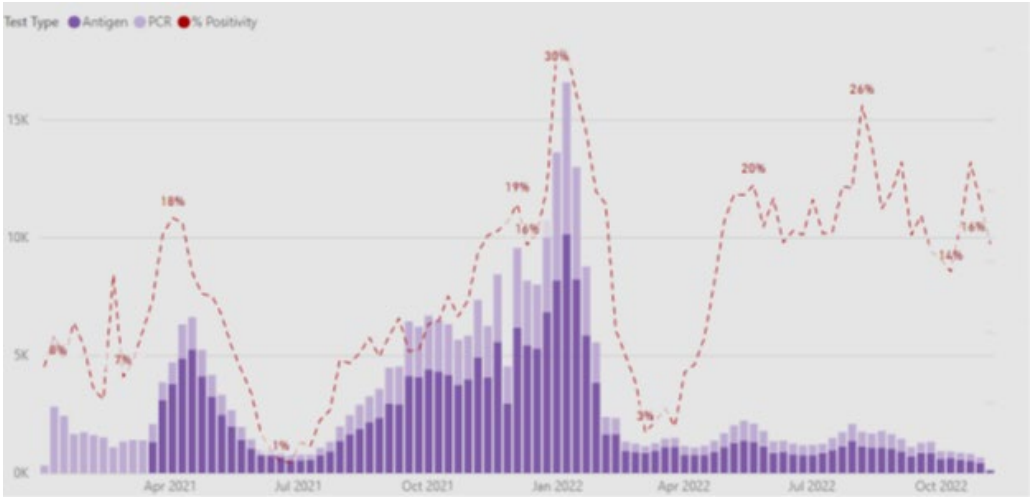
Between August 2020 and November 2022, neighborhood testing sites hosted 7,365 different testing events – administering at least 364,104 COVID-19 tests (PCR, Antigen). The average number of tests provided per event increased from 41 to 67.4 tests between July 2021 and July 2022, and then decreased from 67.4 to 17.3 tests from July to November 2022, reflecting the lower demand for testing over time (Figure 4, see also Figure 5). During that period, 57% of those who provided their self-identified race and ethnicity were Black/African American. Those tested were mostly under 50 years old (70%), with a large concentration in the millennial (20s and 30s) subset (34%). There was also a significant Arab and Hispanic/Latinx population making use of the sites, though many of those testing did not report their ethnicity, and issues regarding invisibility in race and ethnicity data collection categories for these populations made it difficult to ascertain their exact testing uptake.

Starting in May 2022, the OTC test kit program distributed over 10,000 test kits in total, with 4,699 of these test kits distributed at neighborhood testing sites. An on-site test was not required for individuals to obtain OTC test kits, and each household was provided with up to six free test kits.



Note: Sourced from MDHHS – Michigan Disease Surveillance System; Data accessed November 2, 2022.

Figure 4. Average of number of tests per neighborhood testing event.



Note: Sourced from MDHHS – Michigan Disease Surveillance System; Data accessed November 2, 2022.

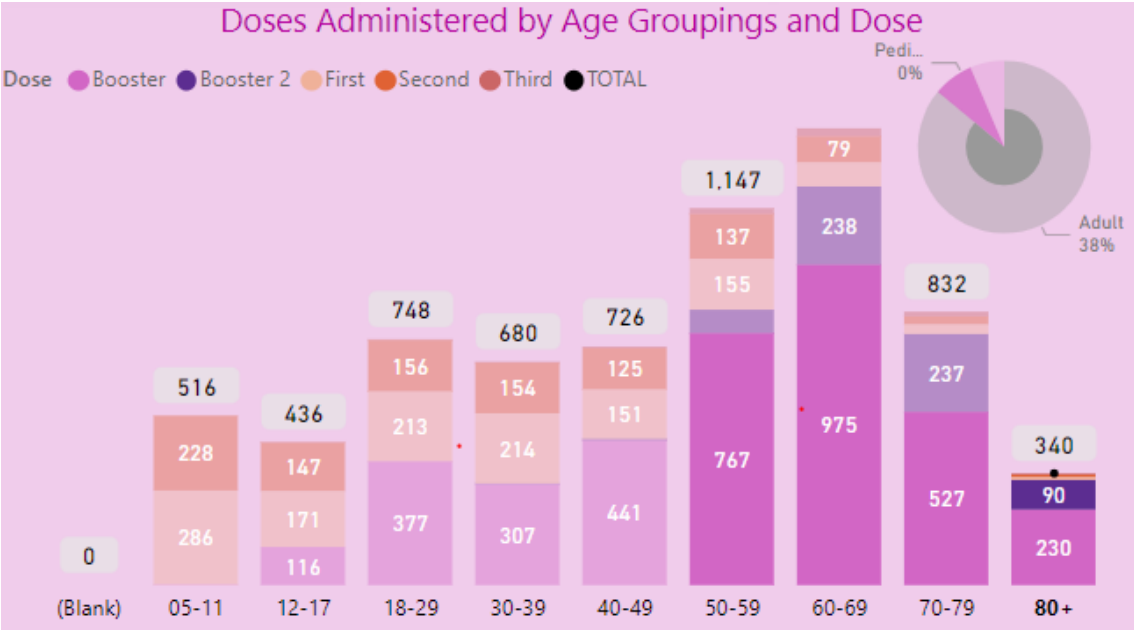
Figure 5. Neighborhood testing events and COVID-19 test positivity.

Immunizations

In the fall and winter of 2020 and 2021, pop-up flu vaccinations were incorporated in the testing sites to combat the annual flu epidemic and further protect community members from COVID-19. Testing sites later expanded to include the Pfizer and Moderna COVID-19 vaccines, which were rolled out between November 2021 and May 2022. As these efforts to rapidly provide services to communities that needed them slowed down due to decreased demand in 2022, the Task Force began to gather data on best practices for COVID-19 response, to be able to effectively respond to potential future needs, such as further waves of COVID-19 and other public health emergencies.

Neighborhood testing sites hosted 2,364 vaccination events, administering 6,815 shots in arms between November 2021 and May 2022. Of those who received vaccines at these sites, 67% identified as Black or African American and another 3% identified as Asian, Hispanic, American Indian or Native American, or other races. Additionally, 4% of those receiving vaccines were of Hispanic ethnicity. About 8% of those vaccinated at the sites said that they were disabled, and 37% were over 60 years old.

As shown in Figure 6, most vaccines provided at neighborhood testing sites were booster doses. Among those above 50 years old, booster doses were the most common vaccines provided; most of these individuals already had received their first two doses and were protecting themselves further with booster doses. Additionally, many young people below 40 years old got their first and second doses at the neighborhood testing sites. Neighborhood testing sites served as an accessible hub for vaccines, serving communities based on their specific needs stratified by age.



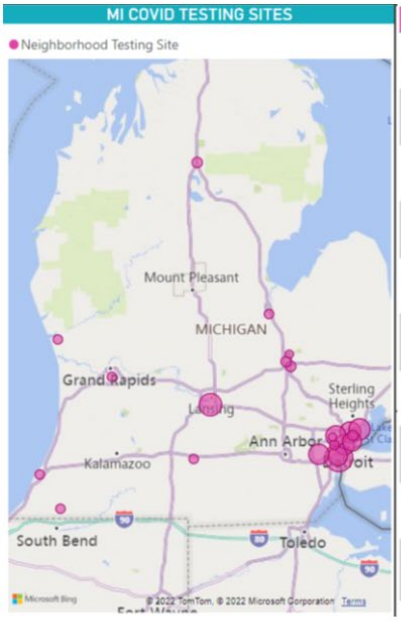
Note: Sourced from MDHHS – Michigan Disease Surveillance System; Data accessed December 7, 2022.

Figure 6. Vaccine dose numbers provided at neighborhood testing sites by age group.

Community Needs Survey and Additional Resources

Throughout the pandemic, sites responded to unprecedented testing needs during the alpha, delta and omicron surges by quickly adapting to new strategies and increasing testing volumes, while prioritizing community engagement, cultural competency, and access. For example, registration at the testing sites started implementing a Community Needs Survey to understand what additional resources the community would use if offered, with the purpose of strengthening community ties to the sites – these included additional health services, counseling, and resource referrals. First-source hiring practices were used to employ members of the community to work at the sites, with residents being given access to hiring before the public. This was intended to increase racial and ethnic representation and economic empowerment. Site leaders were considered subject matter experts in the sites at which they worked and provided oversight. Finally, eight community town hall sessions were hosted with site partners and MDHHS staff to address key topics surrounding COVID-19 and overall wellness.

While the neighborhood testing sites program faced some challenges, such as linking community members with vaccine education and access after the end of the vaccination program, navigating fluctuating testing volumes and managing relationships with vendors, it was able to mitigate them through robust resource management, problem-solving, and building trusting community relationships with vendors. The Task Force provided strong support of this program through general oversight.



Neighborhood Site	Event Times	link	City
Albion College - Washington Gardner	Mon 12pm-7pm Wed 12pm-7pm Fri 9am-5pm		Albion
All God's People Church	Tue 10am-3pm Wed 10am-3pm Thu 10am-6pm		Roseville
Bethel Baptist Church East	Mon 10am-5pm Wed 10am-6pm Fri 10am-5pm		Detroit
Bethel United Methodist Church	Tue 10am-4pm Wed 10am-4pm Thu 1pm-7pm		Flint
Christ Temple Church	Mon 10am-4pm Tue 10am-5pm Thu 12pm-7pm		Muskegon Heights
Epicenter of Worship	Tue 10am-6pm Thu 10am-5pm Fri 9am-4pm		Lansing
Hartford Memorial Baptist Church	Mon 10am-5pm Thu 10am-5pm Fri 9am-4pm		Detroit
Historic King Solomon Site	Thu 10am-6pm Fri 10am-6pm Sat 9am-2pm		Detroit
Hope Community Church	Mon 10am-5pm Wed 10am-5pm Thu 12pm-7pm		Niles
International Gospel Center	Mon 10am-6pm Tue 10am-6pm Wed 10am-6pm		Ecorse
Kirtland Community College	Tue 10am-5pm Wed 10am-5pm Thu 10am-6pm		Grayling

Neighborhood Site	Event Times	link	City
Macedonia Baptist Church	Mon 10am-3pm Fri 10am-3pm Sat 10am-3pm		Flint
Mt. Calvary Lutheran Church	Wed 12pm-7pm Thu 9:30am-4:30pm Fri 9:30am-4:30pm		Warren
New Beginnings Deliverance Ministry	Mon 10am-5pm Tue 10am-5pm Thu 10am-5pm		Saginaw
New Hope Missionary Baptist Church	Mon 10am-6pm Wed 12pm-8pm Fri 10am-6pm		Wayne
Pilgrim Rest Baptist Church	Tue 10am-5pm Thu 10am-5pm Sat 10am-2pm		Benton Harbo
Renaissance Church of God in Christ (COGIC)	Mon 10am-5pm Wed 10am-5pm Thu 1pm-6pm		Grand Rapids
Southwestern Church of God	Mon 10am-6pm Wed 10am-6pm Thu 10am-6pm		Detroit
The Open Door Church of God in Christ	Tue 10am-6pm Wed 10am-6pm Thu 10am-6pm		Detroit
Triumph Church	Mon 10am-6pm Wed 10am-6pm Fri 10am-6pm		Detroit
Wayne County Community College District Northwest Campus	Tue 9am-5pm Wed 11am-7pm Sat 10am-2pm		Detroit
Word of Life Church Site	Tue 12pm-6pm Wed 12pm-6pm Thu 12pm-6pm		Flint

Note: Sourced from MDHHS – Michigan Disease Surveillance System; Data accessed December 7, 2022.

Figure 7. Neighborhood testing sites and event times as of December 2022.

Mobile Health Units

Mobile Health Units (MHUs), developed by Dr. Phillip Levy and his team (Levy, et al., 2021), were launched by MDHHS and Wayne Health and supported by the Task Force. In 2020, $6.8 million was allocated for MHU purchasing and setup. Since November 2020, nine MHUs have been launched—with locations in Genesee, Ingham, Kent, Muskegon, Wayne Counties. MHU sites were selected to concentrate on majority-minority areas with large Black populations. MHUs have the unique capability to meet Michiganders where they are – whether that is at churches, community centers, schools, or homes. The MDHHS and Wayne Health teams worked to eliminate barriers to care, such as transportation, disabilities, time, and challenges associated with rural and urban areas. All vehicles were designed and upfitted specifically for mobile services in collaboration with Ford Motor Company. Since June 2021, MHUs have administered 52,460 COVID-19 tests and 28,308 COVID-19 vaccinations.

MDHHS supported the staffing and service arrangement for the MHUs, which quickly expanded beyond testing and vaccination due to substantial state and federal funding. In addition to the issues that emerged around COVID-19 disparities in communities of color, MHUs began to address existing public health issues emerging from systemic racism, such as excess risk attributable to chronic conditions such as diabetes, heart disease and high blood pressure. As prevention care for these conditions is underutilized even amongst insured individuals in communities of color, there was a need for providing care with fewer barriers to patients in these communities (Brook et al., 2022).

Services offered included behavioral and substance use, cardiovascular and chronic health screenings, HIV, hepatitis and STI testing, women's health services, PPE distribution, referrals, linkages to further care, food, transportation, homelessness assistance and vaccine hesitancy education. The full array of services offered in each county is shown in Table 2.

Table 2. MHU Services offered in Genesee, Ingham, Kent, Muskegon and Wayne Counties.

Health Service/Resource	Genesee	Ingham	Kent	Muskegon	Wayne
Behavioral health	X				X
Blood pressure screening		X			X
Blood work screenings					X
Cardio Screenings*					X
Cholesterol Screening		X			
COVID-19: Antigen Testing					
COVID-19: OTC Test Distribution		X		X	X
COVID-19: PCR Testing	X	X			X
COVID-19: Vaccinations	X	X	X	X	X
Flu vaccinations	X	X	X	X	X
Food assistance	X				X
Glucose Screening		X			

HIV/STI testing		X	X		X
Homelessness assistance					
Lead case management referral				X	
Lead testing		X	X		X^
Mask distribution		X		X	
Medicaid Outreach		X			
Mental Health Referrals					X
Mentoring Referral				X	
PCP links					X
Rapid HCV Testing					X
SDOH referrals	X				X
Specialist referrals					X
Sterile Need Exchange					X
SUD support/referrals	X	X			X
Suicide Prevention					
Transportation assistance					X
Vaccine hesitancy education	X		X	X	
Vector-borne illness education				X	
Vital signs					X
WIC services			X	X	

*Coming Soon

^Partnership with MDHHS lead program

MHUs also implemented the OTC testing kit program, allowing MDHHS to directly purchase kits as needed. A large part of the work to implement MHUs was creating a linkage between the MHUs and primary care referrals as well as various wraparound services. MHUs in Genesee, Ingham, Kent, and Wayne Counties have had community navigators on site to assist with patient linkage to care as well as insurance and Medicaid enrollment. The MHU in Muskegon County does not routinely have community navigators on site but is sometimes co-located with partners at events who offer this service; however, it is not an inbuilt feature of the site at this time. Additionally, therapeutics education was made available to patients, and quarterly gatherings were scheduled with all MHU representatives to share insights and improve the program.

Challenges in implementation of MHUs mostly were in vehicle purchase and in reimbursement of laboratory costs. The TTC team worked to mitigate these challenges. Initially, MDHHS engaged in the vehicle purchasing process; MDHHS was not accustomed to this process. As the program progressed, MDHHS staff shifted the process so local health departments (LHDs) could purchase the vehicles instead. Contracts added funding to support LHDs in purchasing the vehicles. Early in the pandemic, some insurance companies were not reimbursing organizations for laboratory costs associated with COVID-19 testing. MDHHS required organizations to bill insurance companies for reimbursement. If organizations were not able to receive reimbursement, MDHHS determined its own reimbursement rate. Very few of the organizations funded for MHUs requested

reimbursement for services. Improvements were needed to track the total costs that were not reimbursed. Finally, sustainability was another concern for MHU implementation; expansion and funding became priorities for the Task Force and MDHHS later in the pandemic, eventually establishing the need for the Mobile Health Workgroup.

Test to Treat Sites

Test to Treat (T2T) is a federally funded telehealth program with the purpose of ensuring rapid lifesaving COVID-19 treatment with oral medications for individuals at high risk. It also allows people with limited access to primary care services to have opportunities for education and empowers individuals to have agency over their own health and manage their COVID-19 symptoms. Michigan was the first state to fully implement T2T, and the only one to roll out the program at community and neighborhood testing sites. The program, which was launched in August 2022 and ended in November 2022, helped Michiganders avoid severe illness, hospitalization and death. Thirteen T2T sites were selected based on high SVI and community need, 12 of which were existing neighborhood testing sites and one of which was a community testing site.

The T2T program ensured early, one-stop access to no-cost COVID-19 oral antiviral medications for individuals who may be at high risk for COVID-19 complications. It also provided education to patients; the program developed and disseminated educational materials about treatment options in areas with limited access to primary care providers and provided virtual and phone primary care services in an accessible location. The T2T program was implemented at existing testing sites, which were already known in communities.

Some challenges in program implementation included the onboarding of sites appropriate for the T2T program criteria, limited program utilization, and network connectivity issues. However, the program was able to mitigate these challenges. The TCC team was able to find alternative sites quickly when they ran into contractual uncertainties that made it difficult to add the T2T program to existing sites. Limited program utilization was addressed by MDHHS creating press releases and promotional materials including program talking points, indoor and outdoor signs, and other educational materials which were distributed via various communication platforms. The TCC team also created training, program education, and registration script materials for all the on-site staff to educate visitors to the sites and conducted site visits to identify gaps in program uptake.

Between August and November 2022, Michigan's T2T program provided telehealth services to 113 individuals; 71 were supported by phone and 42 were supported by video visit on site (Table 3). The most utilized T2T site was Albion College with 46 individuals. Thus, the T2T program was able to reach an underserved population in a rural area. An evaluation plan for the T2T program was created, which includes data analysis on program utilization, technical aspect evaluation, process evaluation and community evaluation. A recent study released by the Centers for Disease Control

and Prevention indicated that national disparities in receiving medications for COVID-19 treatment such as the antiviral pill Paxlovid continue to persist (Boehmer, 2022). Such findings make the utility of T2T initiatives critically important for vulnerable communities.

Table 3. Test to Treat Sites Utilization

Site Name	Days Live	Tests Administered	Tests Positive	Total Patients	Total Rx	Support by Phone	Support by Video
Southwestern Church of God (Detroit)	53	92	13	0	0	0	0
Bethel Baptist Church East (Detroit)	56	366	28	7	4	2	5
Wayne County Community College Northwest Campus (Detroit)	74	380	33	2	2	1	1
New Hope Missionary Baptist Church (Southfield)	58	227	33	4	4	4	0
International Gospel Center (Ecorse)	57	129	15	2	0	2	0
Albion College (Albion)	74	656	172	48	36	27	21
Pilgrim Rest Baptist Church (Detroit)	52	59	6	1	1	0	1
Christ Temple Church (Muskegon)	52	189	40	16	11	9	7
New Beginnings Church (Saginaw)	64	161	18	4	2	2	2
Macedonia Baptist Church (Flint)	63	470	65	4	3	3	1
Word of Life Christian Church (Flint)	74	528	85	13	9	12	1
Westwood Mall (Marquette)	57	433	104	12	10	9	3
Mt. Calvary Lutheran Church (Warren)	50	67	10	0	0	0	0
Total		3,757	622	113	82	71	42

Migrant Farmworkers: Reductions in Infections and Vaccine Accessibility Efforts

During the pandemic, migrant and seasonal farmworkers became uniquely at risk of contracting and spreading COVID-19. Due to their essential role in the production of state and national food supplies of dairy, egg, meat and other foods, these workers were exempt from stay-at-home orders early in the pandemic and had difficulties in maintaining social distancing at work. Additionally, congregate housing for greenhouse and asparagus harvesting operations reported significant COVID-19 outbreaks. Due to these conditions, as well as compounding chronic conditions, Michigan's migrant and agricultural workers were at increased risk of serious illness, hospitalization and death. Barriers to preventing COVID-19 spread and access to care were also pronounced in this population, including a lack of health insurance, living in rural areas with limited transportation to

health care services, and immigration status and racism, which contributed to an increased mistrust of government and other authorities. It was difficult to impose isolation and quarantine periods on migrant workers, due to the nature of their jobs. Workers are often paid weekly or daily, and isolation or quarantine periods could force them to forgo income or food. Additionally, migrant worker camps did not always have facilities on site appropriate or adequate for isolation or quarantine.

In response to these conditions, the Executive Office of the Governor (EOG) worked with various migrant services agencies within the state government, including the Office of Migrant Affairs (OMA) at MDHHS, the Michigan Labor Housing Program (MLHP) at the Michigan Department of Agriculture and Rural Development (MDARD), and the Office of Education and Training at the Michigan Department of Labor and Economic Opportunity (LEO-E&T). They developed eight community workgroups which collaborated with local health departments, federally qualified health centers (FQHCs) and community action agencies.

Health priorities of the community workgroups focused initially on ensuring access to PPE, including masks and sanitizing supplies. The LEO-E&T Agricultural and Foreign Labor Services Section developed safety outreach guidelines for their staff so that they could provide orientations to agricultural employers and their staff about COVID-19 prevention. There were 1,667 orientations held to train 11,500 workers. The Office of Global Michigan and Mexican Consulate of Detroit also translated and disseminated important educational materials and documents in Spanish to help increase trust.

COVID-19 testing and treatment were another major health priority. Emergency Services Only Medicaid was expanded to include coverage of inpatient and outpatient testing services and treatment in May 2020, so agricultural workers who were recent immigrants, H-2A recipients, or undocumented could qualify for this government benefit. Challenges arose in trying to increase voluntary COVID-19 testing, however. Thus, the Task Force advocated for a public health order to be issued by MDHHS, which directed agricultural employers to provide adult residents in licensed migrant labor housing and other high-risk agricultural employees testing and quarantining. In 2020, 370 employers and housing facilities provided testing for 14,156 workers. The state also supported provision of isolation and quarantine housing for suspected and confirmed COVID-19 cases for those who could not isolate at their own housing sites. COVID-19 testing was expanded in 2021 to include community testing locations and MDHHS and MDARD collaborated to provide migrant camp providers free COVID-19 test kits. Through July 2021, a further 61 employers provided testing for 1,528 workers.

Additionally, migrant and seasonal farmworkers were prioritized as essential workers for vaccine access between March and May 2021, as they were considered a vulnerable population. The Protect Michigan Commission (PMC), which was charged with helping raise awareness about the

safety and effectiveness of the vaccines, sought feedback from the community workgroups about migrant workers' needs and concerns. They found that workers were most concerned about vaccine cost, whether it was available regardless of their immigration status and what information and identification would be requested from them at vaccination sites. The PMC created a communication toolkit to address these issues, and the MDHHS OMS staff engaged agricultural workers on the vaccine to educate them, dispel myths and connect them with vaccinations. MDHHS also worked with FQHCs that were tasked with partnering with employers and migrant labor housing providers for onsite vaccinations and setting up sites in other locations. The Michigan Primary Care Association (MPCA) also created an online method for requesting vaccinations, which the community workgroups publicized. The FQHCs were able to provide migrant and seasonal workers more than 4,000 vaccinations between March and June 2021.

Public Health Data Monitoring Improvements & Data-Driven Resource Allocation

The Task Force prioritized various public health data improvements, such as the tracking of race and ethnicity in COVID-19 demographic data and statistics and supported related efforts by MDHHS and the State of Michigan. Many response initiatives in Michigan employed tools such as the social vulnerability index (SVI) and census tract data to assess community vulnerability and inform strategic site locations. SVI is a metric developed by the CDC to assess and map community-level vulnerability to natural and/or human-caused disasters. It is measured by a score comprised of 16 different socioeconomic factors – including variables related to housing, minority status, language use, socioeconomic status, household composition and ability status. An investment in data disaggregation and quality improvement also helped shape the direction in which the response moved throughout the pandemic.

Homebound Vaccination

Michigan has a significant population of seniors who are considered homebound, as they are unable to leave their homes. It is estimated that there are around 100,000 homebound seniors in Michigan, making them an especially vulnerable population in need of linkage to COVID-19 vaccination services. In collaboration with MDHHS, the Detroit Area Agency on Aging (DAAA) worked to provide COVID-19 vaccines to seniors who were not able to leave their homes in the Detroit area. This was an especially underserved population, as it comprised mainly of isolated seniors from communities of color. According to the Dying Before Their Time III report in 2020, which was commissioned by DAAA and prepared and completed by the Wayne State University School of Medicine, older adults in the Detroit area were dying at 2 to 2.5 times the rate of their counterparts elsewhere in Michigan (Detroit Area Agency on Aging, 2020).

DAAA conducted a vaccination pilot program for homebound seniors and people with disabilities in 2021, in collaboration with MDHHS. They identified people to vaccinate through a robocall campaign to contact approximately 4,000 individuals who had prior contact with the agency. An infrastructure was built for homebound vaccination; DAAA procured Moderna vaccines, program

training for nurses, data management and project medical advisors through a partnership with the Health Centers Detroit Foundation, a community health center organization. They also contracted with six home health agencies to provide 25 nurse staff. Through this pilot, DAAA was able to vaccinate 300 individuals in two days. Lessons learned included ensuring that extra syringes were available in case of faulty tips and improving scheduling. The pilot helped inform a broader rollout of homebound vaccination in Michigan and improved knowledge of the staff and resources needed to carry out such an effort to scale.

MDHHS partnered with Area Agencies on Aging (AAAs) around the state, as well as Meals on Wheels programs, Medicaid and local health departments to identify homebound seniors to vaccinate and begin making vaccination house calls. By early April 2021, around 21,000 homebound seniors throughout the state had received the COVID-19 vaccination series. Later in June 2021, the DAAA planned a large push to get the estimated remaining 40,000 homebound seniors in Michigan vaccinated.

Vaccine Equity Work

As the COVID-19 vaccine was rolled out to the public, MDHHS conducted efforts to improve equity in vaccine distribution and uptake among communities of color. The MDHHS Department of Immunizations identified the top 15 priority census tract areas in Michigan, based on high SVI, low vaccine coverage rates and accessibility of and distance to vaccine providers. Five of these areas were rural, and 10 of them were urban. These areas included: Pontiac (2), Taylor, Detroit (2), Flint, Buena Vista Township, Hamtramck, La Grange Township, Inkster, Bangor Township, Vassar Township, Coldwater, Adrian and Covert Township.

In May 2022, meetings were held with local health departments (LHDs) in each of these areas to review data and discuss characteristics of each census tract including existing partnerships, ongoing equity work, and collaboration opportunities to address vaccine hesitancy in each community. LHDs expressed the need to address misinformation, rebuild trust in communities and create forums to discuss vaccine equity efforts with peers. A vaccine equity tracking list was created and shared to increase transparency between MDHHS and the LHDs, and a monthly workgroup for LHD partners to meet was established. This workgroup met four times in 2022, sharing best practices from each of their respective areas. The MDHHS Department of Immunizations team also created a vaccine equity and hesitancy toolkit, which was shared with the workgroup.

In December 2022, the LHD workgroup was reconvened for planning efforts with Medical Network One, a state-funded contractor for mobile health clinics. LHDs are actively working with Medical Network One to increase vaccine uptake in priority census tracts. These clinics will begin offering vaccines in 2023. Additionally, Michigan's Chief Medical Executive Dr. Natasha Bagdasarian participated in nine grand round speaker opportunities in 2022 to discuss vaccine confidence, barriers to vaccine uptake and the essential role that providers play as trusted messengers in communities.

Vaccine Hesitancy Focus Groups

After vaccine rollout, vaccine hesitancy among communities of color in Michigan remained. Vaccination rates among young children were also low in Detroit; only 7% of children between age 5 and 11 were vaccinated in early 2022. The Task Force wanted to learn more about the impact of vaccine hesitancy on Black and Brown children in Detroit. The Detroit Metro Area Communities Study (DMACS) survey showed that in 2021, 75% of adults in Detroit were vaccinated but only 49% of parents of children in Detroit were vaccinated; most of these parents said they were either uncertain or uncomfortable about the vaccine, and this hesitancy extended to their children (Detroit Metro Area Communities Study, 2022).

The Task Force was provided funding to conduct focus groups to learn more about vaccine hesitancy among parents in Detroit. Focus groups provided an opportunity for the Task Force to build on previous research and learn more about the factors contributing to vaccine hesitancy among parents and to identify potential strategies and approaches to the issue.

Along with MDHHS and JFM Consulting Group, a Detroit-based planning, strategy and evaluation consulting firm, focus groups were conducted in 2022. JFM Consulting Group conducted five focus groups, each lasting one hour, and two supplemental interviews. All 22 participants were recruited from local school districts. Sixteen participants had children enrolled in Detroit Public Schools Community District (DPSCD), four were from charter schools, and two were recruited from the Detroit Parent Network (DPN). Additionally, interviews were conducted with public officials and other key informants.

The main findings of these focus groups were:

- Many participants were concerned about vaccinating their children due to historical harm done to Black communities by the medical establishment.
- Major factors in vaccine hesitancy included the fast pace of approval and lack of studies that included participants like their children (e.g., Black children with asthma and other conditions), concerns about long-term side effects and a lack of confidence in the vaccine's effectiveness.
- Public officials warned that disparities in vaccination rates could have strong negative effects on education for Black and Brown children.
- Trusted sources varied, but generally included doctors, nurses, pastors, family and friends; on the other hand, many parents were wary of broad mass-marketing campaigns.
- Mandates generally do not help build trust among parents.
- Public officials underscored the value of parents having personal interactions with their trusted sources.
- Creating targeted information for parents of Black and Brown children would be helpful.

COVID-19 Vaccine Learning Tables

The Task Force was provided funding in 2022 to organize learning tables for leaders in local and state government to discuss and share strategies for increasing vaccine uptake in communities of color, both in Michigan and throughout the United States. All learning tables were conducted by The Barthwell Group, a Detroit-based consulting firm. In total, there were four two-hour learning tables – two intrastate (within Michigan) and two interstate (throughout the US).

First, the intrastate learning tables were conducted with 16 representatives from 11 geographical areas in Michigan. During the initial Learning Table, participants shared high-level insights regarding general strategies and processes to promote vaccine uptake. During the second Learning Table, participants discussed with greater specificity tactics, methodologies, successes and challenges to enhance vaccinations among underserved populations. They often differentiated successful vaccination strategies for African Americans, Hispanics/Latinx, Native Americans and migrant workers.

The interstate learning tables were conducted with 11 representatives from nine different geographical areas in the U.S. The initial Learning Table provided the foundation to discuss the focal points of vaccination strategies that worked. Participants discussed how they selected priority areas, utilized infrastructure and data for vaccine distribution and developed strategies to promote or educate about the benefits of vaccination. In the second Learning Table, participants compared specific strategies which were effective for different demographic groups, sources of distrust and types of messaging. Participants shared frustrations regarding challenges and collaborated on effective solutions (The Barthwell Group, 2022).

Strategic Communication Strategies

Throughout the pandemic, the MDHHS Communications team developed communications and campaign strategies critical to reaching Michiganders where they were and focusing on those who were the most vulnerable. Increasing education and awareness and removing barriers became top priorities to reduce severe illness and deaths in communities across Michigan. Many of the factors that made some Michiganders more vulnerable to the virus, such as a lack of technology, access or trust, also served as barriers that made them difficult to reach through traditional communication channels. The MDHHS Communications team examined and deployed innovative approaches to ensure that critical information reached these populations.

Among rapidly shifting information, the Communications team responded in a fluid manner. Being able to respond quickly and connect with local and community partners was critical to successfully reaching as many Michiganders as necessary to increase education and reduce harm. A combination of paid and earned media, research and targeted outreach, digital and virtual strategies, and connecting with residents where they live, was critical to influencing behavior and

building awareness. This messaging was about best practices for staying safe, access to testing and vaccination services, and linkage to critical resources and care.

Targeted campaigns involved diverse platforms, including YouTube, Hulu, Connected TV, radio, Spotify and Pandora, print ads, gas station TV, outdoor billboards, posters at salons and barbershops, social media (e.g., Reddit, TikTok, Snapchat, Facebook, Instagram, Twitter and Nextdoor), and website embedding. Additionally, in collaboration with Mario Morrow & Associates, LLC, a public relations consulting firm based in Southfield, Michigan, detailed messaging strategies for communities of color were developed with an emphasis on faith-based organizations and community engagement.

The Communications team also created materials to address vaccination demographics through media advertisement campaigns and social media. This notably included the "Between Friends" program in 2021, which was created to address Michiganders who are millennials or Gen Z'ers and developed with the support of the Task Force and Mario Morrow & Associates, LLC. As young Black and Hispanic people between 16 and 39 years old had the lowest vaccine completion rates and comprised a substantially high percentage of new COVID-19 cases at that time, they were the selected target audience for this campaign. A campaign for MDHHS Communications was created to distribute videos on social media channels that included conversations in a live podcast form about the vaccine between local influencers such as community leaders, medical professionals and others that young people of color consider trustworthy. These videos were intended to educate young people with accurate information about the vaccine and equip them with talking points and resources such as the Mi COVID Alert App.

To assess the extent to which such campaigns were successful, we looked at vaccination coverage by age group. Data show that over 6.1 million Michiganders have completed the primary series, or 62% of the state population, with completion rates ranging from 65.6% to 91% across different age groups. The percentage of Michiganders who have received the updated Bivalent booster vaccine is higher compared to corresponding percentages nationally (Table 4).

Table 4. Updated booster vaccination coverage by age group as of 11/25/2022.

Age Group	Michigan %*	U.S. %*
≥ 5 years	14.2%	12.7%
≥ 12 years	15.4%	13.8%
≥ 18 years	16.2%	14.7%
≥ 65 years	37.1%	32.6%

*Percentage of residents ages 5 years and older with an updated (bivalent) booster dose.

In addition, the latest monthly survey findings from November 2022 of the Vaccine Confidence Survey conducted by the CDC (Trends in COVID-19 Vaccine Confidence) suggest that the percentage of Black/African American adults in Michigan with no intention of getting vaccinated may be as low as 1.2%. However, vaccine uptake disparities by race and geography persist (see Supplementary Figures 6 through 10 in Appendix I), and the work outlined above needs to continue to combat these disparities.

Reducing Longstanding Disparities in Health Care

The COVID-19 pandemic revealed the systemic way in which racial disparities embedded themselves in health care for communities of color. The magnitude of these disparities prompted the Task Force to focus on the consequences of longstanding structural inequalities with respect to access and utilization of health care among underserved minority populations. A major initiative in this area included efforts to reduce Michigan's uninsured minority population and connect individuals with primary care services. Other critically important efforts included extending access to health care to people with sickle cell disease, the vast majority of whom are Black or Hispanic, and improving the health of infants and mothers, including women of color who are more likely to die from pregnancy-related causes than white women, and whose infants are more likely to die before they reach their first birthday. Finally, the Task Force focused on integrating vaccine services with school-based health care in Detroit and other areas with large communities of color.

Uninsured Minority Population

The COVID-19 pandemic led to a historically high number of uninsured and underinsured people in Michigan, disproportionately impacting the Black and African American community. This has exacerbated the burden of chronic health conditions and severe COVID-19 for Black individuals. Several short- and long-term efforts were launched to connect those in vulnerable communities to existing state infrastructure to assist them in navigating the health care system. The Task Force supported efforts to connect uninsured individuals with insurance enrollment and health care navigation.

Medicaid Enrollment & Navigation

MDHHS and the Michigan Department of Insurance and Financial Services (DIFS) have historically worked together to help Michiganders learn about their options for affordable care, including Medicaid and federal marketplace insurance. Earlier in the pandemic, a "no wrong door" approach was developed to use COVID-19 testing and quarantine and isolation follow-up as opportunities to screen and refer residents to insurance enrollment programs.

A partnership was also formed between MDHHS and the Michigan Departments of Treasury and Labor and Economic Opportunity (LEO). Those who lost their health insurance during the pandemic due to job loss or other reasons and who were eligible for Medicaid were identified to facilitate enrollment. Identified individuals could then request information on benefits and how to get enrolled.

According to the Centers for Medicare and Medicaid Services **(**CMS) Enrollment Trends report, the 13.9% increase of Medicaid enrollment between February 2020 and January 2021 is largely attributed to the impact of the temporary 6.2% payment increase in Federal Medical Assistance Percentage (FMAP) funding (Centers for Medicare and Medicaid Services, 2021). Michigan qualified for this payment increase by adhering to the Maintenance of Effort requirement, which ensures eligible people enrolled in Medicaid stay enrolled and covered during the PHE. Medicaid and CHIP enrollment in Michigan also increased 28.2% between February 2020 and September 2022 (Kaiser Family Foundation, 2023).

Federal Marketplace Enrollment

Throughout the pandemic, DIFS took a series of actions to facilitate an increase in enrollment of Michiganders in private health insurance plans through the federal marketplace. In 2020, Governor Whitmer and DIFS called on the federal government to expand insurance enrollment opportunities by opening a special enrollment period at the beginning of the pandemic. Later in the year, they also promoted extending the open enrollment period for the next year. Other enrollment opportunities were promoted, such as coverage for those who lost their job or a drop in income, and special enrollment periods for American Indians and Alaska Natives. Around $1 million was invested in community-based organizations that helped contact 1 million Michiganders about open enrollment through the CARES Act.

In 2021 and 2022, Governor Whitmer and DIFS continued to work together to educate and support Michiganders in open and special enrollment for marketplace plans. This included securing an agreement with all nine marketplace insurers to allow consumers to take advantage of expanded tax subsidies under the American Rescue Plan without restarting their deductibles and securing extended agreements with more than 90% of commercial insurers to provide consumers coverage for COVID-19 testing and treatment at no cost. Under the Inflation Reduction Act in 2022, marketplace premium subsidies were extended until at least 2025. DIFS also issued guidance for insurance companies to reduce their rates for 2023 because of the extension of premium subsidies.

The 2021 open enrollment period (November 2021-January 2022) newly enrolled 303,550 Michiganders, which was a 14% increase from the previous year, and an almost 16% increase over 2019 before the pandemic. These were the highest enrollment numbers during the COVID-19 pandemic, with an increasing trend throughout the pandemic; the 2020 open enrollment period enrolled 267,070 Michiganders, and the 2021 special enrollment period enrolled 47,306.

To market enrollment, DIFS put out several press releases each enrollment period, created social media toolkits for legislators and other stakeholders and held virtual town halls. In 2021, DIFS worked with Senator Gary Peters on a virtual press conference to promote the special enrollment period. For the 2022 open enrollment period, DIFS also hosted three open enrollment town halls in

December 2022 and January 2023, which were intended to inform Michiganders about new health plan options, newly extended savings and increased opportunities for free enrollment assistance.

Sickle Cell Disease

Sickle cell disease is a condition associated with significant health complications across the lifespan, such as pain, stroke, infection and reduced average life expectancy. The risk of adverse health outcomes is exacerbated in Black and Hispanic communities, which experience a high prevalence of the disease. Until recently, the Children's Special Health Care Services (CSHCS) program, which serves children and some adults with special health care needs, only covered Michigan residents with sickle cell disease up to 21 years of age, while the same program covers both adults and children for other similar diseases such as hemophilia and cystic fibrosis.

In FY22, a proposal for $6.7 million was accepted regarding sickle cell disease treatment improvement. In November 2021, Michigan expanded CSHCS coverage to include people living with sickle cell disease over 21 years of age who are not eligible for Medicaid ($5.3 million). This addressed the institutional racial disparity in coverage. To successfully implement this coverage expansion, MDHHS partnered with the Michigan Sickle Cell Data Collection (MiSCDC) program at the University of Michigan to identify adults with sickle cell disease who are newly eligible for CSHCS coverage. The partnership identified 2,569 adults living with sickle cell disease in Michigan who are eligible to enroll in the new CSHCS expansion. Initially, only 400 eligible people were identified using CSHCS enrollment data. However, an additional 2,169 eligible people were identified by leveraging the multi-source MiSCDC database. Of the additional people identified, 24% were adults who had been enrolled in CSHCS prior to 2015, while the remaining 76% were adults who had never been previously enrolled in CSHCS.

In addition, this funding enhanced and expanded services provided by the Sickle Cell Disease Association of America to improve quality of life ($690,000). MDHHS worked with the Sickle Cell Disease Association of America to expand on existing services to increase advocacy, outreach and referral services that go beyond medical treatment.

Finally, this program invested in statewide clinical treatment and testing capacity at the Children's Hospital of Michigan, and clinics in Detroit, Flint, Lansing, Grand Rapids and Ann Arbor ($610,000). Clinics used these funds to support staffing costs, improve care coordination with multidisciplinary providers and health plans, and establish more robust provider networks. Investment in clinics was intended to improve access to long-term follow up, statewide disease education opportunities and outreach for sickle cell trait testing.

Mothers and Infants

The Task Force identified mothers and infants as a group facing worsening disparities during the COVID-19 pandemic. Governor Whitmer announced the Healthy Moms Healthy Babies program to address these disparities. The Task Force has consequently worked with MDHHS staff to help the EOG secure expanded Medicaid coverage for a full 12-month postpartum period to ensure the health and well-being of mothers and infants across Michigan. This coverage expansion has now been approved by CMS.

School-Based Health

A city of Detroit grant was provided to the Detroit Health Department to implement a vaccination pilot program in 2022. MDHHS partnered with the Detroit Health Department to move the pilot over to the Detroit Public School Community District (DPSCD) instead, which would begin a program to provide students, parents, staff and other community members all immunizations, including COVID-19. DPSCD has 100 schools, of which 18 have school-based health centers. The purpose of this funding was to obtain initial vaccine storage equipment at two schools that did not already have school-based health centers. A city of Detroit vaccine coordinator was hired to manage this project. District nurses were trained to vaccinate at all DPSCD schools. The school pilot planned to equip nurses with transport and coolers, which they could then take to each school where they offer vaccinations.

Addressing the Root Causes of Racial Disparities

The Task Force and workgroups understood what was driving the disparities to begin with: bias in health care provision, environmental factors and exposure and disparities in comorbidities, such as heart disease and obesity. Each workgroup was developed to support initiatives within MDHHS and other State of Michigan departments, in collaboration with community organizations. Initiatives that responded to the causes of the racial disparities during the COVID-19 pandemic were meant to create sustainable, lasting change in the face of systemic disparities. This included addressing implicit bias among individuals who provide essential services to the State of Michigan and the residents within it, equity impact assessments to assist state departments in addressing inequities within their operations, improving language access for inclusion in various State of Michigan departments, implementing environmental health and climate initiatives that support communities of color, and addressing gaps in maternal and child health that lead to high rates of morbidity and mortality amongst Black and Brown mothers and babies.

Implicit Bias Training

The Task Force supported statewide efforts to reduce systemic racism within the state government and health care facilities by encouraging the implementation of implicit bias training for state employees and health care workers. These efforts were pushed strongly by the Task Force's collaboration and recommendations to implement tools which would strengthen equity within these organizations, as well as for patients of color seeking health care.

State of Michigan Employees

Starting December 2020, an executive directive from Governor Whitmer stated that State of Michigan employees were required to take implicit bias training. For existing State of Michigan employees, implicit bias training delivered by a virtual or live training developed by departmental equity officers was required to be completed by the end of 2020 and subsequently retaken every other year. As of November 2022, of the estimated 47,000 state employees, 45,663 successfully completed the training, representing an overall 97% compliance rate with this directive.

Implicit bias training completion is also required upon hiring for new State of Michigan employees and one training is offered every month as part of the onboarding process. This training was also developed and delivered by equity officers across the state government departments. Between December 2020 and November 2022, 1,058 new employees participated in live or virtual implicit bias training.

State of Michigan Contractors

Starting December 2021, State of Michigan contractors were also required to complete implicit bias training. As of November 2022, of the 4,789 contractors who were scheduled to complete implicit bias training, 4,058 contractors participated in the live or virtual implicit bias training. There has been an overall 85% compliance rate with this directive.

Health Professionals

Governor Whitmer and the Michigan Department of Licensing and Regulatory Affairs (LARA) announced that beginning June 1, 2022, a requirement would go into place that mandated that health care professionals must go through live or virtual implicit bias training when renewing their licenses. Depending on their professions, health care professionals would go through this training every two to four years. New professionals were also required to undergo implicit bias training.

So far, between June 1 and October 31, 2022, 60,784 individual health professionals, not including veterinary professionals, attested to completing the implicit bias training while renewing their licenses. Another 18,559 health professionals received new licenses and completed this training as part of licensing requirements.

Equity Impact Assessment (EIA)

In 2020, as part of Governor Whitmer's Executive Directive 2020-9 Addressing Racism as a Public Health Crisis, the MDHHS Office of Equity and Minority Health (OEMH), proposed and conducted a demonstration of an Equity Impact Assessment (EIA) with three to seven member teams in three work areas at MDHHS. They were the Economic Stability Administration (ESA); Behavioral, Physical Health, and Aging Services Administration (BPHASA); and Bureau of Children's Coordinated Health Policy and Supports (BCCHPS). To conduct the demonstration, the Government Alliance for Race and Equity's (GARE) Race Equity Tool was selected and adapted. During implementation, the three work area teams participated in an EIA technical assistance/coaching designed and delivered by the programming team of OEMH. Additionally, a comprehensive process and outcome evaluation was designed and conducted by an evaluation team comprised of staff from Michigan Public Health Institute (MPHI) and Public Research and Evaluation Services (PRES). The process evaluation examined implementation of the EIA and the outcome evaluation examined whether the EIA demonstration resulted in changes in participants' self-perception of their knowledge and ability to execute tasks that should occur in the short-term (immediately post-training), medium-term (three to six months post-training) and long-term (one to three years post-training).

The MDHHS EIA process was guided by a theory of change and logic model. Technical assistance/coaching focused on the following topics:

1. Health equity and race equity foundations.
2. Implementing the EIA process.
3. Data collection and interpretation.
4. Root cause analysis and problem statement.
5. Engagement of priority populations and stakeholders.
6. Proposal/consensus building.
7. Testing and data analysis (including SMART objectives).
8. Standardization, accountability and sustainability.
9. Exploring implicit bias in equitable decision-making.
10. Peer to peer learning cohort.

With technical assistance from the Evaluation Team, the three demonstration sites also created their own theories of change and logic models around their selected problem statements which were:

1. Black women are 2.8 times more likely to die as a result of pregnancy or childbirth. (BPHASA)
2. Black children are underrepresented in the group receiving Trauma Focused Cognitive Behavior Therapy (TF-CBT). (BCCHPS)
3. SNAP participation is lower for Hispanics in poverty with a visual disability (41% compared to 53% for non-Hispanics). (ESA)

The EIA demonstration project was designed and conducted in various phases, starting in May 2021. Phase I established MDHHS leadership buy-in to EIA and delivered foundational trainings; Phase II launched with a pre-intervention readiness assessment and introduction to the EIA evaluation model; Phase III delivered six technical assistance sessions, as well as open dialogue and check-ins with each work area; and in Phase IV, a final evaluation report and publication of an EIA staff training toolkit will be completed (Figure 8).

Figure 8. Phases of the EIA demonstration project at MDHHS.

Evaluation findings indicate that overall, participants experienced growth in the short-, medium- and long-term competencies aligned with each session. For example, across all surveys, the number of respondents ranged from n=3 to n=11 (average n=7) and on average, 93% of them strongly agreed or agreed that the sessions increased their understanding or would help them become more competent in implementing the EIA process or its components. In July 2021, competencies were created for each topic and beginning with technical assistance/coaching sessions held in September 2021, participants were asked if they felt able to accomplish the types of short-term tasks outlined in the EIA competencies. Tasks included: report on and distinguish how inequities operate within the four levels of advantage and disadvantage (presented during Root Cause Analysis) and outline the steps for engaging priority populations and directly impacted communities in shared decision-making (presented during Engaging Priority Populations). An average of 91% of participants strongly agreed or agreed that they could accomplish these tasks.

In addition, as part of the process and outcome evaluation, EIA participants' perspectives were measured in April 2022, almost one year after the demonstration project launched. Data showed that 92% of respondents (n=12) strongly agreed or agreed that the EIA process is helping to accomplish the Governor's goal of addressing racism as a public health crisis. Eighty-two percent of respondents strongly agreed or agreed that they had gained an increased desire to address inequities.

In September 2022, when asked to rate their proficiency in executing specified tasks, 75% of participants (n=12) felt they had advanced or moderate skill to self-evaluate their own interpersonal and internalized biases that may contribute to systems of advantage and disadvantage and look at a problem statement in their work area and determine potential solutions.

Evaluation of the demonstration project is still being completed and the data will inform the implementation of a new pilot with up to eight sites. A draft report of detailed pilot data will be disseminated in 2023.

Maternal and Infant Health

Maternal and infant health was another major priority for the Task Force. Meetings between leaders and subject matter experts in maternal health have occurred to discuss and further the cause of reporting discrimination of providers towards Black and Brown maternal health patients.

Language Access

Language access has been a large part of Task Force-supported initiatives thus far – including inclusion in services at neighborhood testing sites and in strategic communication about COVID-19 to affected communities. Equity officers were appointed to prioritize supporting language access and implicit bias training. There are now 25 full-time equity officers across the state.

A broad initiative to increase language access planning within all state government departments was coordinated by the Office of Global Michigan. State entities which receive federal support are required to implement language access plans under Title VI of the Civil Rights Act of 1964 and Presidential Executive Order 13166 from August 2000. Federal funds must be budgeted to include a language access component. The infrastructure for implementing language access within the State of Michigan has been created over the past two years through intensive strategic planning and work with an external consulting firm.

Environmental Justice

The COVID-19 pandemic highlighted many of the systemic challenges associated with climate change that intersected with COVID-19 infection and deaths in communities of color. Below are listed some of the environmental justice initiatives spearheaded by the Michigan Department of Environment, Great Lakes, and Energy (EGLE) and supported by the Task Force.

Integration of Environmental Justice into Climate Initiatives

To collaborate more closely and align the goals of EGLE and the Task Force, members of the Task Force joined the Michigan Advisory Council on Environmental Justice (MAC-EJ) to help develop further recommendations about the disparate effects of air quality and COVID-19 on communities of color. The formation of this group was supported by the Governor's MI Healthy Climate Plan to integrate environmental justice (EJ) into climate initiatives. Additionally, a 14-member Climate Solutions Council began meeting in March 2021. Within MAC-EJ, a five-member Climate Justice Brain Trust was created, which pursued incorporating equity in the Governor's MI Healthy Climate Plan. The integration of EJ into climate initiatives included:

- Conducting an EJ analysis within long-term energy and utility planning processes to ensure that air quality and climate justice are considered in utility decision making.
- Planning to help communities and workers transition equitably from old polluting energy facilities while protecting their job opportunities and tax base.
- Identifying disparate racial impacts on EJ communities in the development of the Climate Solutions Plan.

Community Air Monitoring

In response to concerns about existing air quality issues and the risk of airborne COVID-19 spread, EGLE Air Quality Division Air Monitoring Unit developed a project targeting EJ communities to add additional air quality monitoring and sensors. An EJ community is defined as a community that contains predominantly persons of color or those below the poverty line who are exposed to a disproportional number of environmental hazards. In the summer of 2021, 10 Purple Air monitors, which track fine particulate matter, were deployed to conduct short-term air monitoring at various locations.

Air Quality Assessments in Environmental Justice Community Schools

The air quality assessment program provided an indoor heating, ventilation and air-conditioning (HVAC) air quality assessment for school buildings within EJ communities. Grants covered the cost of the assessments; funding was set aside to conduct assessments at schools in Southwest Detroit. The assessments were used to provide schools recommendations for improvements to make indoor air more protective against the spread of the COVID-19 virus, as well as identify funding for the schools to make these improvements, such as through American Jobs Plan and American Rescue Act funding.

A confidential survey was distributed to Michigan K-12 public schools to gather information about their current HVAC system, recent improvements and current needs. EJ schools were not required to complete the survey to receive an assessment. Schools that completed the survey were eligible for free assistance from a licensed HVAC contractor. Assessments were limited to two buildings per school district. Participating schools received a status report on their HVAC system and a list of recommendations that could lower infectious aerosol transmissions within the building, as well as cost estimates for equipment, retrofits and installation. The assessments also identified energy efficiency opportunities.

In total, 107 out of 886 school districts responded to the survey, providing data on 532 buildings. Subsequently, 109 schools completed an onsite HVAC assessment by a licensed HVAC contractor.

Of the K-12 schools assessed:

- 47% of school buildings have not updated their HVAC system in the past 15 years.
- 35% have not updated their HVAC system in the past 20 years, and,
- 21% have not updated their HVAC system in the past 25 years.

Among EJ community schools, responses showed that 67% have not had HVAC system updated in 25 or more years.

These results showed that communities throughout Michigan, especially communities of color, have substantial opportunities for improvements in air quality and subsequent reduction in disease transmission within schools, and for improving or replacing their HVAC equipment. The Task Force supported this effort due to its purpose of identifying community EJ needs and finding effective ways to address those needs.

Enhancement of Statewide Emergency Notification System

As of 2021, the possibility of enhancing statewide emergency notification systems was still being explored by EGLE. The statewide emergency notification system would be expanded to include climate emergencies and to better communicate important information about emergencies that disparately affect communities of color.

Limitations

The present report is focused on assessing the impact of Task Force-supported interventions in mitigating disparities for racial minority groups, specifically Blacks/African Americans and American Indians/Alaska Natives, bearing the heaviest burden of negative impacts during the pandemic. However, other racial or ethnic minority groups, particularly, immigrant and marginalized groups such as Arab Americans, have also experienced adverse disproportionate impacts

(Dallo et al., 2022). Although Arab Americans are a unique ethnic group, they are classified as white because they do not have a specific ethnic identifier. To assess the burden of COVID-19 among Arab Americans, the Task Force supported a program to estimate COVID-related cases and deaths in this ethnic group by matching Arabic and Chaldean surname lists to state data. Based on the results of these efforts, targeted interventions were designed and implemented as part of the RRI. However, for the purposes of this report, data on death rates for Arab Americans could not be reliably desegregated to assess the impact of Task Force-supported interventions targeting this ethnic group.

PROPOSALS AND RECOMMENDATIONS

As the Task Force ends in January 2023, each workgroup was asked to generate recommendations – formal and informal funding and operational proposals. These proposals are intended to foster long-term sustainability by expanding on and creating new ways to support the programs created during the pandemic with the Task Force's support. The Task Force was able to provide a robust platform for collaboration, feedback, community engagement, and ultimately shaping the types of work pursued by the state and other community-based organizations. These are the plans for medium- and long-term sustainability of these programs, as expressed by each workgroup.

Centering Equity Workgroup

The Centering Equity Workgroup's priorities for sustainability mainly focus on expanding the initiatives that the Task Force worked on and prioritized in improving health equity. There are several recommendations and proposals for the work supported:

Implicit Bias Training Requirement

There is an existing infrastructure for offering implicit bias training to health care professionals that is planned to continue. This includes the continued oversight and maintenance of the training being offered to health care professionals. Additionally, it would be beneficial to determine an effective way to measure race and ethnicity data of new and renewing licensees, to better assess the reach of this requirement and create avenues through the Michigan Department of Civil Rights for patients to report discrimination by their providers. For State of Michigan employees and contractors, sustainability of the implicit training bias entails continuing offering training every other year and working with departmental equity officers to ensure continued maintenance of curriculum, development and enforcement of the requirement.

Equity Impact Assessments

The Centering Equity workgroup recommends expanding the EIA model to other State of Michigan departments beyond those in the pilot and initial departments, through a Disparity Reduction Initiative spearheaded by the Office of Race, Equity, Diversity, and Inclusion (REDI). REDI is responsible for setting the strategic direction for MDHHS to address issues of health and racial

inequities, and improve diversity, equity and inclusion in both its practices and policies. A funding request been submitted for this program, expected to be implemented between October 1 and September 30, 2026. The budget for this proposal is expected to be $10 million over all three years.

The Disparity Reduction Initiative aims to harness organizational change to embed critical decision points into MDHHS' policies, program development, practice implementation and service delivery. For this proposal, 15 staff members are planned to be hired to promote and implement an organizational change model. They will develop the REDI Curriculum Pathway, provide training to 6,000 employees annually, offer at least 10 activities annually to build a culture of disparity reduction, train staff and provide support in implementing the EIA process in up to 15 areas and develop and implement up to 15 employee resource groups (ERGs), which are employee-led groups that bring together individuals from diverse backgrounds to share ideas, network, and accomplish business goals while providing them a safe and inclusive space.

REDI has already developed the REDI Curriculum Pathway, which is a comprehensive and multi-faceted effort founded in organizational change and system-based approaches. The REDI Curriculum Pathway proposes a mechanism for fostering the learning progression and development of MDHHS staff and building a supportive structural culture that strengthens the integration of equity tenets into staff daily work and achieves fidelity with the use of tools like the EIA.

The REDI Curriculum Pathways include:

1. **Phased approach to foundational and other critical trainings** – Cultural and linguistic competence; implicit bias; equity and history 101 (equity vs equality); othering and belonging; diversity and intersectionality.
2. **Equity Impact Assessment Process, including technical assistance and coaching** – 24 hours of foundational training: data collection and interpretation; root cause analysis and problem statement; engagement of priority populations and stakeholders; proposal/consensus workshop; testing and data analysis; standardization, accountability and sustainability; and an average of 24 hours of technical assistance.
3. **Employee Resources Groups, for a diverse state government audience, staff hiring and retention** – Leadership Accountability Group; Leaders of Color; Resilience Intentional Strong and Emergent (Emerging Leaders); "LGBTQ+ Employees and Allies for Diversity. Equity, and Respect" (L.E.A.D.E.R.S); White Leaders Confronting Racism Group; Arab and Chaldean; Asian and Pacific Islander; Native American; Hispanic/Latino.

Expected outcomes include:

- Short-term (immediately post trainings): increases in awareness, knowledge and capacity in equity concepts and application.
- Medium-term (three to six months post trainings): increases in competencies and skill development.
- Long-term (one to three years post training): behavior changes and decision-making on practices, procedures and policies; disparity reduction in morbidity and mortality rates; disparity reduction in access to services by race and ethnicity.

Specific metrics include:

- Six thousand staff to complete training annually.
- At least 75% of trained staff will report increased competencies in equity and cultural competency.
- Up to 15 work areas will complete the EIA training and technical assistance process annually.
    - Number and description of policy, procedure and practice changes.
    - Number of residents participating in engagement opportunities – key informant interviews, surveys, focus groups, etc.
- Number of staff participating in Employee Resource Groups.

The Centering Equity Workgroup recommends that State of Michigan leadership implement EIA widely in various departments through this proposal, as an important strategy to support Governor Whitmer's declaration of racism as a public health crisis.

Sickle Cell Disease Funding

The Centering Equity Workgroup advocates for a more equitable treatment of sickle cell patients – furthering the work supported by the EOG that has already been done over the past two years. Task Force recommendations for sickle cell anemia funding will also be shared with the delegation of the relevant federal policy that may come before them in the next Congress in 2023.

The Task Force also recommends improving value-based care for sickle cell patients. Preventive care is essential for reducing morbidity associated with sickle cell disease, especially in pediatric care. The Centering Equity Workgroup is interested in exploring the adoption of the Medicaid quality collaborative plan model developed by a joint team at the University of Michigan and MDHHS, with funding from the Michigan Health Endowment Fund. The National Quality Foundation (NQF) endorsed associated quality metrics including: the number of children who have more than 300 days of prescribed antibiotic prophylaxis, the number of children who have more than 300 days of prescribed hydroxyurea for pain crises prevention, and the number of children who have completed an annual transcranial doppler screening. These metrics would also be reported annually for performance improvement within the MDHHS Annual Health Disparities Report.

The quality collaborative model uses an innovative, population-based approach, where Medicaid managed care organizations work together within a prosperity region to drive improvement in health outcomes for children with sickle cell anemia, for joint incentives that depend on improvement across all organizations. In a pilot in Michigan Prosperity Region 10 that began in 2021, case managers, community health workers and Medicaid plan leadership worked together to meet incentive benchmarks, across all organizations. They also learned from each other through listening sessions and workgroups and from families of children with sickle cell disease, driving quality preventive care through shared learning and training. Some improvements in outcomes have been seen, and changes that benefit children with sickle cell disease such as longer refill time frames, have been implemented. However, there is room for improvement, which would be mitigated in a project scaled statewide.

Maternal and Child Health

The Centering Equity Workgroup pushes for continuing to uplift the importance of feedback and accountability in improving the quality of maternal health care that Black and Brown individuals receive in Michigan. While mortality from COVID-19 reduced among Black Michiganders, maternal and infant mortality gaps persisted. According to the most recent MDHHS data, there were about 70% more maternal deaths among Black women than among white women, and almost 50% more than the Michigan average. Thus, the workgroup recommends a statewide adoption of a mechanism to gather real-time, customer service data from women about their experiences in the health care system throughout their pregnancies, including experiences with discrimination and systemic racism. The state could use these mechanisms to drive transparency and accountability for Black women and others who regularly access maternal health care services. The Workgroup recommends a review by the EOG of potential tools to include in its maternal health initiatives.

Two ideas for these data collection mechanisms include the Irth App and the Prem-OB Scale. The Irth app was created by Kimberly Seals Allers of Narrative Nation, which is a New York-based nonprofit organization that creates narrative-centered media and technology to address health inequities. It is a new digital platform made to address systemic racism as a root cause of Black maternal and infant mortality and bring public accountability and transparency to the health care system. On the app, women of color can leave reviews about the care they received and find reviews from other Black and Brown women about the prenatal, birthing, postpartum and pediatric care they received. Doulas, lactation consultants and other birthing professionals can also leave reviews based on what they experienced during their client's birth. Each submission is peer-reviewed by a team of experts before being posted on the app. The cost of implementation of the Irth app in other cities has been around $500,000.

The Irth app is currently being implemented in a pilot at the Ascension St. John Hospital in Detroit. People who have given birth at Ascension St. John Hospital in the past two years have been encouraged to download the Irth app and leave a review. Based on the results of this pilot, the Irth app could potentially be a solution for driving changes in maternal care.

The Prem-OB Scale, developed by Dr. Karen A. Scott in 2019, examines obstetric racism, as defined for, by, and with Black women and birthing people during hospital stays for labor, birth and postpartum. The domains of measurement of quality of maternal care in this model include safety, autonomy, communication, racism, empathy and dignity (SACRED). This tool focuses primarily on building hospital and community capacity to recognize and respond to systemic racism in maternal health care.

The implementation and oversight of such data collection mechanisms could be supported by the Michigan Department of Civil Rights and other stakeholders within the State of Michigan.

Language Planning

To support language planning, a proposal was submitted to the State of Michigan and accepted to create a full-time position of Language Access Coordinator. This position has already been created and, as of November 2022, is in the process of being hired, along with a full-time technician who will assist in this work. The Language Access Coordinator would work with equity and inclusion officers from across state departments to develop Language Access Plans and ensure compliance with federal mandates. The Language Access Coordinator is planned to conduct a statewide survey and audit of existing language access resources and services and identify gaps. This includes a department-by-department review of existing language access policies and procedures, and a review of department and state-level contracts with Language Service Providers (LSPs) for inclusion of best practices. This assessment would be done by the Michigan Department of Technology, Management, and Budget, in coordination with the Office of Global Michigan.

A proposal has been submitted and accepted by the State of Michigan for language access assessment, training and technical assistance ($700,000). The technical assistance part of this proposal is planned to be a Request for Proposal (RFP) process and may collaborate with various strategic partners outside the state. State departments are being provided training as a primer for the launch of this initiative.

Strategic Infrastructure Workgroup

The Strategic Infrastructure Workgroup also developed recommendations for extending and sustaining the work done within the Neighborhood Testing Sites (NTS) over the past two years. A FY24 proposal of change for $40 million was submitted by the team for neighborhood health and wellness sites – an expansion built off the current NTS model to offer additional health and wellness services that could be performed in a non-traditional setting.

NTS became invaluable community resources, establishing themselves as essential change agents in community-integrated access to care. Federal cooperative agreements fund the sites until FY24, but these agreements are narrowly focused on COVID-19 services. There has been a strong, collaborative and successful program built at these sites and there is an opportunity to transform these sites into complete neighborhood-based community hubs – this includes resource "referral" hubs which provide accessibility to SDOH resources at the local and state level for community members, testing centers which focus on rapid, accessible testing services for community members and training sites which provide rotating classes that educate the community on everyday needs. This would help increase access to preventive health care services and increase trust in the traditional health care system.

Additionally, the workgroup recommended that the sites increase their capacity to offer additional services. This includes searching for funding sources for program allocation and connecting with local and state agencies to bring various health services to sites. Each site may choose what services are most valuable to their clients, allowing services delivered to be driven by community engagement and user needs and feedback, with the State of Michigan providing supplementary funding, training, program evaluation, fiscal stewardship and monitoring, bulk purchasing and vendor management.

Services offered would include routine testing for COVID-19, flu, sexually transmitted infections, and Hepatitis C, screening for blood pressure, diabetes, and cholesterol, vaccinations and navigation to health care, social services, or health insurance. The sites may also be able to offer clients respite from environmental and structural challenges, such as warming and cooling centers for extreme cold or heat and shelter during power outages. Sites are recommended to have a greater focus on OTC supplies going into the post-flu COVID-19 season in 2023 onwards, including MDHHS providing sites free OTC test supplies.

Impacts of the proposal extend beyond strengthening access to preventative health and wellness for individual neighborhoods. Large-scale coordination of the NTS model creates economies of scale that will more efficiently leverage centralized purchasing and distribution streams, keeping operation and supply costs low. Collective learning, continuous quality improvement and experience sharing will help sites tailor their services and approaches to best meet community needs. A strong program evaluation process will demonstrate the qualitative and quantitative impact of the sites.

Metrics of success will include number of visits to the site, referrals, events, numbers of preventative health screenings and other related services. Ongoing customer satisfaction surveys will be used for continuous quality improvement to better inform services, practices and partnerships and ensure efficient and effective use of resources.

Primary Care Connections Workgroup

The Primary Care Connections Workgroup's priorities for longer-term sustainability focus on supporting programs that increase access to and quality of health care for communities of color. Many of these proposals utilize existing infrastructure and add innovative, equitable approaches within these structures to target improved health outcomes for people of color and other vulnerable populations, including implementation of primary care community hubs, insurance enrollment, value-based incentives, health IT and telehealth. Detailed recommendations include:

Insurance Enrollment

A major priority for improved health outcome is maintaining and increasing insurance enrollment for communities of color through Medicaid and the federal marketplace. includes maximizing Medicaid enrollment, including supporting cross-enrollment from other state programs. The Primary Care Connections Workgroup recommends targeting those who have recently lost employer-sponsored coverage to enroll in Medicaid or ACA plans through a partnership between MDHHS (Medicaid), LEO (UIA and MichiganWorks!), and DIFS (Health Insurance Marketplace). Other populations to consider targeting include college students, undocumented individuals, individuals with low socioeconomic status, full-time and part-time workers, children of those uninsured due to job loss, and homeless individuals.

After the end of the COVID-19 public health emergency (PHE) and federal legislation related to COVID-19, the Medicaid Continuous Coverage requirement will end March 31, giving states the opportunity to process renewals and redeterminations for Medicaid eligibility starting April 1. Guidance for provisions and expectations for this transition process is expected to be issued by CMS soon. In the meantime, MDHHS has an ongoing outreach campaign and website which provides resources for providers, community partners and the public regarding changes to the Medicaid program's eligibility, administration and policies. This website will continue to be updated as the transition continues.

MDHHS' primary partners in the transition will be the Medicaid Health Plans (MHPs), which have the state's approval to allow them to continue outreach to residents on behalf of the state about the Medicaid eligibility renewal process. To facilitate this work, MDHHS and DIFS will coordinate to share electronic information regarding individual eligibility to ensure prompt enrollment and renewals. They will also share information with MHPs about which beneficiaries are undergoing

renewal, which ones are being terminated, and, if possible, information about why beneficiaries lost eligibility to assist in outreach and education to improve their access to coverage with minimal gaps in service. MDHHS also has temporary approval to automatically reenroll beneficiaries in their Medicaid managed care plan for up to 120 days after their initial loss of coverage, which provides them a grace period and time for MHPs to assist individuals appropriately. These recommendations are supported by the Task Force, as they will ensure that Medicaid recipients in Michigan, especially those of vulnerable populations, remain connected to primary care after the end of the PHE.

Health Care Quality and IT Infrastructure

Current gaps in health IT and technology have led to issues in overall patient care, which contribute to long-term disparities. Different providers often use different platforms, which makes it difficult to consolidate data between and within organizations. Ongoing issues in interoperability between electronic health care systems prevents adequate sharing of patient data. The Primary Care Connections Workgroup recommends that a central repository of patient data be created to share with EHRs and other social service organizations.

Another recommendation by the Primary Care Connections Workgroup includes undertaking efforts to improve the number of well visits patients have per year. These efforts could include incentives for Medicaid providers to remain connected with their patients and for patients who completed their wellness check visits through “rewards” including bus fare cards or other gift cards.

School-Based Clinics

The Primary Care Connections Workgroup as well as the Task Force at large supported the use and expansion of school-based clinics. Recommendations for the future include leveraging existing school-based health clinic facilities to increase access to primary care and vaccination services to all families in the surrounding community, not just those with students enrolled at the school. The expansion of school-based clinics would also include hosting webinars targeted to parents of students to highlight the importance of primary care and how their children can utilize the services available at school-based health clinics.

Current plans to expand school-based clinics in the future include collaborations with Marygrove College in Detroit and DPSCD to create a sustainability model and secure funding for operations. A proposed operational model would make DPSCD a health care delivery service, which contracts with health insurance companies. These health insurance contracts would be made with Medicaid managed care organizations with a per student, per year capitated rate to deliver students a prevention care “package” including sports physicals, annual wellness exams, vaccines and mental health screenings. School nurses would manage student health panels and monitor achievement of wellness and prevention activities. Health care would be delivered at a school, or at a regional district hub; Marygrove College in Detroit has been proposed as an initial hub for a pilot. This

program would not cover episodic and chronic health care needs of students, but it would develop relationships with health systems to enable direct referrals.

Migrant and Agricultural Worker Health

A budget priority for an enumeration study ($874,000) was launched in 2022, which aimed to understand the needs of migrant and agricultural workers in Michigan and enable the State of Michigan to use data to make informed decisions when planning and allocating resources for this population. MDHHS is currently working with its Office of Migrant Affairs to create a point of prevalence survey, which would help them to collect better data about the vaccination status of migrant workers and their families. This survey is planned to be distributed in 2023.

State of Michigan leadership is also expected to create a plan to decentralize existing migrant services in the upcoming years. Currently, three different departments serve migrant populations, which can create competing priorities. The migrant worker population is highly transient and requires dynamic and swift response efforts dependent upon coordinated interagency and interdepartmental efforts. A reorganization of leadership to incorporate a local workgroup model has been recommended, which integrates the varied departmental approaches of serving migrant workers and their families locally but requires centralized quality assurance standards. Consequently, the budget for this priority ($235,800) includes the hiring of positions to support this reorganization.

MDHHS also plans to expand migrant health services by sustaining and expanding its Migrant Program in meeting the population's vaccination and health needs. A proposed budget of $703,500 would allow for a closer partnership between the Migrant Program and the FQHCs that provide this population health care services including vaccinations. This recommendation would allow for family independence services staff from the Migrant Program to be stationed at migrant health clinics to help migrant workers and their families overcome health care barriers. Other plans for future work include the implementation of a community ambassador program for college students from migrant worker communities and weekend and evening outreach to farmworkers at community events such as food drives. Health care barriers that migrant workers face beyond COVID-19, such as Medicaid coverage, translation, transportation and chronic disease comorbidity will also be explored.

Mobile Health Workgroup

The Mobile Health Workgroup developed recommendations to maintain sustainability of the MHU program. The MHU program created a unique infrastructure to fill important gaps in access and care delivery that contribute to rural and urban health and racial disparities; however, the workgroup supported further funding and programmatic support for longer-term sustainability. MHUs helped bridge medical mistrust and ensured that communities of color and others in less

affluent regions had equitable access high-quality care. A study by the Wayne State MHU team, funded by a grant from the Kellogg Foundation, to align mobile health unit programs in Southeast Michigan showed substantial improvements (up to 25%) in vaccination rates across the city of Detroit over a six-month period through coordinated MHU deployment.

A Proposal of Change for the Michigan Mobile Health Corps (MMHC) Sustainability and Growth Program for the 2024 Fiscal Year was submitted by MDHHS to maintain sustainability of the existing MHU program. This program requests $28.5 million over four years and is planned to be implemented from October 1 to September 30, 2027. As $4.3 million in CDC Emerging Infectious Diseases (ELC) funding was already secured by the Office of Equity and Minority Health to sustain MHUs through July 2024, this proposal will continue to help develop the long-term infrastructure needed to support MHUs.

The MMHC Sustainability and Growth Program is an MDHHS programmatic and policy change in collaboration with CMS to enhance access to prevention and other services, delivering to communities in need through a coordinated network of MHU teams that support population health initiatives. The program supports the MMHC by creating an administrative center and integrated data hub to support MHU deployment and fund staffing of existing MHUs.

Sustainability is planned through the continued deployment of MHUs in pandemic and non-pandemic times, which requires policy changes. Thus, the proposal requests billing codes and establishing alternative payment models that designate MHUs as distinct clinical settings, which would pave the way for long-term changes in fee structures for services delivered in a mobile setting, such as value-based models. Current partnerships with Molina, Meridian and United Healthcare to support a single screening price for various services, using a value-based, per-member, per-month, risk-adjusted subscription model, are planned to be scaled for implementation throughout the state.

The proposal also provides support to increase community awareness of mobile health options and streamline data-sharing across organizations to enhance the referral process for social service and clinical needs. Currently, as part of Wayne State's nationally funded ACHIEVE GREATER program, the Population Health Outcomes and Information Exchange (PHOENIX) system integrates electronic health record (EHR) data with several other data sources to ensure the MHUs are deployed in areas with high risk around the city of Detroit. This type of granular data sharing is planned to be rolled out statewide as part of the MMHC Sustainability and Growth Program.

The program is expected to run 200 days a year with a total of 1,800 events annually. Its success is planned to be evaluated by:

- **Reach**: Number of different communities and people served by MHUs, number and types of services provided and number of community organization partners.
- **Effectiveness**: Number of medical or social service needs identified and addressed, clinical outcomes of program participants, satisfaction of program participants and cost savings/benefits of the program.
- **Adoption**: Proportion of targeted groups who participate in the program, level of program engagement, uptake of new payment models amongst payers and number of new MHU programs that develop during the proposal period.
- **Implementation**: Number of MMHC events conducted, types of services provided at MMHC, proportion of MMHC events where PHOENIX was utilized, success of establishing new payment models for MHU services and number of people enrolled in programs supported by new payment models.
- **Maintenance**: Ongoing use and growth of mobile health delivered services, proportion of people who continue to receive care using new payment models and degree to which supported MHU programs have achieved sustainability or expanded service delivery.

Environmental Justice Workgroup

The Environmental Justice Workgroup recommends that EGLE continues to strategically target funding for their air quality assessments for schools in areas with a high SVI and prevalence of COVID-19 infection and asthma. They recommend a strong collaboration with MDHHS and the Michigan Department of Education to ensure the appropriate health outcomes focus.

EGLE is planning to reach out to more K-12 schools again in late 2022 through the Restart grant program to assess more EJ school buildings and gather information on what actions the districts have taken to lower infectious aerosol transmissions within buildings that were already assessed. The Restart program also conducts HVAC air quality assessments at houses of worship.

Other sustainability plans include:

- Engaging the Retired Engineers Technical Assistance Program (RETAP), which provides free energy conservation and waste reduction audits by teams of retired engineers.
- Continuing to prioritize the EJ needs of schools in low-income communities.
- Reaching out to school districts that responded to the survey and received an onsite assessment over the next six months to determine which districts made improvements, gather cost data and ascertain effectiveness of improvements.
- Continuing to offer free onsite HVAC, energy efficiency, waste reduction assessment and other value-added services to any Michigan K-12 public schools through RETAP.

CONCLUSION

Informed by the scientific knowledge of the underlying causes of systemic racism, the Task Force drew on remarkable expertise in public health disparities to support the implementation of a series of data-driven, community-centered strategies to address a grossly disproportionate impact of the COVID-19 pandemic on people of color in Michigan. Providing critically important resources within affected communities in a timely manner almost certainly played a determinant role in the remarkable reduction in death rate disparities, which was measured to be greater in Michigan than a corresponding reduction in death rates nationally.

Additional accomplishments of the Task Force include reductions in Michigan's uninsured minority population and increased access to and utilization of health care among various disadvantaged and underserved minority groups.

Although the task of evaluating the long-term impact of initiatives undertaken by the Task force is left for future reports, the groundwork has clearly been laid for continued progress toward dismantling racial health disparities in Michigan. The Task Force serves as a model for doing similar kinds of work in Michigan and in other states, and for governance and leadership across the nation.

Lessons Learned

There were several lessons from the Task Force workgroups that may apply to current and future initiatives addressing health disparities.

COMMUNICATION, TRANSPARENCY AND TRUST IN COMMUNITY PARTNERSHIPS

- Acknowledge site partners as subject matter experts of their community's needs and include them fully in the decision-making process. Their insights and contributions are invaluable for all stages of program development: planning, implementation and evaluation.
- Establish an open-door policy for communication and building trust with site partners.
- Increase the partnership between community sites and local/state programs to support and sustain program effort.
- It is important to not tokenize site partners; include proper compensation, consistent inclusivity and shared appreciation.

CONTINUOUS EVALUATION IN PROGRAM DESIGN AND IMPLEMENTATION

- Early evaluation and frequent reassessment of community needs and wants are crucial in keeping a program relevant and beneficial to the community.
- Understanding the needs/demands of the community is essential in determining the utilization of a program.
- Engagement of all groups, including community partners, early on in the program planning and design is important for a successful program.
- Setting realistic expectations and timeline for community buy-in and uptake of a program is important.

AUTHENTIC COMMUNITY ENGAGEMENT

- Meeting people exactly where they are is crucial to success.
- Community engagement and promotional advertisement should be prioritized early when bringing new program to a community.
- Establishing a relationship built on transparency and trust with the community helps to alleviate concerns when offering new programs.
- Community members need time to learn about any new program, understand its importance, develop trust and feel comfortable using that program.

TARGETED COMMUNICATION CAMPAIGNS FOR PUBLIC HEALTH EDUCATION

- Utilizing trusted messengers such as health care providers, pastors and other community leaders, rather than government authorities, to disseminate public health messaging is effective.
- Targeted, engaging, scientifically accurate, well-funded campaigns have been used by MDHHS and the Task Force to communicate with Gen Z and Millennial populations.
- Work closely with partners to establish means to communicate to constituents that a resource is available within their community.

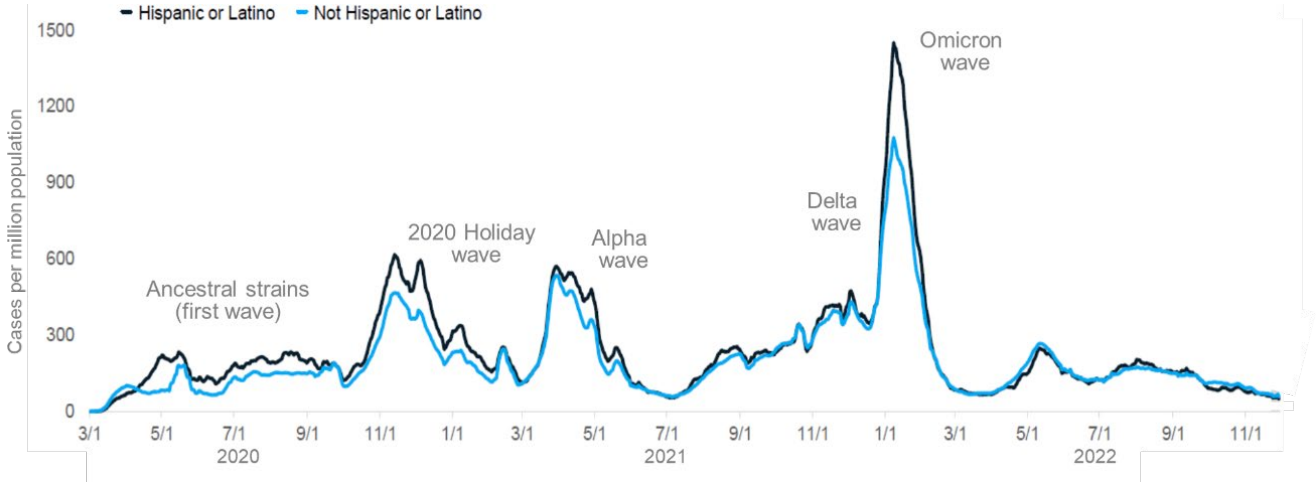
QUALITY IMPROVEMENT IN DATA

- Data-driven strategies to identify areas of high need, target testing and vaccination efforts were crucial in all programs.
- Tracking monthly and quarterly data points, and regular check-ins and sharing data openly with all parties to identify areas of improvement, is important.
- Data disaggregation in race and ethnicity data helps in targeting testing, vaccination and treatment initiatives to groups that are otherwise invisible in outcomes data.
- Improving health information technology and optimizing sharing of patient health data in patient care is essential to providing targeted primary care to communities of color.

PROGRAM SUSTAINABILITY

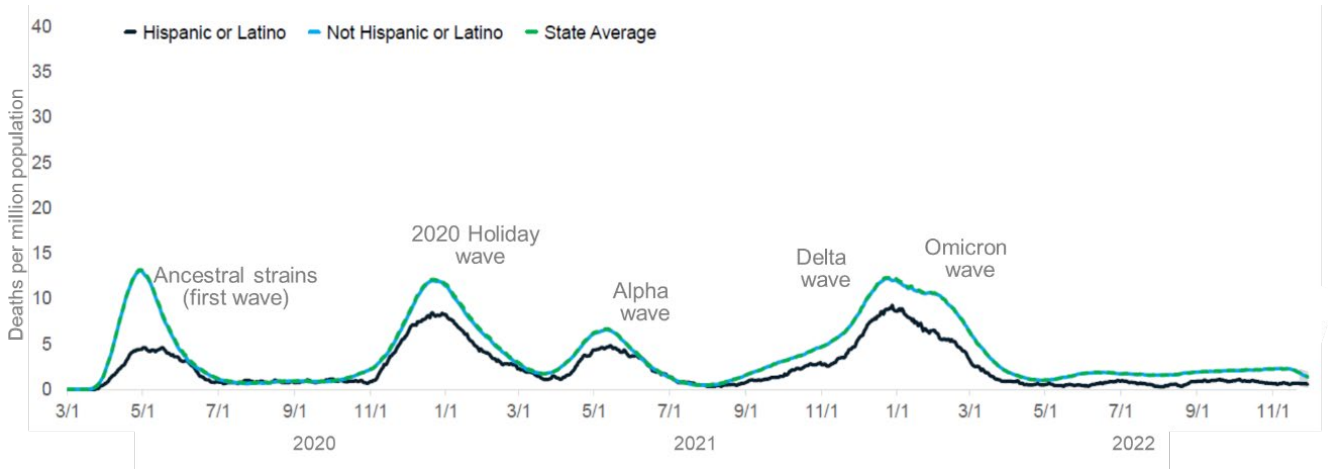
- Securing sustainable sources of funding is crucial for long-term program success.
- Future community involvement is necessary to identify specific needs and requirements for the area a program reaches.

APPENDIX I. Supplementary data



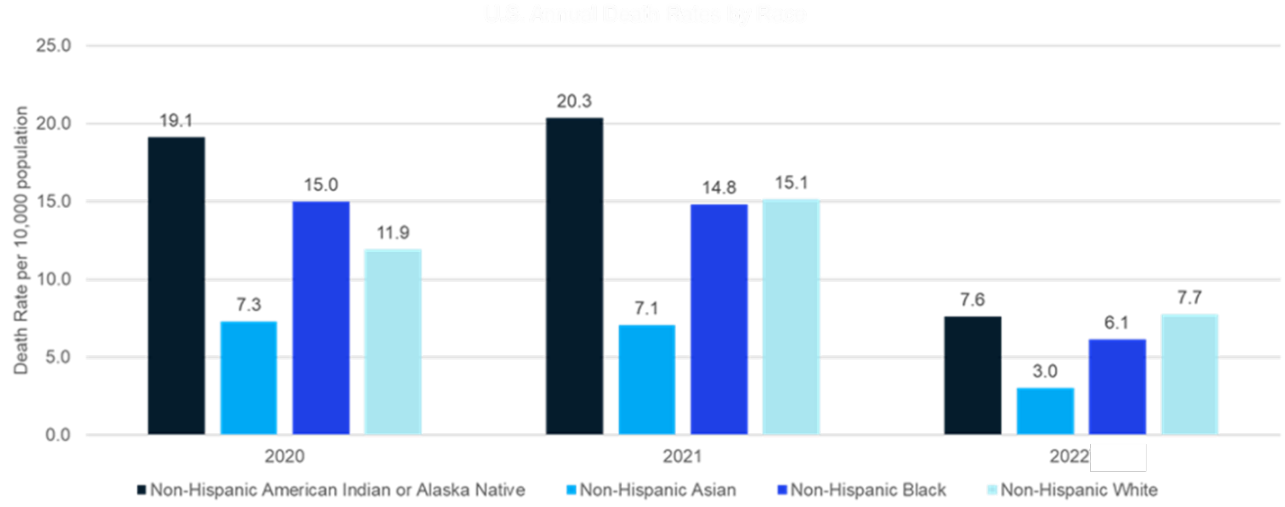
Note: Sourced from MDHHS – Michigan Disease Surveillance System; Data accessed November 2, 2022.

Supplementary Figure 1. Seven-day rolling average daily COVID-19 cases per million by ethnicity in Michigan.



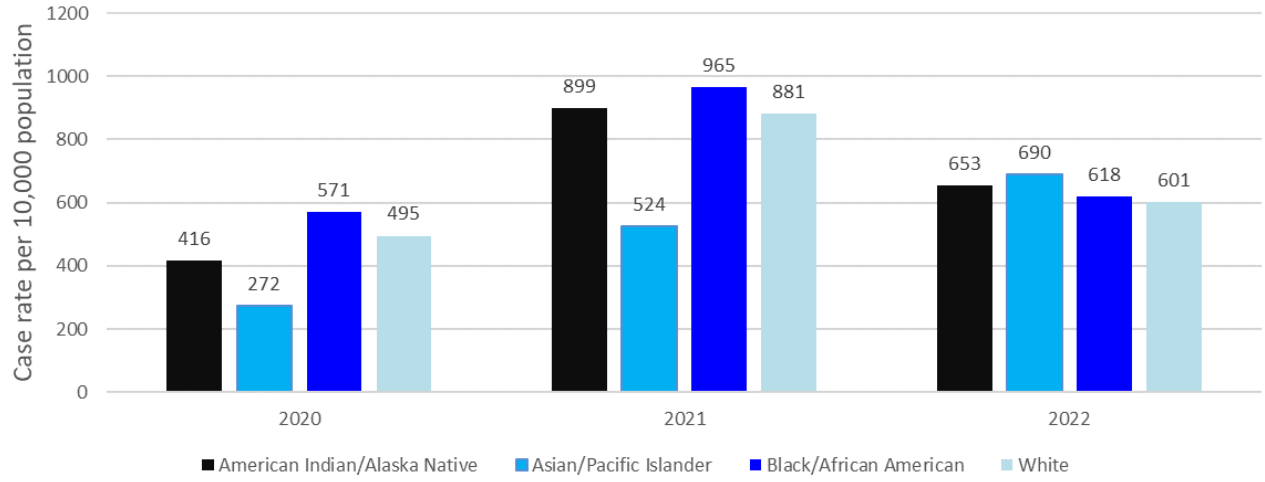
Note: Sourced from MDHHS – Michigan Disease Surveillance System; Data accessed November 2, 2022.

Supplementary Figure 2. Thirty-day rolling average daily COVID-19 death rates per million by ethnicity in Michigan.



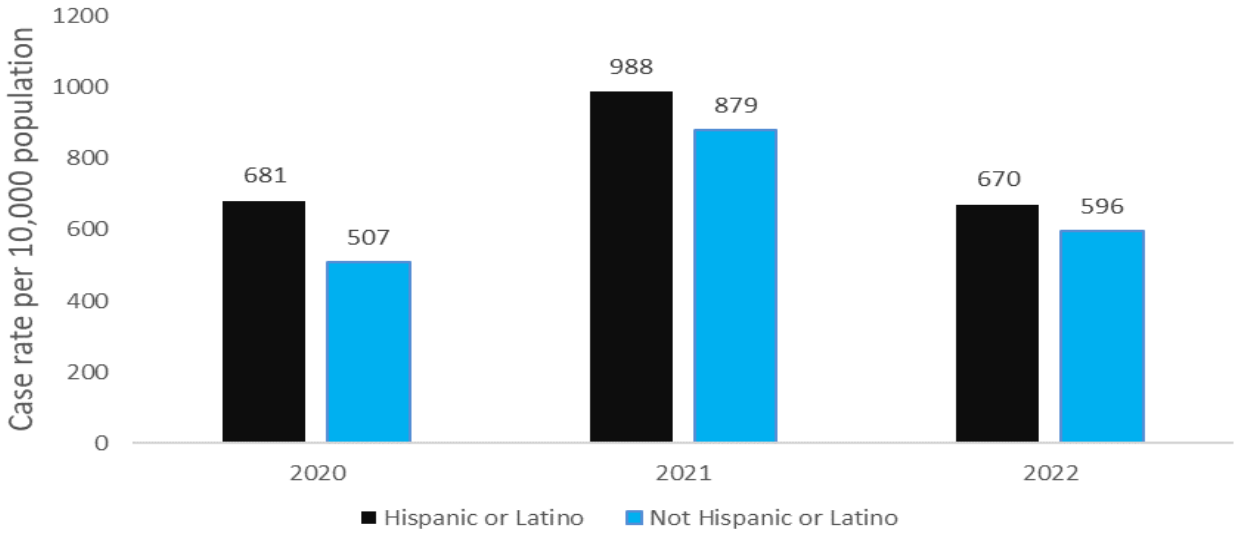
Note: Sourced from MDHHS – Michigan Disease Surveillance System. Data reflect the date of death of confirmed and probable cases; 2022 data are inclusive of dates of death through October only; Data accessed November 2, 2022.

Supplementary Figure 3. Year-over-year COVID-19 death rates by race in USA.



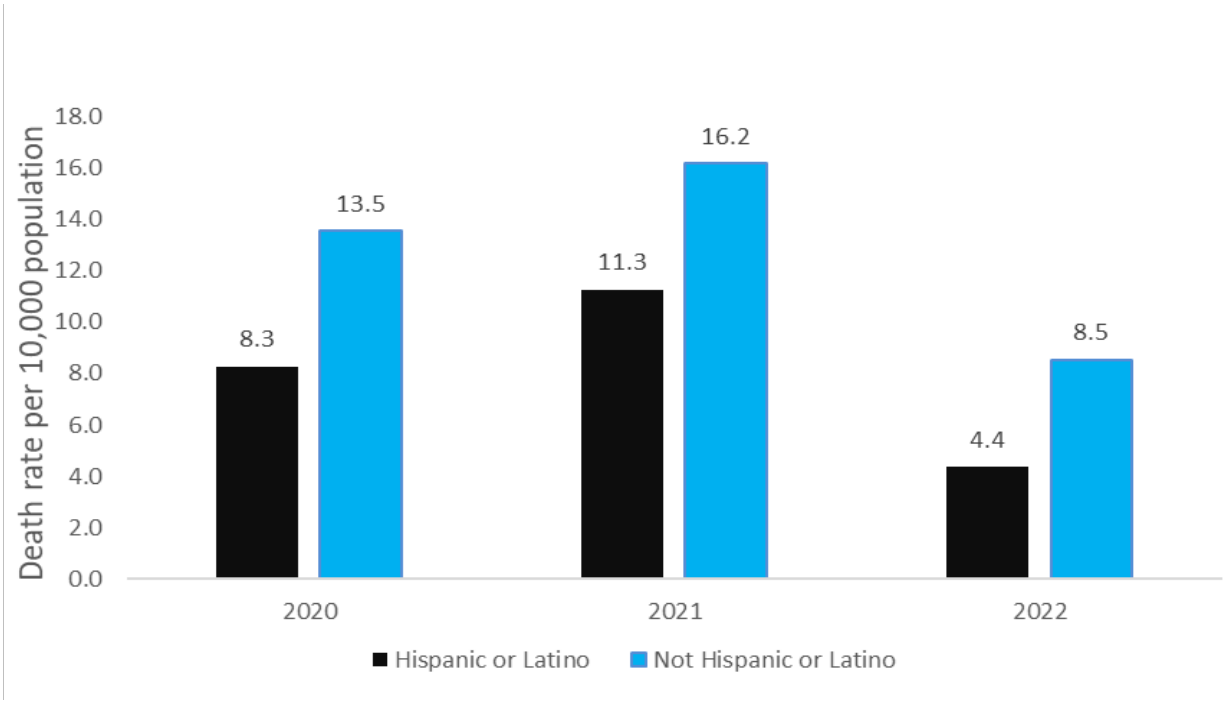
Note: Sourced from MDHHS – Michigan Disease Surveillance System; 2022 data are inclusive of cases through October only; Data accessed November 2, 2022.

Supplementary Figure 4. Year-over-year COVID-19 case rates by race in Michigan.



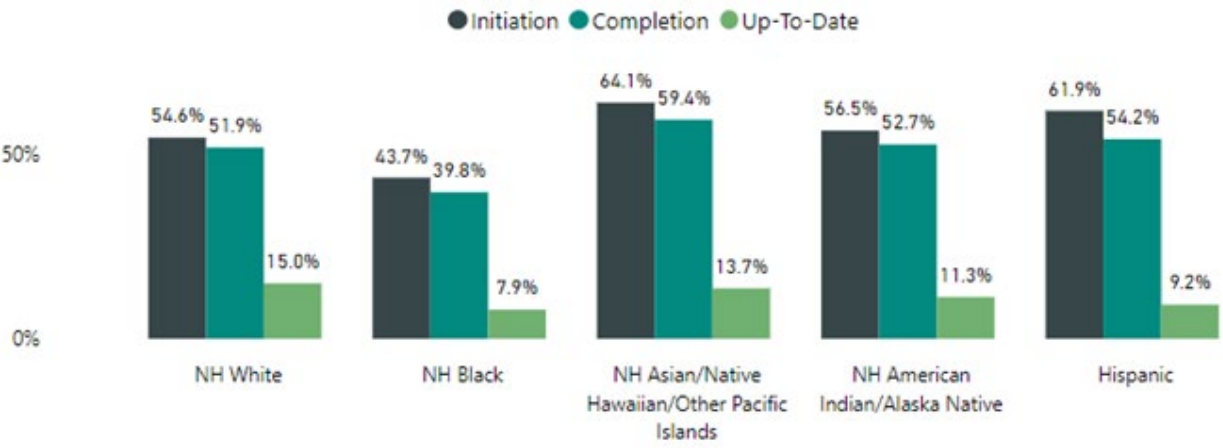
Note: Sourced from MDHHS – Michigan Disease Surveillance System. Data reflect the date of death of confirmed and probable cases; 2022 data are inclusive of dates of death through October only; Data accessed November 2, 2022.

Supplementary Figure 5. Year-over-year COVID-19 case rates by ethnicity in Michigan.



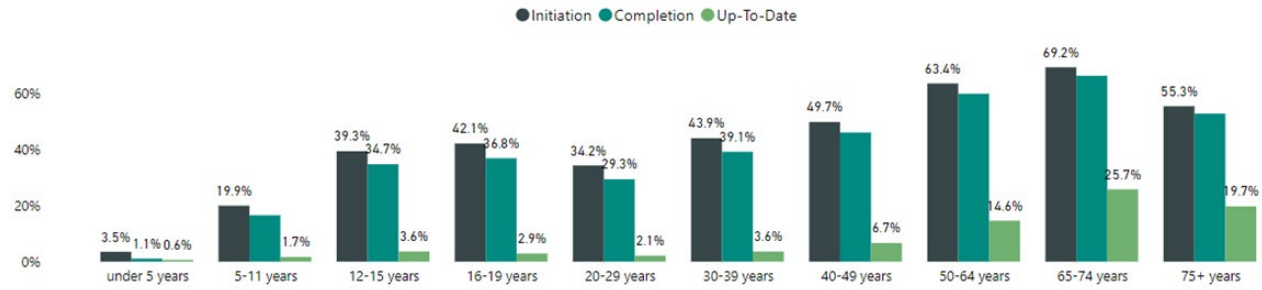
Note: Sourced from MDHHS – Michigan Disease Surveillance System; 2022 data are inclusive of cases through October only; Data accessed November 2, 2022.

Supplementary Figure 6. Year-over-year COVID-19 death rates by ethnicity in Michigan.



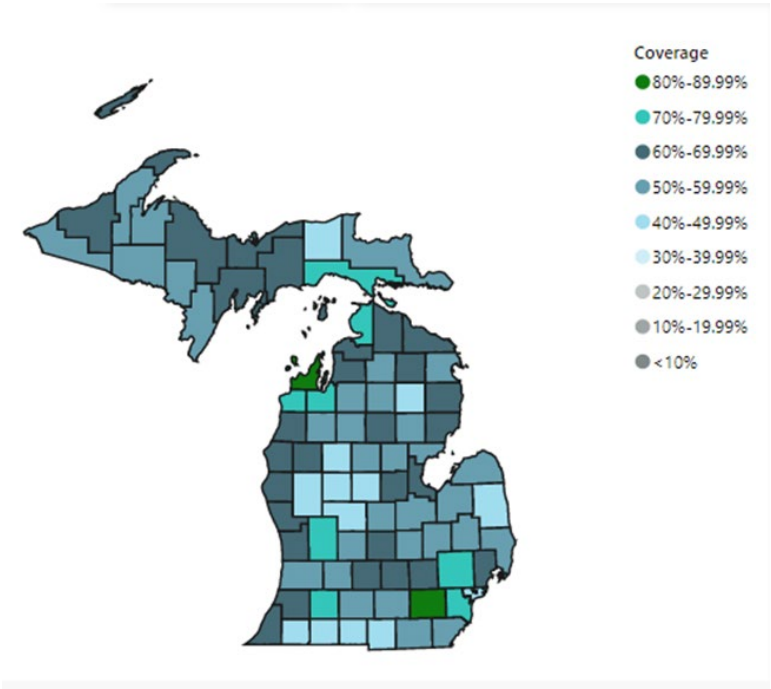
Note: Sourced from MDHHS – Michigan Disease Surveillance System; Data accessed January 17, 2023.

Supplementary Figure 7. Percentage of COVID-19 vaccine coverage among Michigan residents 6 months or older by race/ethnicity.



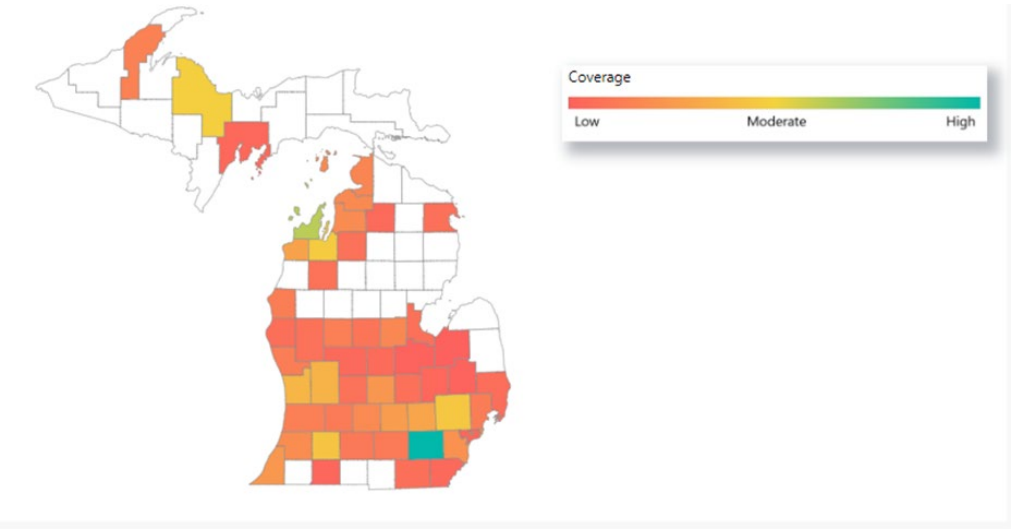
Note: Sourced from MDHHS – Michigan Disease Surveillance System; Data accessed January 17, 2023.

Supplementary Figure 8. Percentage of COVID-19 vaccine coverage among Non-Hispanic Black/African American Michigan residents by age group.



Note: Sourced from MDHHS – Michigan Disease Surveillance System; Data accessed January 21, 2023.

Supplementary Figure 9. COVID-19 primary series vaccine initiation coverage by county in Michigan.



Note: Sourced from MDHHS – Michigan Disease Surveillance System; Data accessed January 21, 2023.

Supplementary Figure 10. COVID-19 vaccine *up-to-date* coverage for under 5-year-olds by county in Michigan.

APPENDIX II: Methods

Approach

Timely assessments of the magnitude and direction of change of health disparities are necessary for public health evaluation of progress, with the accuracy of such assessments supported by reasoned methodological choices (Penman-Aguilar, et al., 2016; Harper et al., 2008). Our main analyses are focused on death rates as they are considered a more accurate reflection of the rate of spread than cases that rely on inconsistent testing standards across jurisdictions.

Following published methodological guidelines, health disparities analyses in this report employ a reference point – the estimate from which differences are measured: the death rate for white people. This choice simultaneously satisfies several criteria for a reference point, including being the largest social group, the social group with the most consistent lower rate and the group with traditionally the greatest social advantage (Braveman, 2014). Group differences are assessed on an absolute scale, although differences on a relative scale are also examined. All between – and within – group differences are evaluated using a pair-wise approach. Binomial tests were conducted for data analyses, using SPSS version 26.0 statistical software (SPSS Inc., Chicago, IL, USA). P values less than .05 were considered significant.

Data Collection

Data used for the main analyses were sourced from MDHHS and the Michigan Disease Surveillance System.

APPENDIX III: Workgroup Membership

Current Task Force Members

Lieutenant Governor Garlin Gilchrist
Attonrey General Dana Nessel or her designee
MDHHS Director Elizabeth Hertel or her designee
Chief Medical Executive Dr. Natasha Bagdasarian or her designee
Dr. Brandi Nicole Basket, Chief Medical Officer for Meridian Health Plan
Dr. Matthew L. Boulton, University of Michigan
Dr. Renée Branch Canady, Michigan Public Health Institute
Denise Brooks-Williams, Henry Ford Health System North Market
Dessa Nicole Cosma, Detroit Disability Power
Dr. Connie Dang, Grand Valley State University
Dr. Marijata Daniel-Echols, W.K. Kellogg Foundation
Dr. Debra Furr-Holden, Flint Center for Health Equity Solutions
Whitney Griffin, Downtown Detroit Partnership
Bridget G. Hurd, Blue Cross Blue Shield of Michigan
Dr. Curtis L. Ivery, Wayne County Community College District
Jametta Y. Lilly, Detroit Parent Network
A. Nzere Kwabena, LGBT Detroit
Mona Makki, ACCESS Community Health and Research Center
Alycia R. Meriweather, Detroit Public Schools Community District
Dr. Randolph Rasch, Michigan State University College of Nursing
Celeste Sanchez Lloyd, Spectrum Health
Jamie Paul Stuck, Nottawaseppi Huron Band of the Potawatomi Tribal Council
Maureen Taylor, Michigan Welfare Rights Organization
LaChandra White, UAW Civil and Human Rights Department
Dr. M. Roy Wilson, President of Wayne State University

Former Task Force Members

Congresswoman Brenda Lawrence
Pastor Solomon Kinloch, Triumph Church
Senator Marshall Bullock
Dr. Audrey Gregory, Detroit Medical Center
Director Robert Gordon, former director of MDHHS
Dr. Joneigh S. Khaldun, former chief medical executive of MDHHS

Centering Equity Workgroup

Renee Canady – *Workgroup Lead*
Marijata Daniel-Echols – *Workgroup Lead*
Mariah Martin – *Administrative Lead*
Alize Asberry Payne
Tonya Bailey
Bridget G. Hurd
Teresa Branson
Yesenia Murillo
David Brown
Alethia Carr
Tedra Jackson
Megen Miller
Liliana Angel Reyes
Cynthia Taueg
Brenda Jegede
Lynn C. Todman
Fatema Mamou
Alfredo Hernandez
Cherie Ross-Jordan
Marlon Brown
Dionne M. Smith
Karen Phillippi
Janee Moore
Celeste Lloyd
Courtney Adams
Robert Orellana
Jamie Stuck
Phyllis Meadows
CJ Eason
LaChandra White
Tawana Nettles-Robinson
Cassy Jones-McBryde
Myra Lee
Bryan Modelski
Sandra Bitonti Stewart

Strategic Infrastructure Workgroup

Brenda Jegede – *MDHHS Policy Staff Lead and Workgroup Chair*
Philip Levy
Aisha Benton
Curtis Ivery
Karen Philippi
Jessie Marshall
Marijata Daniel-Echols
Maureen Taylor
Robert Orellana
William Marshall
Afton Shavers
Bre'Anna Harper
Anita Sharma
Nina Talarico
Ariel Ragin
Emma Schmidt
Ashley Tanksley
Aarti Dave

Primary Care Connections Workgroup

Randolph Rasch – *Workgroup Chair*
Danielle El-Amin – EOG Policy Staff Lead
Brandi Basket
Denise Brooks-Williams
Bridget Hurd
Jametta Lilly
Audrey Gregory
Tawana Nettles
Zaneta Adams
Celeste Sanchez Floyd
Connie Dang
Jacquetta Hinton
Alize Asberry Payne
Wenona Singel
Crystal Brown
Kathleen Oberst
Jon Breems

Mobile Health Workgroup

Philip Levy – *Workgroup Chair*
Deborah Schaefer
Christina Olsen
Juwon Harris
Alicia McGirl
Neila Sanders

Data Subcommittee

Provided and analyzed data about the direct and indirect impact of COVID-19, which was presented and utilized in Task Force work.

Beth Anderson
Christi Bramer
Joe Coyle
Michelle Doebler
Darline El Reda
Sarah Esty
Chris Fussman
Hannah Foresythe
Juwon Harris
Haifa Haroon
Christopher Jackson
Julie Johnson
Joneigh Khaldun
Prudence Kunyangna
Tom Largo
Sarah Lyon-Callo
Katie Macomber
Fatema Mamou
Patti McKane
William Marshall
Erin Mobley
Yesenia Murillo
Christina Olsen
Robert Orellana
Lauren Spadafora
Yan Tian

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