2022-2024

# Michigan's Roadmap to Healthy Communities

*Phase II: The Holistic Phase*

Addressing the social determinants of health through a collaborative, upstream approach to remove barriers to social and economic opportunity, improve health outcomes, and advance equity

Social Determinants of Health Strategy

Michigan's Roadmap to Healthy Communities

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# Letter to Stakeholders

Dear Partners,

We are proud to announce the launch of Phase II of the MDHHS Social Determinants of Health (SDOH) Strategy, *Michigan's Roadmap to Healthy Communities*. Phase II of the SDOH Strategy builds on the improvement and alignment efforts of Phase I to advance health equity through structural interventions and multisector collaboration.

The MDHHS Policy and Planning Office has had the opportunity to meet with a wide range of partners and stakeholders to garner input for the development of the strategy's successive phases. We are deeply appreciative of the significant amount of time and effort spent providing insightful feedback and informing the development of Phase II. We know that the success of this strategy is dependent on meaningful collaboration and will continue to be strengthened by input from diverse perspectives.

Phase II of the SDOH Strategy focuses on four structural interventions to positively support the social drivers of health, including Community Information Exchange, Community Health Workers, a SDOH Accelerator Plan to Reduce Chronic Disease Social Drivers, and partnerships to advance health equity. These interventions serve as 'vehicles' to drive this work forward and promote equity in opportunity.

To help ensure the success of this strategy, we are committed to staying connected to communities and supporting the expansive work happening throughout the state. We will continue working to identify and implement policies to alleviate identified barriers and support holistic, community-driven solutions.

Thank you for your continued dedication to this work. We appreciate the work being led at the local level to support communities.  We look forward to continuing to work together to ensure that all Michigan residents have the opportunity to be as healthy as possible.

Sincerely,

Ninah Sasy, Director, Policy and Planning
Michigan Department of Health and Human Services

# Introduction

*Eliminating health disparities and improving health outcomes requires a holistic approach that integrates efforts across silos and across sectors.*

### *Phase I: The 'Refinement' Phase*

Phase I of the SDOH Strategy promoted the alignment of efforts at the state, local, and community level and the improvement of programs and policies through an in-depth internal review. It prioritized efforts in three focus areas – health equity, housing stability, and food security – to be most impactful and align with existing State of Michigan-sponsored initiatives and taskforce recommendations.

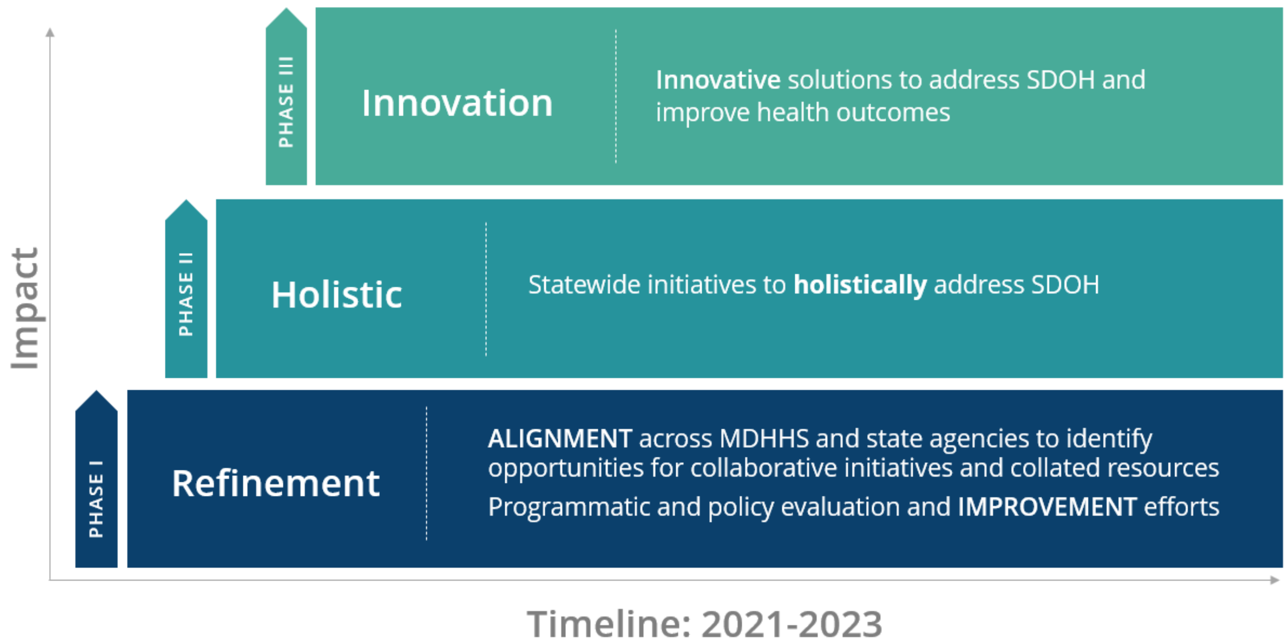



**Figure 1. Phases of the SDOH Strategy**

*SDOH Strategy Framework: Building on improvement and alignment efforts from Phase I*

In Phase I, the SDOH Strategy stratified efforts based on opportunities for ***improvement*** and ***alignment*** by assessing current State of Michigan administered programs. A wide range of MDHHS program areas were examined to identify process and qualitative improvements to current initiatives and policies, prioritizing items that were connected to Phase I focus areas. These improvements are currently being assessed and monitored to ensure measurable benefit.

Phase II will continue to promote improvement and alignment, while making more space for ***innovative*** initiatives and cross-cutting policies to address upstream prevention.

**Figure 2. The process of improvement, alignment, and innovation outlined by the SDOH Strategy**

## *Bridging the Work: Moving from Phase I into Phase II of the Social Determinants of Health Strategy*

The Phase I focus areas – health equity, housing stability, and food security – promote the alignment of efforts and allow for in-depth internal review to improve programs and policies. Phase II of the SDOH Strategy will build on these alignment and improvement efforts, while establishing the framework for structural interventions to advance this work. Phase II efforts will continue to promote alignment through multisector collaboration and support holistic solutions though structural interventions.

Phase II of the strategy is not intended to replace Phase I. Rather; it outlines interventions that aim to expand on existing efforts. Each intervention can be thought of as a vehicle to drive this work forward and establish mechanisms to more effectively advance health equity.

## *Social Determinants of Health*

The **social determinants of health** (SDOH) are the conditions in which people are born, grow, work, live, and age. When we think about these conditions, we often think about a person's physical or built environment, including factors like housing, food, and transportation. However, we must also consider the wider set of forces and systems that impact health outcomes – including structural, systemic, and political factors that drive health disparities and inequities.

*"The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world."* [1]

The background and circumstances of a person's life have a significant impact on their ability to meet basic needs and access services, which can ultimately *determine* a person's health. However, the word *determinants* can suggest that these factors somehow force health to be fated or destined. Rather, differences in population health status are remediable. The SDOH Strategy seeks to address health disparities by identifying opportunities to improve existing programs and services, aligning efforts across sectors, and through the identification and implementation of innovative policies that have the potential to create meaningful change.

### *What is driving our health?*

When talking about the social determinants of health, it is essential that we acknowledge the roles we play in actively shaping and investing in the structures and systems that create inequities. There are many **social drivers** of health, including racism, discrimination, and other forms of oppression. The embeddedness of racism in the social determinants of health and the lived experience of racism prevent many people from achieving optimal health. Health risks are not independent from systems of oppression; we know that systemic forms of racism and oppression increase the risk for poor health outcomes and continue to drive health disparities. Unjust policies and structures also continue to act as systemic and unfair barriers to health.

Phase II of the SDOH Strategy takes a more holistic approach to addressing the social determinants of health, acknowledging that we must move past the limited scope of simply addressing physical health and find ways to positively impact social drivers of health.

### *Risk Multipliers*

Though we often think about factors within the domains of the social determinants of health, there are also factors, called **risk multipliers**, that can greatly exacerbate negative health outcomes. For example, climate change acts as a significant risk multiplier for its potential to contribute to air pollution, food shortages, disease vectors, and many additional factors that contribute to poor health. Another significant risk multiplier that we have seen is the COVID-19 pandemic.

### *Lessons Learned from the Pandemic*

Like the rest of the U.S., inequalities in health and socio-economic outcomes in Michigan are significant, persistent, and have been exacerbated by the COVID-19 pandemic. Throughout the development of the SDOH Strategy, efforts have been made to identify and integrate lessons learned from the pandemic, including:

1. Address inequities – Though health disparities existed well before the first cases of COVID-19, these disparities were exacerbated by the pandemic, where people of color have been more likely to be infected by or die from COVID-19 [2]. These longstanding disparities are patterned, unfair, and unjust, and must be addressed.
2. A one-size-fits-all approach does not work – The pandemic also served as a reminder that a singular, 'one-size-fits-all' approach is not always effective. Communities and populations across Michigan have varying needs that require tailored solutions. The SDOH Strategy will continue to prioritize community engagement and ensure that proposed policies and interventions are community-led.

*Equity in Opportunity*

*The SDOH Strategy aims to improve the health and social outcomes of all Michigan residents while working to achieve health equity by eliminating disparities and barriers to social and economic opportunity.*

To achieve this goal, its strategies and objectives must work toward equity in opportunity through:

1. Establishing new, or strengthening enforcement of, existing policies supporting health equity and racial equity.
2. Asserting adverse or disproportionate social, economic, or environmental impact upon disproportionately burdened communities. These communities, or populations, include populations that have been underserved by health and social services, historically excluded, or disproportionately affected by health disparities.
3. Alleviating barriers to access programs, services, and resources that improve health and quality of life.

# Overview of Phase II

*Phase II of the SDOH Strategy will build on improvement and alignment efforts from Phase I, with a focused effort on health equity through multisector collaboration and supporting holistic solutions.*

**Health equity** remains foundational to the SDOH Strategy, not only as an outcome to strive for, but also as an essential *process* – or the *action* of removing economic, environmental, and social obstacles to health. Phase II of the SDOH Strategy identifies ***structural interventions*** – intended to be actionable mechanisms – to better advance health equity.

Four structural interventions form the foundation of Phase II of the SDOH Strategy:

**Figure 3. SDOH Strategy Phase II Structural Interventions**

### *A Holistic Approach*

Phase II of the SDOH Strategy has been designated the 'holistic' phase because it takes a more systemic approach to improving health by focusing on developing and enhancing infrastructure to provide comprehensive care. While the initiatives in Phase II each have a different focus, they all support the advancement of health equity and other strategic initiatives. For example, there is significant evidence demonstrating the value and impact of CHWs in preventing and managing a variety of chronic diseases [3]. Throughout implementation of Phase II, the SDOH Team will continue to promote integrated efforts for a greater impact.

# Health Equity Priorities for Phase II

Through the established framework of the SDOH Strategy, which includes *alignment*, *improvement*, and *innovation*, three priorities have been established to advance health equity:

**ALIGNMENT: Align efforts with statewide entities and health equity partners to take collective and coordinated action toward advancing health equity.** The MDHHS Policy and Planning Social Determinants of Health Team is partnering with the Office of Race Equity, Diversity, and Inclusion (REDI) and the Michigan Center for Rural Health (MCRH) to advance health equity, racial equity, and reduce rural health disparities.

**IMPROVEMENT: Develop policy recommendations that address the social determinants of health and support health equity.** Through the expanding and ongoing implementation of the SDOH Strategy, several policy recommendations will be developed to promote change at a systemic level. These policy recommendations will emerge from the SDOH Steering Committee, following a thorough review of input from various work groups and community engagement efforts. Improvement activities will be primarily driven by community input to ensure solutions are community-led. The SDOH Strategy seeks to be proactive in engaging communities before implementing improvements or new initiatives.

**INNOVATION: Enhance care coordination and connection to services by providing communities with the guidance and resources needed to establish SDOH Hubs.** The strategic initiatives in Phase II form the foundation to start building out Social Determinants of Health (SDOH) Hubs throughout the state. These hubs will promote regional, multisector collaboration and provide the infrastructure for a sustainable statewide framework that supports addressing the social determinants of health.

# Community Information Exchange (CIE) Priorities for Phase II

Through the established framework of the SDOH Strategy, which includes *alignment*, *improvement*, and *innovation*, three priorities have been established to support community information exchange as a strategic imperative:

**ALIGNMENT: Establish a Community Information Exchange (CIE) Task Force to elevate perspectives from consumers and social service providers in the development of statewide CIE.** To facilitate the creation of a statewide CIE, MDHHS has convened a CIE Task Force, with representation from healthcare, payers, health information technology (HIT), community-based organizations, consumers, and organizations serving communities facing health inequities. The CIE Task Force will work to achieve a set of objectives, honoring that coordinated care and health equity, supported by electronic exchange of information, is vital to improving the overall health and well-being of individuals.

**IMPROVEMENT: Develop a comprehensive blueprint for statewide Community Information Exchange to establish protocols for data governance and support system interoperability.** This person-centered approach seeks to understand multiple aspects of social and clinical needs while maintaining autonomy and dignity for those seeking supportive services. Recommendations from the CIE Task Force will be utilized as a blueprint to develop local CIEs that share technical standards to support data exchange, a resource database, and an integrated technology referral platform.

**INNOVATION: Support the development and sustainability of regional and statewide CIE through funding and technical assistance.** The MDHHS Policy and Planning Office awarded $486,500 in planning grants to local health departments (LHDs) and public health alliances, representing a total of 21 LHDs across the state, to advance planning for CIE through investments in screening platforms and additional technology. The planning grants will be implemented in FY23, with plans to make funding recurring and sustainable.

# Community Health Workers (CHW) Priorities for Phase II

Through the established framework of the SDOH Strategy, which includes *alignment*, *improvement*, and *innovation*, three priorities have been established to support community health workers as a strategic imperative:

**ALIGNMENT: Convene specialized groups to align and guide statewide CHW efforts, including a CHW Subcommittee, a CHW Internal Alignment Work Group, and a CHW Community Feedback Forum.** Through the SDOH Strategy, specialized groups have been established that will form the foundation for informing investments in community health workers.

**IMPROVEMENT: Address barriers to the successful establishment of community health workers as healthcare professionals.** To promote the expansion and sustainability of the CHW workforce in Michigan, it is important to address identified barriers through policies and system-level changes.

**INNOVATION: Invest in recruiting, training, and retention of community health workers throughout the state.** Investing in community health workers is critical for increasing access to healthcare and improving health outcomes. As such, the CHW work groups established through the SDOH Strategy will be proactive about developing sustainable funding for the recruitment, training, and retention of community health workers.

# SDOH Accelerator Plan to Reduce Chronic Disease Social Drivers Priorities for Phase II

Through the established framework of the SDOH Strategy, which includes *alignment*, *improvement*, and *innovation*, three priorities have been established to support the Accelerator Plan as a strategic imperative:

**ALIGNMENT: Increase collaboration and engagement across multisectoral partners to address the burden of chronic disease.** The increasing prevalence of chronic disease and related risk factors requires a more coordinated approach to chronic disease prevention practices. Phase II of the SDOH Strategy seeks to build capacity in coordinated chronic disease prevention and mitigating the burden of chronic disease for people most impacted. This coordinated approach seeks to better address common risk factors and the determinants that influence health behaviors, reduce duplication of program efforts, and have a greater impact in improving health outcomes.

**IMPROVEMENT: Integrate a Health in All Policies approach to chronic disease prevention programs.** The SDOH Strategy continues to seek out opportunities to integrate a Health in All Policies approach. Domains that may not traditionally consider their impact on chronic disease prevention, such as transportation, will be encouraged to identify opportunities to incorporate a health lens into the provision of programs and services. This, in turn, will impact the social, economic, and physical environments that shape people's opportunities to make healthy choices, ultimately helping to prevent chronic disease and reduce inequities in disparately impacted communities.

**INNOVATION: Develop an implementation ready SDOH Accelerator Plan to Reduce Chronic Disease Social Drivers.** Development of the Accelerator Plan will build on the existing framework of the SDOH Strategy and utilize the expansive reach and resources of MDHHS. This existing infrastructure, which includes programs, policies, and local partnerships, will support the successful development and implementation of an Accelerator Plan, ensuring capacity and promoting sustainable outcomes.

# A Closer Look at Phase II

*Phase II Structural Interventions*

Structural interventions attempt to alter the overarching context through which health disparities emerge and persist by changing the social, physical, economic, environmental and/or political environment that shape health outcomes [4]. They target factors such as food insecurity and housing instability, as well as conditions like systemic discrimination and lack of resources, which limit a person's ability to be as healthy as possible. For a greater impact on population-level health improvement and to reduce health disparities more effectively, multisectoral and multilevel structural interventions are needed.

Four structural interventions serve as the vehicles through which Phase II of the overarching Social Determinants of Health Strategy will advance efforts to address the social drivers that impact health. They include partnerships to advance health equity, Community Information Exchange (CIE), Community Health Workers (CHW), and a Social Determinants of Health Accelerator Plan to Reduce Social Drivers of Chronic Disease (often referred to more concisely as the "Accelerator Plan").

These structural interventions seek to advance meaningful and sustainable improvements in population health and reduce health disparities at the intersection of social determinants of health domains (including physical and built environment) and policy. Each intervention emerged following a thorough review of evidence to support their effectiveness in reducing structural inequities that lead to health disparities and were developed through a series of partner meetings to garner input from subject matter experts and stakeholders.

# Health Equity

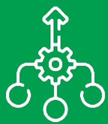
In Phase I of the Strategy, three priorities were identified for the health equity focus area:

1. Supporting people made vulnerable to health outcomes
2. Improving MDHHS-driven equity programs and policies
3. Strengthening community engagement to support community-driven solutions

Phase II of the strategy expands on these priorities through its framework of *improvement*, *alignment*, and *innovation*. Through the SDOH Strategy, we are working to *improve* the social programs and services that can help reduce health disparities, identifying and implementing institutional changes and policies that support SDOH. *Alignment* – which includes collective action – and *innovative* initiatives are also necessary to tackle health inequity and ensure a healthy environment for all.

## Health Equity Priorities

Health equity is integrated throughout the strategy and its implementation. Through the established framework of the SDOH Strategy, which includes *alignment*, *improvement*, and *innovation*, three priorities have been established to advance health equity:



**ALIGNMENT:** Align efforts with statewide entities and health equity partners to take collective and coordinated action toward advancing health equity.

The MDHHS Policy and Planning Social Determinants of Health Team is partnering with the Office of Race Equity, Diversity, and Inclusion (REDI) and the Michigan Center for Rural Health (MCRH) to advance health equity, racial equity, and reduce rural health disparities.

### *Partnership with the Office of Race Equity, Diversity, and Inclusion (REDI)*

The MDHHS SDOH Team is partnering with the REDI Office to support initiatives to advance equity and develop an updated, statewide Health Equity Roadmap.

### *Health Equity Initiatives Led by the MDHHS Office of Race Equity, Diversity, and Inclusion (REDI)*

**PUBLIC ACT 653**

The Minority Health Law (PA 653) has several provisions and is aimed at addressing racial and ethnic health disparities in Michigan to improve health equity. This legislation was passed by Michigan's 93rd Legislature in 2006 and became effective in January 2007. It amends the Michigan Public Health Code (1878 PA 368; MCL Section 333.2227). Public Act (PA) 653 focuses on five racial, ethnic, and tribal populations in Michigan: African American, Hispanic/Latino, Native American, Asian American/Pacific Islander, and Arab/Chaldean American.

Five of the provisions of the law require MDHHS to:

- Develop and implement a structure to address racial and ethnic health disparities in the state of Michigan;
- Develop and implement an effective statewide strategic plan for the reduction of racial and ethnic health disparities;
- Establish minority health policy;
- Promote workforce diversity; and
- Take additional actions to advance health equity as specified in the provisions of the act.

### *Supporting PA 653 through the SDOH Strategy*

The SDOH Team is currently fostering conversations on ways to better support PA 653 through initiatives to promote diversity in nursing and through addressing social needs through the nursing profession. Considerations on updating the law's language will be assessed. Securing resources to fund implementation of strategies is needed. Conversations are ongoing and specific initiatives will be developed in FY 23.

*Health Equity Initiatives Led by the MDHHS Office of Race Equity, Diversity, and Inclusion (REDI), continued*

### EQUITY IMPACT ASSESSMENT

The **Equity Impact Assessment (EIA)** will guide MDHHS leaders to think through the full implications that decisions (i.e., programs, policies, practices, etc.) have on marginalized populations and produce equity outcomes. The EIA provides equity-based training, technical assistance, and tools to build awareness, increase knowledge, and strengthen capacity of pilot work areas to use equity tenets to make decisions, develop, and implement practices, procedures, and policies that incorporate an equity lens.

The Equity Impact Assessment process includes 24 hours of foundational training, as well as training and technical assistance on:

- Data collection and interpretation
- Root cause analysis and problem statement
- Engagement of priority populations and stakeholders
- Intervention Proposal/Consensus Workshop
- Testing and data analysis
- Standardization, accountability, and sustainability

The Office of Equity and Minority Health (OEMH) led an EIA demonstration project to address Governor Whitmer's Executive Directive 2020-09 – Addressing Racism as a Public Health Crisis.  The EIA demonstration project was initiated in May 2021 and will end the beginning of 2023.  The EIA process will be replicated though a pilot within up to eight additional areas within MDHHS in addition to other state offices addressing SDOH.

Outcomes will include:

- Increase in awareness, knowledge and capacity in equity concepts and application.
- Increase in competencies and skill development – the ability to use one's knowledge effectively and readily in executions or performance in equity considerations.
- Behavior change 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.

*Health Equity Initiatives Led by the MDHHS Office of Race Equity, Diversity, and Inclusion (REDI), continued*

## REGIONAL HEALTH EQUITY COUNCILS

The MDHHS Office of Equity and Minority Health (OEMH), in partnership with the Michigan Public Health Institute (MPHI) offered a unique opportunity for local community organizations to serve as a backbone organization (BBO) for the establishment of **Regional Health Equity Councils**. The expected impact of the councils on Michigan residents is twofold; The first impact is to build on MDHHS' desire to establish an advisory infrastructure between MDHHS and the community. The second impact is to provide more of the decision-making power within communities and in the hands of those with the lived experience to shift the imbalance of power and uplift the direct needs among populations at high-risk and underserved, including racial and ethic minority populations and rural communities.

Through the configuration of each council is unique to their region, each council is representative of the racial and ethnic minority populations in the region, includes grassroots organizations, community-based organizations, tribal organizations, or local health and human service providers, as well as cross-sector partners like education, transportation, housing, and community members with lived experience. Regional Health Equity Councils will self-determine their priorities based on the needs of their community in accordance with efforts that seek to accomplish five key goals:

1. A reduction in COVID-19 disparities in impacted communities specifically among Michigan's five racial ethnic minority populations
2. Planned reduction of community identified priority risk factors
3. Development and implementation of practices and policies to promote equity and reduce health disparities
4. Equitable distribution and efficient use of resources to support affected communities, including organizations both existing and emerging
5. Community driven, not agency driven, decision making and priority setting

### *Partnership with the Michigan Center for Rural Health*

Michigan residents living in rural areas are a population that experience significant health disparities, including higher incidence rates of chronic illness such as diabetes, hypertension, and obesity [5]. These disparities are often driven by factors such as geographic isolation, lower socioeconomic status, limited access to healthcare and other resources, and limited job opportunities. This inequality is intensified as rural residents are less likely to have employer-provided health insurance coverage.

To better support rural communities, the MDHHS SDOH Team is partnering with the Michigan Center for Rural Health (MCRH) to reduce rural health disparities and support communities that have been underserved by health and social services. Together, MDHHS and the MCRH will develop an actionable plan to address the social and economic factors that greatly impact health status and vulnerability to adverse health outcomes. The plan will outline strategies to improve access to services and resources, including healthcare providers, transportation, and broadband internet.

### *Partnership with Communities*

Building bridges for collaboration is a crucial part of our strategy to establish healthy communities. Community feedback will be incorporated throughout the development and implementation of the SDOH Strategy to ensure that the strategy supports equitable, community-driven solutions.

Robust community engagement efforts will ensure that residents are able to provide meaningful input on policies and programs. Utilizing fair compensation practices for community members is necessary to demonstrate our commitment to engaging community voices and recognizing the value those with lived experiences add to our work. Valuing residents as experts and adequately compensating them for their time is a crucial facet of our community engagement model.

The MDHHS SDOH team will clearly define engagement criteria before engaging community members in any activity. These criteria may include, but are not limited to, a person's lived experiences, expertise, and/or skills that are relevant and aligned with the targets of the activity. Criteria for engagement and compensation will be clearly communicated before and during recruiting community members to participate in the activity.

To review the SDOH Strategy Community Engagement Strategy and Compensation Policy, please see Appendix K.

## **IMPROVEMENT:** Develop policy recommendations that address the social determinants of health and advance health equity.

Through the expanding and ongoing implementation of the SDOH Strategy, several policy recommendations will be developed to promote change at a more systemic level. These policy recommendations will emerge from the SDOH Steering Committee, following a thorough review of input from various work groups and community engagement efforts.

Improvement activities will be primarily driven by community input, to ensure solutions are community-led. The SDOH Strategy seeks to be proactive in engaging communities before implementing improvements or new initiatives.

*Community Engagement Strategies*

**Mini-Grants to Support Community Engagement**

The MDHHS Policy and Planning Office may provide mini-grants to community partners to support community-led engagement; funds can be used to organize and facilitate multiple layers of community engagement including stakeholder workshops, community conversations, equity action labs, and action team sprints to access community voice to create ways to use the power of MDHHS to support the priorities identified by the community.

**Compensation to Support Community Participation in SDOH Task Forces/Work Groups**

The MDHHS Policy and Planning Office may provide compensation to community members and small non-profit organizations to serve on SDOH task forces, workgroups, subcommittees, etc.

For more information about community engagement strategies and providing compensation to community members for their input, please see Appendix K.

During Phase II, an evaluation of Phase I initiatives will commence, seeking out opportunities for better alignment, improvement, and innovation. Through this evaluation process, the SDOH Team will work to identify policy opportunities, best practices, and solutions to address barriers.

## **INNOVATION:** Enhance care coordination and connection to services by providing communities with the guidance and resources needed to establish SDOH Hubs.

The strategic initiatives in Phase II, outlined in more depth in subsequent chapters, form the foundation to start building out Social Determinants of Health (SDOH) Hubs throughout the state. These hubs will promote regional, multisector collaboration and provide the infrastructure for a sustainable statewide framework that supports addressing the social determinants of health.

Funding will also be allocated to support this infrastructure. In November 2022, the MDHHS Policy and Planning Office awarded $500,000 in planning grants to local health departments (LHDs) and public health alliances, representing a total of 21 LHDs across the state, to:

a. Implement Community Health Needs Assessments (CHNAs) to aggregate needs and assess capacity
b. Develop Community Health Improvement Plans (CHIPs) based on findings of CHNAs that prioritize interventions to meet identified community needs; and
c. Support the implementation of community-driven solutions to address SDOH priorities outlined in Community Health Improvement Plans (CHIPs).

The planning grants will be implemented in FY23, with plans to make the funding recurring and sustainable.

**PHASE II STRUCTURAL INITIATIVE:**

# Community Information Exchange (CIE)

As identified in Phase I of the SDOH Strategy, Community Information Exchange (CIE) is vital to the success of our statewide SDOH efforts:

***Strategy DS-2: Promote interoperability between health care and social care organizations through the establishment of a Closed-Loop Referral System.***

*Interoperability*

**Interoperability** refers to the extent to which systems and devices can exchange and understand shared data. To ensure interoperability, data must be able to be shared across varied settings, like a doctor's office or food bank, that may have different software applications and information technology vendors. The SDOH Strategy seeks to promote interoperability to facilitate the secure electronic exchange of social and clinical care information so that providers can treat people holistically. This goal is essential to enabling individuals and providers to have appropriate access to information that supports holistic (all-inclusive), coordinated care, and improves health outcomes.

**Initiative DS-4.0.3** Identify and work with regional collaboratives (e.g., organizations that facilitate community-clinical linkages) and academic institutions to determine and disseminate replicable and evidence-based practices to end health disparities.

***Strategy FS-8: Increase cross-enrollment rates in public assistance programs through outreach and barrier mitigation.***

To advance these efforts, Community Information Exchange is one of four structural initiatives outlined in Phase II of the Strategy.

## What is Community Information Exchange?

At a high level, a Community Information Exchange (CIE) is an evolving set of best practices and technology guided by the goal of identifying and addressing social needs. It creates an infrastructure so that both clinicians and community providers can make more informed decisions at the individual and community level to address social needs and improve health. CIE is characterized by a "no-wrong door approach" meaning that any entity that a person engages with, whether it is clinical or community-based, provides a pathway to identify an SDOH need and connect them with someone who can help them to address it.

Organizations involved in CIE rely on technology and data to make this work. Data from screenings and referrals can then be used to better understand the needs of the individual and community. There is also a strong component of consumer mediated access to information, where the individual receiving services has agency in their data sharing, treatment decisions, and community referrals.

For more information about CIE, please see Appendix G: Community Information Exchange Diagram and visit www.Michigan.gov/SDOH.

## The Benefits of CIE

CIE offers distinct benefits to individuals, partners, and the community-at-large (Healthier Here).

Individuals benefit from a universal, person-centered record of life events and system interactions that enable providers to proactively tailor services to individual needs. Using a universal longitudinal record also supports trauma-informed care by reducing the need for individuals to repeatedly share their experience and situation to different service providers. The CIE allows for a responsive and proactive system, allowing quicker connections to appropriate services, no wrong door, shared decision-making, and better connection to culturally and geographically appropriate care.

At the agency level, a CIE empowers providers to efficiently collaborate across health and social sectors using shared language and shared metrics to deliver comprehensive care while generating streamlined referrals. CIE provides better awareness of community resources, less duplication of efforts, and access to outcome data to inform plans and assess impact.

CIE provides the community with insights into broader trends, building a system that can proactively address unmet needs and barriers, as well as disparities in access to services. This data also can be used to drive more informed and equitable allocation of resources, inform local planning and funding priorities, and to advocate for policy change.

## Components of a Successful CIE

CIE isn't a one-size-fits-all solution but there is a shared set of characteristics. *Screening* is a critical component, but there are a variety of standard and non-standard options differing in what questions are asked, who asks them, and how they are captured and coded. Ultimately, the SDOH Strategy seeks not to implement a standardized screening tool, but to provide guidance on screening to ensure that information can be easily shared and commonly defined across providers and organizations.

Essential to success, is an up to date and accurate ***resource directory***, preferably with detailed information on service array, available appointments, and payments accepted. Currently, Michigan's primary resource directory is 2-1-1, a service that connects residents with local community-based organizations across the state offering thousands of different programs and services. Efforts are currently underway to bolster 2-1-1 to support a comprehensive, up-to-date resource directory.

A ***referral system*** involves both technology and people. Successful community information exchange requires widespread access to broadband and technology and a workforce trained in its use, agreed protocols around data collection and coding, staff with dedicated time to facilitate the referral process, and a robust network of referral partners. The chosen technology needs to facilitate referrals, follow-through on referrals all while capturing quality data and being interoperable with other systems. Ideally, it also includes metrics and methods to ensure it's effective – that a person referred for help also receives it which is referred to as a *closed-loop referral*. One such referral system is MI Bridges, a tool that connects Michigan residents to resources specific to their locations, needs, and circumstances. Continuous efforts to improve the MI Bridges platform are underway, including the *No Kids Hungry Closed Loop Referral Project*, outlined in Phase I of the SDOH Strategy.

## Community Information Exchange Priorities

Through the established framework of the SDOH Strategy, which includes *alignment*, *improvement*, and *innovation*, three priorities have been established to support community information exchange as a strategic imperative:

**ALIGNMENT:** Establish a CIE Task Force to elevate perspectives from consumers and social service providers in the development of statewide CIE.

To facilitate the creation of a statewide CIE, MDHHS has convened a CIE Task Force, with representation from healthcare, payers, health information technology (HIT), community-based organizations, consumers, and organizations serving communities facing health inequities. The CIE Task Force will work to achieve a set of objectives, honoring that coordinated care and health equity, supported by electronic exchange of information, is vital to improving the overall health and well-being of individuals.

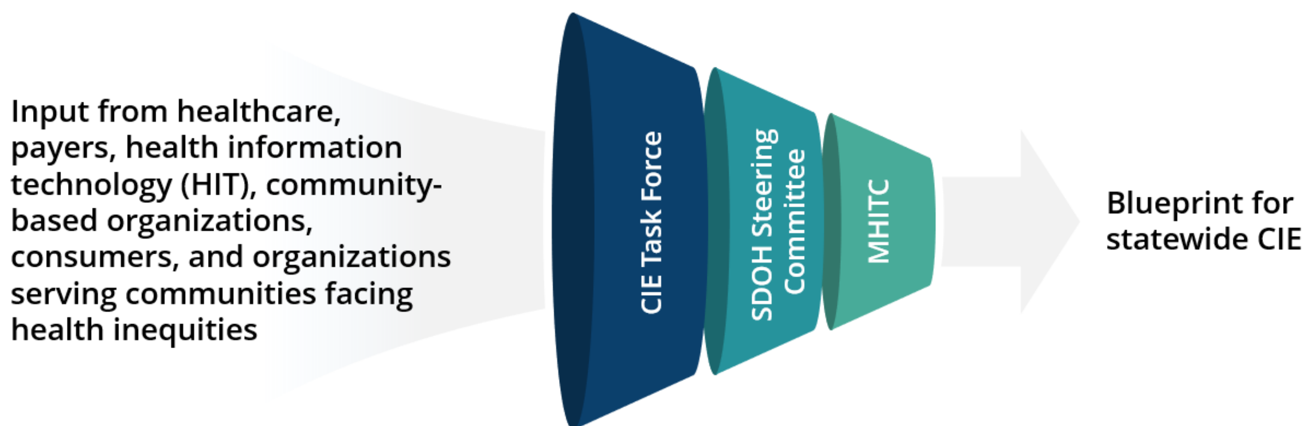



***Figure 4. Input guiding the development of the statewide blueprint for CIE, with the CIE Task Force providing recommendations to the SDOH Steering Committee and the Michigan Health Information Technology Commission (MHITC).***

### *CIE Task Force Objectives*

The Community Information Exchange (CIE) Task Force is chartered to:

1. Create a coordinated knowledge resource in service of:
    a. The Michigan Health Information Technology Commission (MHITC) Roadmap, *Bridge to Better Health*
    b. The Michigan Department of Health and Human Services (MDHHS) Social Determinants of Health Strategy, *Michigan's Roadmap to Healthy Communities*
2. Examine CIE related perspectives from all interested parties and partners, with an emphasis on community and those organizations on the forefront of providing services to communities who face health inequities with a goal to advise.
3. Examine promising state, national, and global strategies that could accelerate, support, and improve CIE in Michigan with a goal to advise.
4. Advise the State of Michigan on the development of a blueprint for CIE.

For more information about CIE and updates on the CIE Task Force, please visit www.Michigan.gov/SDOH.

**IMPROVEMENT:** Develop a comprehensive blueprint for statewide CIE to establish protocols for data governance and support system interoperability.

This person-centered approach seeks to understand multiple aspects of social and clinical needs while maintaining autonomy and dignity for those seeking supportive services. Recommendations from the CIE Task Force will be utilized as a blueprint to develop local CIEs that share technical standards to support data exchange, a resource database, and an integrated technology referral platform.

## **INNOVATION:** Support the development and sustainability of regional and statewide CIE through funding and technical assistance.

The MDHHS Policy and Planning Office awarded $486,500 in planning grants to local health departments (LHDs) and public health alliances, representing a total of 21 LHDs across the state, to advance planning for CIE through investments in screening platforms and additional technology. The planning grants will be implemented in FY23, with plans to make the funding recurring and sustainable.

The planning grants build on existing local efforts, while promoting alignment to establish a long-term statewide framework that supports addressing the social determinants of health.

## Opportunities to Support Statewide CIE

Community collaboration is essential to align systems, leverage data to identify and address gaps, and generate consensus around essential policy change. As these efforts progress, there is an opportunity for social and clinical care partners throughout the state to improve data sharing and collaborate on data collection.

Following the SDOH Strategy framework, agencies can advance these efforts through:

- Ensuring local CIE efforts are in ***alignment*** with forthcoming recommendations from the CIE Task Force and the blueprint for statewide CIE. Alignment is key to moving toward interoperability.
- Identifying opportunities for ***improvement*** of existing data collection and sharing practices and implementing these improvements.
- Seeking out ***innovative*** solutions to collaborate on data collection between clinical and social service agencies to improve access to programs and services.

## PHASE II STRUCTURAL INITIATIVE:

# Community Health Workers (CHW)

While technological approaches are important to connect people to resources, a person-centered approach is also needed to ensure those connections are made for people who face barriers to access. In Phase II of the SDOH Strategy, community health workers (CHWs) have been identified as a strategic imperative, fulfilling the need for a person-centered approach to support statewide SDOH efforts. This bilateral approach – utilizing both technological and person-centered strategies – helps bridge the gap between social and clinical care services, with the aim of more holistic (all inclusive) care and reducing barriers to access programs and services.

These efforts were initially outlined in Phase I of the SDOH Strategy within the health equity focus area:

***Strategy HE-6: Build community capacity by supporting local efforts that improve regional collaboration and integration of social care into health care delivery.***

- **Initiative HE-6.0.2:** Increase community health workers (CHWs) among communities of historically marginalized populations to build a workforce that integrates social care into health care delivery.
    - Collaborate with CHW partners in Michigan to fund training/certification of CHWs for individuals who are from historically marginalized communities and/or people whose primary language is not English.

In Phase I of the SDOH Strategy we worked with the Michigan Community Health Worker Alliance (MiCHWA) on workforce development and training. We are continuing to expand our partnerships with CHW partners by ramping up our efforts in Phase II to advance health equity through our CHW alignment and sustainability efforts.

## What are Community Health Workers?

*"A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."*

- American Public Health Association

*CHWs may be known by many titles, which include, but are not limited to:*

- Certified Peer Support Specialist
- Community Health Advocate
- Community Outreach Worker
- Community Neighborhood Navigator
- Family Health Outreach Worker
- Outreach and Enrollment Worker
- Community Health Representative
- Recovery Coach
- Community Health Outreach Worker
- Community Health Worker
- Early Intervention Services (EIS) Worker
- Maternal Child Health Worker
- Promotor/a

## The Benefits of Community Health Workers

Cross-sector collaboration requires person-centered approaches, including working with community health workers. CHWs play an important role in addressing health disparities, because they are most often trusted members of the communities they work in and connect those they serve to a wide range of services.

Studies have shown that when implemented correctly, CHW programs can:

- ✓ Increase organizational awareness of social determinants of health and local community resources,
- ✓ Increase patient/consumer satisfaction and trust in health care organizations, and
- ✓ Provide a number of other important services to improve outcomes and reduce costs, particularly in communities most affected by inequities [6].

Alignment and expansion of CHW efforts could have positive impacts on Michigan communities experiencing the greatest health disparities by addressing health more holistically.

The current body of scientific evidence demonstrates the value of CHW services to improve health care outcomes. Many interventions that integrate CHW services into health care delivery systems are associated with reductions in chronic illnesses, better medication adherence, increased patient involvement, improvements in overall community health, and reduced health care costs [3].

A study conducted in Detroit's Cody Rouge neighborhood found that program participants assisted by CHWs had fewer visits to the emergency department and more outpatient ambulatory care resource use [7].

CHWs have also been shown to contribute to improving patterns of service utilization, reducing health inequities, improving health literacy and patient navigation, chronic illness prevention and management, community development, and preparedness [8].

## Community Health Worker Priorities

Through the established framework of the SDOH Strategy, which includes *alignment*, *improvement*, and *innovation*, three priorities have been established to support Community Health Workers as a strategic imperative:

**ALIGNMENT:** Convene specialized groups to align and guide statewide CHW efforts, including a CHW Subcommittee, a CHW Internal Alignment Work Group, and a CHW Community Feedback Forum.

Through the Strategy, specialized groups have been established that will form the foundation for informing investments in Community Health Workers.

### *CHW Subcommittee*

The CHW Subcommittee will focus on alignment and expansion efforts across Michigan to support sustainable CHW efforts. This group will be inclusive of partners on the ground doing CHW work. Selection of subcommittee candidates included a systematic analysis of their experience working as a CHW, working with CHWs, and assessment of the composition of the group as a whole. This rubric guided review process ensures representation of diverse perspectives by including consideration of representation from underserved and/or historically excluded populations, inclusion of varying organizations, and representation from those living and working across distinct areas in Michigan.

The priorities of the CHW Subcommittee are:

1. Better align CHW efforts by consistently sharing best practices and coordinating approaches to mitigation of barriers
2. Identify meaningful measures of CHW work to demonstrate value and illustrate impacts
3. Build a community engagement strategy to raise awareness of the importance and impacts of CHW work
4. Create recommendations to support a standardized basic training for CHWs as well as opportunities for specializations to support community needs
5. Explore sustainable funding models and opportunities

These priorities will be refined, and measurable goals will be established as the group continues to meet.

### *CHW Internal Alignment Work Group*

The CHW Internal Alignment Work Group is comprised of MDHHS staff that are working on initiatives that include CHWs. The Work Group takes an inward look at how CHWs are being integrated into state-level programs and services, and seeks out ways to scale them, address barriers, and identify best practices. Its priorities include:

- Advise and support the CHW Subcommittee in identifying appropriate policy and funding levers to expand and align the CHW workforce and maximize the positive impacts of CHWs on SDoH in Michigan.
- Develop an aligned path forward in working with entities that support CHW development, training, certification and the broader CHW profession to support future CHW projects and initiatives.
- Identify opportunities to connect and partner with other CHW stakeholders invested in addressing health equity in Michigan.
- Address gaps in how CHWs are recruited and how their unique perspectives and strengths are leveraged to support MDHHS programs and priorities.

### *CHW Community Feedback Forum*

While the CHW Subcommittee and the CHW Internal Alignment Work Group are limited in membership, the CHW Community Feedback Forum provides an opportunity to capture broader input as these efforts progress. The Forum is open to CHWs and other partners interested in CHW efforts to provide feedback to the CHW Subcommittee before recommendations are finalized. Its aim is to elevate community voices and capture a broad range of perspectives, ensuring that this work continues to be community-driven.

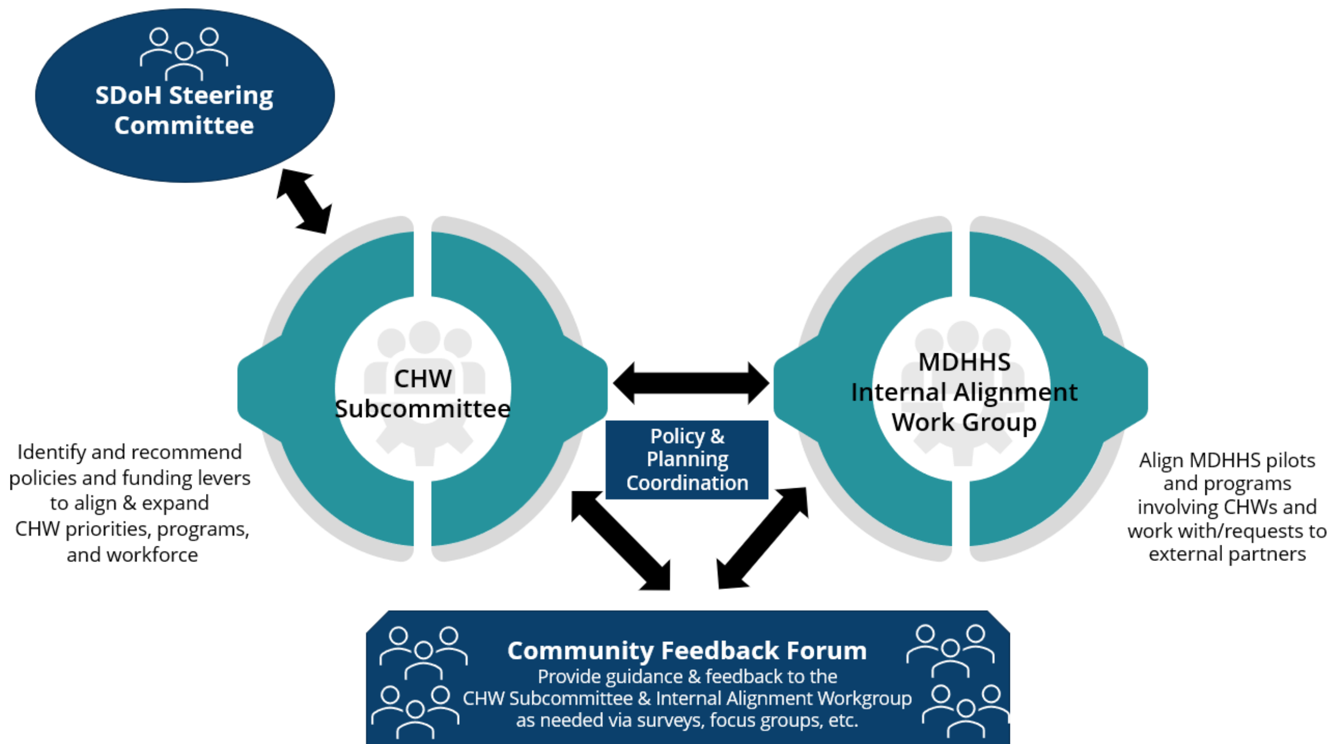



Figure 5. A diagram showing the various groups guiding CHW efforts in Michigan

## **IMPROVEMENT:** Address barriers to the successful establishment of community health workers as healthcare professionals.

To promote the expansion and sustainability of the CHW workforce in Michigan, it is important to address identified barriers through policies and system-level changes.

As part of our lead up to Phase II of our strategy, we met with a range of stakeholders both internal and external to MDHHS, and at our August partner meeting, we asked for feedback on some of the barriers to CHW work, sustainability, and expansion in Michigan. Barriers identified through the partner meeting correspond with barriers identified nationally in 2019.

*CHW Barriers, according to the National Academies of Sciences, Engineering, and Medicine (2019)*

- Inconsistencies in the scope of practice, training, and qualifications
- Insufficient recognition by other health professionals
- Lack of sustainable funding

*CHW Barriers Identified in August 2022 SDOH Partner Meeting Breakout Sessions*

- Need to clearly outline CHW definitions and roles and there is a need for training and certification/credentialing standards
- CHW pay and staffing concerns: CHWs are stressed, underpaid, and overworked
- Organizational/systemic issues, most often related to funding and billing (including Medicaid)

The work groups established through the SDOH Strategy will work to align CHW partners across the state to collectively address these barriers.

*Addressing CHW Barriers*

**CHW Training Requirements**

Michigan does not currently have standardized requirements for CHW certification, however, MiCHWA has developed CHW training and education standards, with the intention that these will be used for future state-level policies.

**CHW Funding**

New funding mechanisms have positively impacted the CHW profession in Michigan. Most recently, the Michigan legislature passed an Omnibus Budget bill with boilerplate language directing MDHHS to establish reimbursement for CHWs.

To review the full boilerplate language, please see Appendix I.

## **INNOVATION:** Invest in recruiting, training, and retention of CHWs throughout the state.

Investing in community health workers is critical for increasing access to healthcare and improving health outcomes. As such, the CHW work groups established through the strategy will be proactive about developing sustainable funding for the recruitment, training, and retention of community health workers.

## Opportunities to support statewide CHW efforts

A collective approach is essential to the success of expanding and supporting the CHW workforce in Michigan. As these efforts progress, there is an opportunity for SDOH partners throughout the state to integrate person-centered approaches to support more holistic care.

Following the SDOH Strategy framework, agencies can advance these efforts through:

- Participating in the CHW Community Feedback Forum to share feedback and promote ***alignment*** of CHW efforts.
- Identifying opportunities for ***improvement*** of existing CHW programs and services, and ways to better support the CHW workforce.
- Seeking out ***innovative*** ways to integrate person-centered approaches to improve access to programs, services, and resources for populations that have been underserved.

**PHASE II STRUCTURAL INITIATIVE:**

# SDOH Accelerator Plan to Reduce Chronic Disease Social Drivers

Within Phase I of the SDOH Strategy, a broad set of objectives to address housing instability and food security were outlined. Phase II of the strategy will build on these focus areas from Phase I by integrating additional determinants that impact chronic disease risk factors.

## What is the Accelerator Plan?

The SDOH Accelerator Plan to Reduce Social Drivers of Chronic Disease, also shortened to the 'Accelerator Plan' will be comprised of strategies to reduce chronic disease by addressing social drivers of health and better support individuals with existing chronic conditions. MDHHS received funding from the CDC's National Center for Chronic Disease Prevention to support engagement with community partners during the development of the implementation ready Accelerator Plan to comprehensively address community conditions driving health inequity.

***The Accelerator Plan aims to reduce disparities in health outcomes related to chronic disease, with a particular focus on populations disproportionately impacted by chronic disease. It will identify strategies to improve food and nutrition security and the built environment (including housing and transportation), while considering risk multipliers, such as climate change and the COVID-19 pandemic.***

Addressing social determinants of health, including built environment and food and nutrition security, has the potential to narrow disparities in many chronic diseases by removing systemic and unfair barriers to practicing healthy behaviors. This ensures everyone has more equitable opportunity to make healthy choices and promotes more sustainable positive health outcomes.

## Chronic Disease in Michigan

Chronic diseases account for seven of the ten leading causes of death in Michigan and are responsible for a great deal of morbidity and disability [9]. More than 60 percent of Michigan's adult population suffers from a chronic disabling condition, such as arthritis, heart disease, hypertension, or diabetes. In addition, over 95 percent of Michigan adults report behaviors that can lead to many chronic diseases, such as smoking, unhealthy diet, lack of physical activity, and alcohol use.

Through broad strategies will be implemented in improve health for all Michigan residents, there is acknowledgement that the burden of chronic disease is not shared equally. To ensure the greatest impact on health and equity, the SDOH Strategy places and emphasis on supporting populations that have been historically disadvantaged by policies, practices, and systems, leading to persistent health disparities and inequities.

Additionally, results from a literature review suggest the following:

- Chronic diseases such as heart disease, diabetes, and kidney disease disproportionately affect racial and ethnic minorities [10]
- Economic factors have been linked to food insecurity and obesity across the life stages [11]
- The influence of socio-economic factors on health is closely related to lifestyle, where health is maintained through opportunity to make healthy lifestyle choices [12]

## The Benefits of Preventing Chronic Disease

While it seems inherent that preventing chronic disease is an outcome to strive for, the benefits of doing so are not limited to health – it can also yield significant savings. More than 75% of the $2 trillion spent in the U.S. on health care each year is attributed to chronic conditions, and nearly 10% of all national medical costs are obesity-related [13]. Cardiovascular disease, uncomplicated diabetes, and hypertension also cost society an excess of $580 billion each year [14]. Trust for America's Health estimates that an investment of $10 per person per year in proven community-based programs to address the risk factors for chronic disease could save the country more than $16 billion annually within five years – a return of $5.60 for every $1 spent [13].

## A Collective Approach

To promote collaboration and ensure the Accelerator Plan incorporates diverse perspectives, a multisector team worked together to develop the grant proposal for the CDC. The team included representation from a wide range of partners, including partners with experience working on climate health, racial equity, and aging services.

This multisector collaboration will continue to provide the foundation for the development of the Accelerator Plan, with partners working together to promote policies and environments that support healthy behaviors and help prevent chronic disease. The development of the Accelerator Plan will also place significant emphasis on community engagement, ensuring that community voices are elevated to drive these efforts.

Though the development of an Accelerator Plan is an outcome of the grant funding, it is only an intermediate outcome of these efforts. MDHHS is committed to providing funding to implement the strategies that will come forth from the completed Accelerator Plan.

## Domains of Focus

Based on the determinants that impact chronic disease risk factors and health outcomes, the SDOH domains of focus that have been selected for the Accelerator Plan are *built environment* and *food and nutrition security*.

These domains of focus align with the established focus areas within Phase I of the SDOH Strategy (housing stability, food security, and health equity), while providing an opportunity to expand their scope. This will allow for the expansion of the housing stability focus area to integrate a wider range of factors that make up the built environment, including access to green space, reduced exposures to environmental hazards, and transportation. It will also allow for a coordinated, holistic approach to integrate efforts across domains to reduce the burden of chronic disease.

## Accelerator Plan Priorities

Through the established framework of the SDOH Strategy, which includes *alignment*, *improvement*, and *innovation*, three priorities have been established to support the Accelerator Plan as a strategic imperative:

## **ALIGNMENT:** Increase collaboration and engagement across multisectoral partners to address the burden of chronic disease.

The increasing prevalence of chronic diseases and related risk factors requires a more coordinated approach to chronic disease prevention practices. Phase II of the SDOH Strategy seeks to build capacity in coordinated chronic disease prevention and mitigating the burden of chronic disease for people most impacted. This coordinated approach seeks to better address common risk factors and the determinants that influence health behaviors, reduce duplication of program efforts, and have a greater impact in improving health outcomes.

### *Leveraging the Social Determinants of Health Interagency Workgroup to promote alignment*

The Social Determinants of Health Interagency Workgroup (SDOH-IW) will launch in January 2023 to act in an advisory capacity, with the goal of assuring that Michigan residents benefit from coordinated efforts across state agencies that support the social, economic, and health of Michigan communities. The SDOH-IW will advise on the development of the Accelerator Plan and promote alignment across state agencies in its implementation.

For a more detailed look at the coordinating bodies advising the development and implementation of the SDOH Strategy, please see Appendix D.

## **IMPROVEMENT:** Integrate a Health in All Policies approach to chronic disease prevention programs.

The SDOH Strategy continues to seek out opportunities to integrate a **Health in All Policies** approach. Domains that may not traditionally consider their impact on chronic disease prevention, such as transportation, will be encouraged to identify opportunities to incorporate a

health lens into the provision of programs and services. This, in turn, will impact the social, economic, and physical environments that shape people's opportunities to make healthy choices, ultimately helping to prevent chronic disease and reduce inequities in disparately impacted communities.

For more information about the Health in All Policies approach, and ways in which it can be integrated into additional initiatives, please see Chapter 7, starting on page 45.

*Supporting populations disproportionately impacted by chronic disease*

Interventions to prevent and reduce chronic disease will be tailored to assert adverse or disproportionate social, economic, or environmental impact upon disproportionately burdened communities. This means that SDOH efforts will be tailored to advance equity in communities that have been made vulnerable to adverse outcomes through discriminatory policies and practices. The SDOH Strategy and Accelerator Plan seek to implement both interventions to meet emergent need and address policies and practices that ultimately impact the SDOH to have a more systemic-level impact on health and well-being.

## **INNOVATION:** Develop an implementation ready SDOH Accelerator Plan.

The SDOH Accelerator Plan to Reduce Chronic Disease Social Drivers will include the following components:

a. Establishment of a Leadership Team to guide development
b. Development of strategies, activities, and objectives that are implementation ready to reduce the social drivers that negatively influence chronic disease
c. Creation of a more robust, comprehensive community engagement strategy
d. Establishment of an evaluation plan that measures short-term, intermediate, and long-term outcomes

Development of a SDOH Accelerator Plan will build on the existing framework of the SDOH Strategy and utilize the expansive reach and resources of MDHHS. This existing infrastructure, which includes programs, policies and local partnerships, will support the successful development and implementation of an Accelerator Plan, ensuring capacity and promoting sustainable outcomes.

### *Leadership Team*

A Leadership Team will advise on the development of the SDOH Accelerator Plan. The Leadership Team will use a community-based participatory approach by ensuring shared decision-making and building on identified existing resources.

Members of the Leadership Team will include diverse and inclusive members, consisting of at least two members of the community that understand the distinct characteristics and culture of the selected population(s) and are recognized by their peers as trusted voices for the community, and at least five additional representatives from different sectors with the expertise and authority to accomplish the development of the Accelerator Plan. To support equitable partnerships, the SDOH Community Engagement Compensation Policy will be employed to provide stipends. Utilizing fair compensation practices for community members is necessary to demonstrate our commitment to engaging community voices and recognizing the value those with lived experiences add to our work. Valuing residents as experts and adequately compensating them for their time is a crucial facet of our community engagement model.

For more information about the Accelerator Plan Leadership Team, please see Appendix J.

### *Policy Scan*

MDHHS will work with external experts to review policies and best practices within the state and around the country. From this, opportunities to create new policy that can accelerate SDOH efforts or remove existing policy barriers will be proposed.

*Community Engagement*

MDDHS will work with coalitions of local health departments, community-based social service providers, and health care organizations to identify and recruit community members with lived experience at the intersection of chronic disease and SDOH. MDDHS will convene regional listening sessions throughout Michigan and help local leaders facilitate conversations with community members to better understand their experiences, starting with their strengths, identifying community priorities, and learning about specific challenges that lead to worsening chronic disease. The qualitative data from the listening sessions will be incorporated into the development of the Accelerator Plan. Listening sessions will also provide an opportunity for MDDHS to build relationships with community influencers who can help sustain the work of the Accelerator Plan and provide additional accountability and review of its implementation.

## Opportunities to support the Accelerator Plan

There is an opportunity for partners throughout the state to support this collective approach to preventing chronic disease:

- Support the ***alignment*** of efforts and share best practices and challenges to preventing chronic disease in your community by participating in community engagement opportunities as the Accelerator Plan is developed.
- Identify opportunities for ***improvement*** of programs and services that prevent chronic disease by better customizing services, linking services, and reducing barriers to access.
- Seek out ***innovative*** solutions to prevent chronic disease by addressing the factors and environments that influence health behaviors.

# Building Healthy Communities

## *Utilizing a Health in All Policies approach to address key drivers of health outcomes and health inequities*

*What is Health in All Policies?*

**Health in All Policies (HiAP)** is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas. It seeks to ensure all policies have neutral or beneficial impacts on the determinants of health and introduces improved health for all and the closing of health gaps as shared goals.

Multisector partnerships are critical to improve health outcomes and reduce disparities. The Health in All Policies approach makes it possible to respond to complex issues impacting health and wellbeing. It supports the development of innovative solutions, utilizing limited resources, to address increasingly challenging problems. Collaboration across sectors breaks down the more traditional silos of government to reduce duplicative efforts, more efficiently uses resources (often decreasing costs), and improves health outcomes.

*"At its core, Health in All Policies represents an approach to addressing the social determinants of health, which are the key drivers of health outcomes and health inequities. It is founded in the recognition that public health practitioners must work with partners in the many realms that influence the social determinants of health, which are largely outside the purview of public health agencies."*

- American Public Health Association, 2013

***Figure 6. Achieving Population Health Together***

## Opportunities to Integrate a Health in All Policies Approach

Following the SDOH Strategy framework, implement a health in all policies approach in your community**:**

***Alignment***

- Establish a workgroup that includes representatives from all sectors.
- Determine a common goal and identify objectives to reach that goal. There may be opportunities to bridge resources and funding for a greater impact in your community.

***Improvement***

- Ensure policies and programs have considerations for the impact on health and well-being in your community.
- Continue to expand partnerships and improve relationships to support common goals of your community.

***Innovation***

- Develop solutions that are cost-effective and beneficial to your community by understanding the impact of health across sectors.

## MDHHS' Approach

The MDHHS Policy and Planning Office will continue to work to align and support Health in All Policies efforts by serving as a bridge to remove barriers and leverage opportunities. Through these efforts, MDHHS has developed robust strategies to leverage the work across sectors and ensure that a health lens is applied. These strategies align with the 'Five Key Elements of Health in All Policies', as outlined in 'Health in All Policies: A Guide for State and Local Governments'.

### KEY ELEMENT 1: PROMOTE HEALTH, EQUITY, AND SUSTAINABILITY

***Strategy HIAP-1: Ensure health, equity, and sustainability considerations are incorporated into policies, programs, and processes across the department.***

- **Initiative HIAP-1.1:** Distribute HiAP resources and host staff workshops to support implementation of HiAP across department.
- **Initiative HIAP-1.2:** Establish non-traditional collaborative partnerships to support sustainable solutions to funding barriers within department programs.

### *Activities to Support a Health in All Policies Approach*

There are frequent opportunities for agencies to incorporate a health lens, engage in intersectoral collaboration, or find additional ways to implement a Health in All Policies approach. These opportunities are presented through various mechanisms of government, including direct service provision, funding, and the development of regulations and legislation. For example, when considering direct service provision, departments can expand or create new services to address social needs, better customize existing services, create connections between services, and reduce barriers to access.

## KEY ELEMENT 2: SUPPORT INTERSECTORAL COLLABORATION

***Strategy HIAP-2: Convene a Social Determinants of Health Interagency Work Group (SDOH-IW), led by the Executive Office of the Governor (EOG), to act in an advisory capacity with the goal of assuring that Michigan residents benefit from coordinated efforts across state agencies that support the social and economic well-being and health of Michigan communities.***

- **Initiative HIAP-2.1:** Identify opportunities to align efforts across agencies to support the health and well-being of Michigan communities.
- **Initiative HIAP-2.2:** Identify barriers to improving food security, housing stability, built environment, and health equity through collaborative efforts across state departments.

## KEY ELEMENT 3: BENEFIT MULTIPLE PARTNERS

***Strategy HIAP-3: Identify innovative initiatives and policy opportunities that benefit multiple partners and ensure more efficient use of resources.***

- **Initiative HIAP-3.1:** Facilitate the development of shared goals to improve health, including improved access to resources.

## KEY ELEMENT 4: ENGAGE STAKEHOLDERS

***Strategy HIAP-4: Provide frequent and easily accessibly opportunities to engage with a variety of stakeholders, including community members, to ensure that solutions are responsive to community needs.***

- Initiative HIAP-4.1: Host quarterly SDOH Partner meetings to bring together a diverse group of partners throughout the state to inform the development and implementation of the SDOH Strategy.
- Initiative HIAP-4.2: Establish various work groups to inform each of the strategic initiatives outlined in Phase II of the SDOH Strategy.
- Initiative HIAP-4.3: Develop a robust community engagement strategy that outlines opportunities to connect with communities and provide community members with compensation for their invaluable feedback.

### KEY ELEMENT 5: CREATE STRUCTURAL OR PROCEDURAL CHANGE

***Strategy HIAP-5: Identify policy opportunities that will promote change at the structural level.***

- **Initiative HIAP-1.3:** Ensure request for proposal (RFP) and funding opportunities established by MDHHS require or highly recommend multisector partnerships to provide opportunities to implement a Health in All Policies approach. with the goal of showing the benefits to all sectors.

Promotion of the Health in All Policies approach will become more robust as the SDOH Strategy continues to expand. Looking ahead, the Policy and Planning Team seeks to collate additional resources on the integration of a HiAP approach that can be widely distributed across department agencies.

# Looking Ahead to Phase III

Phase III of the SDOH Strategy will create more space for innovation and will further expand on community-driven solutions. This will include providing funding and support to expand and sustain SDOH Hubs, promotion of Health in All Policies multi-sectoral initiatives, and the release of an updated Health Equity Roadmap. As our capacity increases, the SDOH Strategy will continue build on previous efforts for a greater impact.

### *Domains to Explore for Phase III*

As we continue to engage with SDOH partners across the state, we will begin to expand our domains of focus to include economic stability, education, and healthcare access. Additional opportunities will be identified to further integrate SDOH domains and promote holistic solutions that impact a range of social and economic factors.

# Next Steps

Following the launch of Phase II, the SDOH Team will continue to promote improvement, alignment, and innovation efforts. Throughout implementation and development of Phase III of the SDOH Strategy, there will be significant opportunities to engage with this work. Robust community engagement efforts will continue to inform policy recommendations and solutions to address the social determinants of health.

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**Appendix A:** Glossary of Terms

**Community Information Exchange** – care coordination practices and technology that bring together providers and data from the health and social services sectors

**Community Health Worker** – a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served

**Food Security** – means that all people, at all times, have physical, social, and economic access to sufficient, safe, and nutritious food that meets their food preferences and dietary needs to an active and healthy life

**Health Disparities** – a higher burden of illness, injury, disability, or mortality experienced by one group relative to another

**Health Equity** – means that everyone has a fair and just opportunity to be as healthy as possible (Robert Wood Johnson Foundation)

**Health in All Policies** – a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas

**Housing Stability** – means that all people, at all times, have physical, social, and economic access to sufficient, safe, and secure housing that meets their needs for a healthy life

**Risk Multipliers** – a condition that creates additional vulnerability for health hazards or threat to become a larger risk

**Social Determinants of Health** – the conditions in which people are born, grow, work, live, and age

**Social Drivers** - the social, political, and environmental conditions affecting health

**Appendix B:** Acronyms and Initialisms

**BBO** – Backbone Organization

**CDC** – Centers for Disease Control and Prevention

**CHW** – Community Health Worker

**CIE** – Community Information Exchange

**EIA** – Equity Impact Assessment

**HiAP** – Health in All Policies

**HIT** – Health Information Technology

**MCRH** – Michigan Center for Rural Health

**MDE** – Michigan Department of Education

**MDHHS** – Michigan Department of Health and Human Services

**MDOC** – Michigan Department of Corrections

**MHP** – Medicaid Health Plan

**MHITC** – Michigan Health Information Technology Commission

**MiCHWA** – Michigan Community Health Worker Alliance

**MPHI** – Michigan Public Health Institute

**MSHDA** – Michigan State Housing Development Authority

**OEMH** – MDHHS Office of Equity and Minority Health

**REDI** – MDHHS Office of Race Equity, Diversity, and Inclusion

**SDOH** – Social Determinants of Health

**Appendix C:** SDOH Partner Meeting Summaries

**Intersecting Social Determinants of Health Partner Convening**

**Wednesday, June 8, 2022, from 1:30-3:00 PM**

**Meeting Summary**

- More than 85 people representing organizations that lead and support housing stability and food security efforts contributed to the meeting. Staff from MDHHS facilitated the meeting and breakout sessions.
- Participants were provided an overview of the overarching Strategy and an overview of the intersection of social determinants.
- Our partners from the Michigan Climate & Health Adaptation Program (MiCHAP) presented on climate as a risk multiplier.
- Participants were asked to join a breakout session most relevant to their work to discuss opportunities to identify existing efforts, barriers, and opportunities related to climate.
- Feedback from each breakout session was captured and compiled. Input will be synthesized and incorporated into the overarching Strategy.

**Discussions**

In breakout sessions, participants learned more about climate intersection with food security and housing stability.

**Participants were asked in Breakout 1- Climate Intersection with Housing Stability:**

1. How does climate intersect with your work?
2. What are opportunities to better address the impacts of climate on housing stability?
3. How has climate change made it more difficult for you to serve your community?

**Participants were asked in Breakout 2- Climate Intersection with Food Security:**

1. How does climate intersect with your work?
2. What are opportunities to better address the impacts of climate on food security?
3. How has climate change made it more difficult for you to serve your community?

**Summaries from these discussions is below.**

**Breakout 1 – Climate Intersection with Housing Stability**

1. **How Does climate intersect with your work?**
    - Change in precipitation amounts and not having sufficient new infrastructure impacts housing due to homes flooding.

- Farm workers working outdoors without AC in high heat waves. Farmers may not have a chance to cool off in evening if their employer provider housing lacks AC.
- Impacts on respiratory issues due to climate change. If people are not able to live in smoke free homes, then respiratory issues could potentially be exacerbated.

2. **What are opportunities to better address the impacts of climate on housing stability?**
    - Look into options available to help during heat waves like how they use warming centers to address the effect of freezing weather.
    - Weatherization program has holistic approaches address the entire structure. What works for keeping cold air in works for keeping warm are in. As climate changes, making sure energy auditing tools are used appropriately to determine the types of measures that are installed in homes.
    - Weatherization Assistance Program clarification- what is installed in a home is determined by the Energy Audit, not by the choice or discretion of the team installing measures. So, any work done on an HVAC system, for example, is called for by the energy audit, which is a tool that gets approved by the Department of Energy in advance each year.
    - If AC is federally allowable expense within weatherization and with the very large amount of funds available over the next 5 years, recommended AC be considered so that low-income households have greater access.
    - Starting this fall funding will be release to community action agencies for weatherization.
    - Because we're talking about extreme heat, here is a Heat Health & Safety Fact Sheet, please feel free to share with your networks.

3. **How has climate change made it more difficult for you to serve your community?**
    - Shelters become fuller and sometimes reach compacity due to housing displacement because of flooding.

**Breakout 2 – Climate Intersection with Food Security**

**1. How has climate impacted your life personally?**

- Increased heat, lack of trees – increased temperature in home, increased cost
- Increased ticks

**2. How does climate intersect with your work?**

- FBCM – dramatic shifts in weather patterns during growing seasons can have an impact on what crops look like and availability to purchase them
- MASS grant – state funds to purchase directly from local Michigan farmers – have heard that the dramatic shifts in weather patterns have been impacting crop yield (reduced access and increased costs)

- Shortages, supply chain issues, increased costs
- SNAP benefits – even after the emergency expires, food costs will remain high
    - SNAP dollars are already not going as far as they were earlier in the pandemic due to the increased costs right now
    - Buying power with benefit programs is greatly reduced

**3. What are opportunities to better address the impacts of climate on food security?**

- With increased funding, what innovative ideas could be pursued?
    - McLaren – partnering with farmers markets in the state to sponsor the double up food bucks (get more for their dollar)
    - Urban grow associations improve access to nutritious food
- Looking to get more money into the hands of individuals
- Online marketplace with built in customer service support and credits – clients can select local fruits and vegetables, additional household and care products
- Delivering food who may not be able to get to a food pantry
    - Allowing them to select what works best for their family's needs

**4. How has climate change made it more difficult for you to serve your community?**

- People with physical limitations need to be able to get to the grocery store

**Nation Outside (Ashley Goldon)**

- Opportunities: looking into the future and see a wetter Michigan, concerned about the rights and well-being of formerly incarcerated people
- Need to consider lack of transportation and having to walk/commute in bad weather
    - Supporting getting people to and from the grocery store
- Workforce development for formerly incarcerated people – urban gardening; getting fresh, local produce to grocery stores
- Bolster these types of programs

**SDOH Partner Meeting: Advancing Health Equity With Community Health Workers**

**Tuesday, August 9, 2022, from 1:30-3:00 PM**

**Meeting Summary**

- More than 100 people representing organizations that lead and support Health Equity, Community Health Workers (CHWs) and/or related work contributed to the meeting. Staff from MDHHS facilitated the meeting and breakout sessions.
- Participants were provided a SDoH Strategy Phase I update, and an overview of what to expect in Phase 2, including a focus on Health Equity and aligning and expanding CHW related efforts.
- Our partners from MiCHWA (Michigan Community Health Worker Alliance) presented on their important work, and collaborative projects with MDHHS
- MDHHS also provided an update on the language in the FY23 Omnibus Budget Bill (Passed June 30), the factors in Medicaid CHW policy development, and methods of engagement that will be used throughout the policy development process.
- Participants were asked to join one of three breakout sessions, where each group shared their feedback on key findings from intern and U of M graduate student Ellie Jorling's environmental scan report.
- Feedback from each breakout session was captured and compiled. Input will be synthesized and incorporated into the overarching Strategy.

**Discussions**

In breakout sessions, participants discussed key findings of an environmental scan of CHWs.

**Key findings include:**

1. CHWs are critical component of the SDOH Strategy: they connect their communities with health and social services.
2. Funding issues: CHWs are overworked and underpaid, and should be paid with Medicaid funding, since there is precedent in other states.
3. CHW certification requirements differ across sectors and employers. To ensure equitable access to quality services and continuity in coverage, an effort to standardize or align requirements for CHWs is necessary.

**Participants were broken up into 3 breakout sessions and asked:**

1. What are your initial thoughts regarding the key findings?
2. What barriers exist to maintaining and expanding the CHW workforce in Michigan?
3. Are there other factors or opportunities that should be considered?

**Summaries from these discussions is below.**

**Breakout 1**

1. **What are your initial thoughts regarding the key findings?**
    - Integral parts of community and very helpful for patient empowerment
    - Supports some standardization on training so that employers know what core competencies to expect
    - The ability of CHWs to be billable should increase the number
    - Variations in pay based on location
    - Use MICHWA's base training
    - "Underpaid + Overworked" Findings may be truer for CBOs. BCBS has 50 CHWs that have been able to spread the work and paid well (CHWs start at $50k @ BCBS Complete)
    - Hopes for flexibilities on training requirements. Believes that BCBS Complete CHW trainings are just as good as MICHWA's
    - Agree on flexibilities on ways to train, but believes state still needs standardization on certifying the curricula submitted from various organizations
2. **What barriers exist to maintaining and expanding the CHW workforce in Michigan?**
    - Need for Spanish speaking workers (*mentioned twice*) +
    - Representation within diverse communities, for example aging populations and LGBTQ populations (*mentioned twice*)
    - **Risk**: Doctors + Nurses claiming to be CHWs without training or being able to represent the community
    - Better integration/collaboration with clinical care team, including physicians
    - Recruitment and training
    - Many potential CHWs lack formal training because they can't afford training before employment
    - Career pathways and long-term growth strategy not established
3. **Are there other factors or opportunities that should be considered?**
    - Higher pay for people who can pass language test for bilingual
    - Supporting CHWs who are paid through other programs BESIDES Medicaid (Katie Commey)

**Breakout 2**

**1. What are your initial thoughts regarding the key findings?**

- The work with MDHHS with 5 state motivation communities are often overlooked with lessons learned on implementing CHWs in the community, and the cost savings that the shires showed in utilizing CHWs (Lori Kunkel Greater Flint Health Coalition)
- I thought they were spot on (unknown)

**2. What barriers exist to maintaining and expanding the CHW workforce in Michigan?**

- The variation in language/titles of CHWs
- A lot of staff turnover because staff don't get paid enough for the work. It is hard work. Medicaid and other reimbursement help with that, but that is a barrier overall (Jennifer).
- Echo sentiment above—a lot of turnovers during pandemic—feedback was:
    - Organization/administrative level: it is so much work to get claims reimbursed/reconcile the billing—many pulled out of the CHW work
    - Individual level: pay not enough
- It is really important to make sure that the billing process is not a burden, and is easy as possible
- Certification process might inhibit certain organizations from engaging CHWs
- Medicaid currently funds health plans to hire CHWs—confusion on a community based vs. a health plan based CHW and how Medicaid will use this term consistently, so we all understand what we are talking about.
- McLaren HealthPlan: We contract with community CHWs when they will contract with us
- We need to make sure that Medicaid funding provides at least as much as current contracts if not more, to be sure that we are not losing funds and workforce
- Some health plans are good about contracting with community CHWs, while others are not at all—we should incentivize those that are since CHWs have really proven their worth & value
- Who will pay CBOs for CHWs in the future?
- Will there be funding opportunities for Community Based Organizations from MDHHS—sharing of opportunities, etc.

**3. Are there other factors or opportunities that should be considered?**

- Excited to see how the Doula program will fit into this model—they are being set up like a CHW—will they end up getting a CHW certification, or how will that look?
    - Also—how might recovery coaches fit in also—how can we better support all our support systems/workers
    - Happy to see Doula program getting recognition, but would like to learn more about the Doula workforce and how to get in contact with one/them
- We need to agree upon a standard definition, and outline of where to find resources
    - Who is included, and who gets what training?
    - It would be great to expand upon training and opportunities
    - We do need to be careful about being sure that CHWs stay the local CHWs who know the communities they are working with
    - CHWs need to be respected as a profession and compensated accordingly
    - From chat: Ensuring that we stay true to the definition of CHWs and not Social Workers of MAs or other higher-level professions being designated as CHWs

- From Chat: Wonder if there can be a collaboration between federal and state. Is there any hope to help a small sample size of recipients of Food, Cash and Housing by requiring them to be helped by a CHWs monthly if they receive benefits. Seeing a disturbing amount of unrest in the homes of beneficiaries receiving Food, Cash and Housing. I do not foresee a change in behavior or health unless they receive more than Food and money to help them with daily living. They need monthly help from CHWs.

**Breakout 3**

1. **What are your initial thoughts regarding the key findings?**
    - Key findings align with what at United has seen
    - Concerns about funding, salary range
    - Experiences: certain trainings garner more pay than others
    - Fund staff to assist with housing crises – also aligns with what they have seen
    - Would support credentialing of these staff for Medicaid reimbursement
    - Many of these agencies don't bill Medicaid – how to make sure they can benefit
    - My first thought is how this integrates nicely with the narrative about building Public Health Infrastructure (e.g., discussions in community re monkeypox, covid, etc). CHWs could be conceived of as an important piece to [re]building the infrastructure and public image of PH.
    - Important as criteria is set for training that we don't establish barriers to entry to CHW workforce
    - Lived experience is essential – often a barrier to other experiences like college

2. **What barriers exist to maintaining and expanding the CHW workforce in Michigan?**
    - CHW is an avenue for folks without access to other professions or who can't go to school, professionalization can erect barriers to entry
    - CHWs don't feel valued – underpaid
    - Hearing their CHWs are stressed and overworked
    - Feel underutilized
    - When looking at credentialing – being very careful to set the bar at an attainable level
    - Can CHWs work under a social worker to provide a supportive structure?
    - Outreach staff – move through community looking for runaway girls – trained with Narcan use and how to have conversations around SUD, sex, etc.

3. **Are there other factors or opportunities that should be considered?**
    - CHWs are excellent additions to many diverse teams in many sectors that touch health through social and non-clinical focus. I think that one barrier to CHW workforce development also exists in sectoral differences. For instance, how do local CBOs who are not otherwise linked with Medicaid or healthcare specifically reimbursed for their quality efforts in moving community health?

**SDOH Partner Meeting: SDOH Chronic Disease Accelerator Plan**

**Tuesday, October 11th, 2022, from 1:30-3:00 PM**

**Meeting Summary**

- More than 100 people representing organizations across the state contributed to the meeting. Staff from MDHHS facilitated the meeting and breakout sessions.
- Participants were provided a SDoH Strategy update, and an overview of what to expect in Phase 2, including a focus on Health Equity and aligning and expanding CHW related efforts, and the development of a SDOH Chronic Disease Accelerator Plan.
- There was a focus on key features of the Accelerator Plan as well as breakout sessions with topics including, effective engagement in your communities & networks, unique opportunities and community assets, and barriers and challenges.
- Feedback from each breakout session was captured and compiled. Input will be synthesized and incorporated into the overarching Strategy.

**Discussions**

**In breakout sessions, participants discussed community engagement success stories, barriers and gaps, and opportunities for improvement. Below are the breakout discussion questions:**

1. Success Stories: What strategies has your organization used to gather meaningful, sustained community engagement?
2. Barriers & Gaps: What challenges have you seen to effective community engagement?
3. Guidance for Mini-Grants: What factors should MDHHS consider as we design funding opportunities to support community engagement for SDOH and Chronic Disease?

**Summaries from these discussions is below.**

**Success Stories: What strategies has your organization used to gather meaningful, sustained community engagement?**

Group 3

- Sustained piece is more difficult
- Regular meetings with CHWs (*mentioned by 2 participants*)
- Health assessments were collecting the right data to find the community members who could contribute (*mentioned by 2 participants*)
- VENUE: Outreach while assisting at local farmers' markets.
  - Helped participant's organization understand its members
  - Know how they access food
  - Great opportunity in certain regions

- Work with partner orgs that already have ongoing engagement at the most local level possible
  - VENUE: Example – Info gathering at schools –> interviewing parents
    - LOCAL PARTNER: **Healthy Livonia Coalition** speaks to schools consistently
- Homeless Vulnerability Level Indicator (HMIS + CC360 integration) HIMS = Homelessness Information Management System
  - Info gathered: Recency and severity of homelessness
  - Contact information of the COC who's helping with person with housing instability
  - Further data linkage to Medical Vulnerability Indicator
    - Creates collaboration mechanism between housing and health case managers

Group 2

- LOCAL PARTNERS: Community Collaboratives, Human Services Collaboratives—cross-sector multidisciplinary groups
  - Some engage community members actively and collaboratively, while some are more focused on professionals
- We stood up permanent advisory groups—incorporate into all activities—standing stakeholder groups—membership may ebb and flow but have been helpful overall to have ongoing feedback/engagement
- Partnered with **Community Health Assessments:** lots of feedback from lots of different sectors—in person, surveys, social media, etc. Also have a really strong **CHW program** where we collect pathway info—what people need—in that way also, as well as community collaboratives as others mentioned
- With the barrier's Middle eastern population face is the lack of identification. Locally in the Metro Detroit Middle eastern community. We can collaborate with nonprofit organizations, LOCAL PARTNERS: **Municipalities** and **religious initiations** (to name a few) to engage with local populations. Having regular communications with those partnerships.
- We have community workgroups of (LOCAL PARTNER) **migrant service providers** to address the Covid-19 pandemic. Similarly, we have 9 **regional migrant resource councils** composed of hands-on local migrant service providers to elevate the health issues that they encounter and can't resolve. Often this is because a farmworker is undocumented or here on an H-2A visa.
- MPSC has conducted a series of agency assistance (VENUES) fairs and listening sessions in various locations across Michigan. **The Low-Income Energy Policy Board**, an advisory board hosted by the Commission has been intentional about including those with lived experience of energy poverty on the Board.
- *Can people also talk about how they foster engagement—incentives? Other benefits of participating?* Often, those who participate are the most comfortable speaking out. How to recruit others?

  - Patients screened for SDoH—some organizations have resources—collect that data to find out what patients need, then we have a seat at the table to advocate for those with unmet needs
- Our team has found that ensuring our approach/setup of the strategic engagement is authentic and accessible to the community supports active engagement. SUPPORTS: For example, **live CC** during meetings, recording meetings, **reviewing documents for appropriate health literacy levels**, etc.

LOCAL PARTNER: The **Ottawa County Health Department** did a comprehensive survey of farmworkers health needs. They got more than 300 responses and greatly increased our understanding of farmworkers in general. TOOL: They provided a gift card for completing the long survey, I believe it was $50. They also used **MDHHS migrant program staff** to help get survey responses from their clients.

***What special community characteristics, assets, and strengths did your engagement efforts reveal?***

***How could aspects of the proposed Accelerator Plan build on or expand these successful community interactions?***

- Looking at budget levels for CBOs and building capacity to make eligible for …

Group 1

- Resident engagement and resident empowerment is crucial to community initiatives to best understand resident voices/ social needs
- CHW are major mechanisms in partner's work
- Utilizing and improving CHNA efforts to collect meaningful data on residents needs
- Leveraging surveys to gain more in-depth details on residents and community member social needs
- Being proactive and directly reaching out to patients as well as utilizing CHWs are Strategies being used to build connections
- Established a resilience zone for community members in Muskegon heights, specifically impacting African American community
  - Lower life expectancy and other disparities are driven by SDOH factors and disinvestment
- Created a council for community members to have a voice and influence decision-making on their own
  - Started at 2 but now there are 6 **neighborhood associations councils** (LOCAL PARTNER)
- Conducting Livability Lab and using CHNA data (TOOLS) to bring community members together and address SDOH efforts and barriers to move the work forward

- LOCAL PARTNER: **Muskegon Pathways HUB** for care coordination (**Trinity Health Muskegon**): Robust CHW efforts with lots of experience & data help better understand patient social needs
- Conducting common assessments which is a tool developed by the CHIR to help gain understanding of population and can utilize the sample data that comes from the surveys
    - Barrier (funding certain aspects)
- Recruited individuals from neighborhood to do surveys in their own neighborhoods in effort to generate more conversation and gain more information about residents
    - Able to have more meaningful conversation and collect more information on community members needs since the **info is not being filtered through organizations**
- Establishing regional health equity council that creates a space for the community to come together in a more structured and meaningful way
- CHWs are conducting SDOH screenings and receiving referrals to link patients to the appropriate care – almost 50 CHWs
- Incorporating the community and other organizations by creating a joint CHNA (TOOL)
- Involving community residents and doing surveys so the community can directly influence and have a voice
    - Survey channeled through social media, partners at (LOCAL PARTNER) **Greater Health Flint Coalition**, community-based organizations
    - Gathered 100 different surveys and analyzed them to ensure they are collecting information from every zip code in the region and specific SDOH factors
    - **Trusted relationships** are important as they continue to seek funding to support their efforts
- Covers 10 counties in Northwest CHIR – only rural region
- Community engagement strategies:
    - Noticed that (LOCAL PARTNER) **Pathways Community Hub** clients are experiencing homeless after being in addiction treatment
        - Convened with clients, addiction agency, and others in the community to figure out how to address the homelessness barrier
        - One lever that need to be changed: when clients are admitted to addiction treatment, they need to ask who is paying rent and reach out to those who are utilizing housing resources to ensure that housing is secured during the 90-day treatment – convening partners and those with lived experience.
    - Robust CHNA work: Hospitals in northern region contribute to the cost of the assessments and the CHIRS prepare reports that go to IRS
        - Designed (TOOL) CHNA so it can align with needs in other region and can be used across organizations that implement CHNA
    - Conducted Community survey (4 flights of pulse surveys) where different community partners included 1-2 intake questions and was able to collect a variety of valuable data around aging, disabilities, income, etc.

    - Community survey mobilizing for action: utilizing best practices for CHNA from national association from city and council framework
        - Received disability inclusion grant for CHNA (high disability rates)
        - Grant for Equity supplement framework
    - REAL time data collected by CHW, and data is given to a host of community groups (governing body, ccl group, behavioral health group, health equity learning network, etc.)
        - Move from community engagement to community empowerment
            - Example: (LOCAL PARTNER) **Resident facilitated substance use groups** in community

- Utilize quarterly community consultations to help assess community capacity for refugee settlement
  - Must talk about the **complexity of refugees** that the community can **sustainably report**
- Continue to convene agencies and individuals from the community to represent housing, health, education, employment and more

**Barriers & Gaps: What challenges have you seen to effective community engagement?**

Group 3

- CC360 + HIMS data not current
- Funding agencies place restriction and parameters that prevent authentic engagement
    - Examples: Demographic, number, and other requirements
- Full continuum of community engagement lacking
    - **Shared decision making** is the more challenging element
    - Intentionality and creativity needed to turn info from community into policy decisions
- Prioritizing the goals within communities where the needs are great

Group 2

- Health services not being available for the undocumented and H-2A farmworkers.
- A big barrier for citizen migrant farmworkers is that MA is so hard to get in Texas, but especially Florida, that they don't want to close their MA cases there to get medical care here.
- Screening SDoH is needed, also utilizing EMR's to gather HEDIS interventions and make outbound calls to appropriate patients.
- At state level community engagement is a challenge for everyone—have had to develop policies to provide incentives, and develop all the appropriate policies to provide those to participants, and we hope to replicate that across the MDHHS

- LOCAL PARTNER 11 Health Equity Councils Set-Up with community members on the councils—with attention to power dynamics, etc. We want to keep them going, but will need to secure continued funding to get ongoing input from community members

- Aging population is growing—when we talk about engagement including surveys, education, etc.—so much has transitioned to online—we can't forget about the digital divide whether it be due to age, rural areas, technology challenges, etc. We need to remember to not overlook traditional, old-fashioned ways of communicating and connecting

***Are there subpopulations you've seen inadequately represented?***

***What would help community members contribute more consistently?***

***What would help your organization convert community guidance into practice change?***

- Having a requirement (possibly of SDoH?) for state's Medicaid Health plans to engage with vulnerable populations. Then grade them on their outreach initiatives.
- Transportation and childcare are two common barriers
- I am trying to get funding for migrant program staff that I can place with migrant health clinics to help farmworkers get MA and other public assistance as well as help them transition from the care we can provide for their chronic conditions here to health care providers in their home state
- We are nearly done with a brochure in English and Spanish (TOOL) to sum up for farmworkers how they can protect themselves from Covid-19 and to urge those with chronic conditions to seek care, especially Paxlovid
- **Arab American/ Middle eastern and the indigenous population**
- Those engaged in the community mental health system are often experiencing **co-occurring disorders** and are some of the most vulnerable.
- Spanish speaking.
- Undocumented.
- H-2A immigrants
- In my work, there is a struggle for CBOs to locate **ASL interpreters for the deaf community** who can accurately translate <u>medical terms</u> into ASL

Group 1

- Exploring ways to incentivizes residents and CHWs for their work (compensation model)
- Lack of trust with residents/community members makes it challenging to empower residents and build meaningful relationships
- Sustainability/ funding

- How can we involve those who need to be a part of community conversation? - Barriers include transportation, childcare
- Language Barriers
- Importance of continuity

- Regional Health equity council is wanting to recognize the value of community resident and having the residents participate in the council
    - Looking for guidance for possibly designing a compensation model that pays/incentivizes their work
- When talking to resident with lived experience and partners, there is a communication challenge – hired consultant in system change to assist
- SDOHs are easy to discuss but the way they impact health equity can take some time
- Barrier: Got to answer the "so what" to get others engaged

- **Lack of trust** with the community (underserved) is a barrier, especially when inviting individuals to resident led opportunities/initiatives
    - Cannot use non-profits to understand voice, want to get resident's true voice
- As funding goes away, must develop a sustainable way of doing work
    - The work takes longer than what's anticipated – end up letting the people down when things finally get to rolling
- Importance of Continuity: replication of CHIR model in areas that do not have a CHIR – opportunity to learn from each other to best address SDOH?
- Massachusetts Waiver 11-15 - addresses Medicaid population to help address SDOH
    - Are there any plans for the state to explore additional waivers? (TOOL)
- There is a need to properly acknowledge the ideas and valuable information that residents share
    - Can be difficult as others monetize the ideas
    - FOLLOW-UP? Has the state looked to partner with CHIRs in other initiatives such as the SDOH Chronic Disease plan?
- Many of the community members that need to be involved in this conversation are living in poverty with several jobs and may not have the time to devote to meetings.
- Possibly could remove barriers like **transportation** (making the meetings remote - TOOL), providing **childcare** at meetings, and ensuring the community will get something out of their participation (too many times communities have been used for their ideas **and received nothing in return**)
- Language can be a challenge, community members who do not speak English are left out of the discussion or require culturally tailored messaging for engagement
- Let folks know that we are not there to take their ideas but to help empower them and build trusted relationships – how do we sustain these relationships

What factors or opportunities should be considered as we develop funding opportunities to support community engagement?

Group 3

***What factors should MDHHS consider as we design funding opportunities to support community engagement for SDOH and Chronic Disease?***

- Be as open as possible to WHO might receive funding
- Reduce the number of requirements
- Be aware of financing and tax implications
- Recognize community members as experts and relinquish control
    - Set aside some funds for smaller orgs within the community
    - Set goals for environmental changes within the frame of the mini-grant
- Use a validated evaluation tool
    - Example TOOL: SFC Systems of Change
        - Tracks changes in power dynamics, relationships, connections among subjects
- Recognize the importance of getting direct feedback from all stakeholders (including health plan members and providers)
- Frame engagement in a way that creates openness and exploration, outside of areas that might be top of mind to MDHHS. (Humans are by nature intersectional).

Group 2

- When we talk about unrepresented groups, community development corporations, community-based organizations neighborhood associations, etc.—are often the ones with the level of trust to work effectively with the community—a lot of times funding goes to larger organizations that don't have those relationships, so funding & working with those on the ground local orgs. is important.
- Interpreting and bilingual staff are important to communities who are ESL learners
- Getting working people to participate during work hours is difficult/impossible. Evenings are better, provide a meal or a token payment for their time.
- Do all of us have the same **framework for community engagement?** This is important—the way we used to do it was a very outreach focused effort—walked away from that because was causing harm to communities—in that we needed data and didn't focus on transparent or long-term relationships/reciprocal. We have problems with how our systems run. Having a long-term committee may be very challenging within our systems. Often rely on surveys and focus groups and that's it. Our culture and organizational philosophy on this need to shift

- Build up on **already existing committees/boards**, etc. that are already there instead of creating something new—can help with sustainability of already established groups

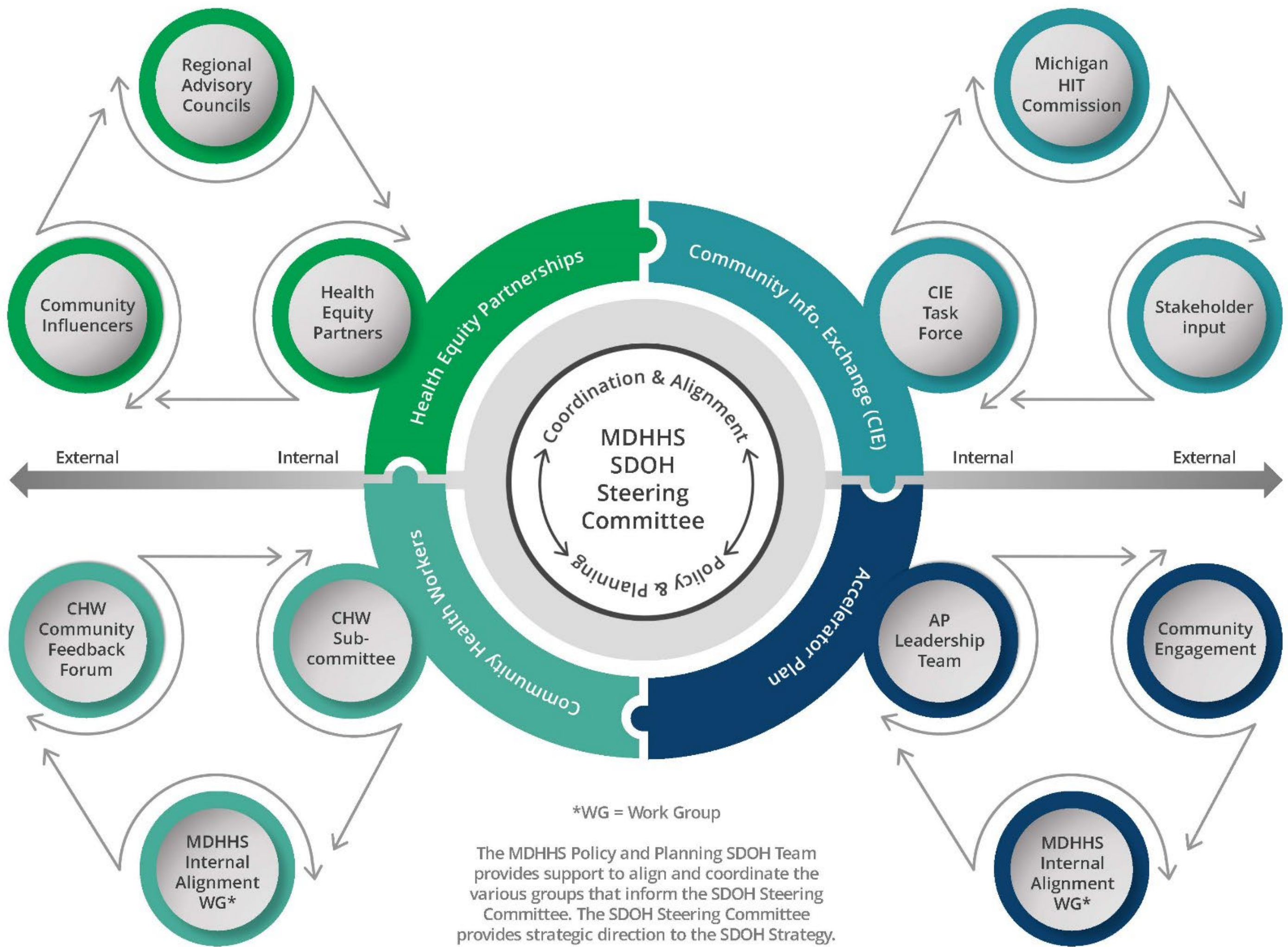
- PARTNER: Children Trust Michigan (formerly Children's Trust Fund) represents 100+ programs serving all 83 counties with primary and secondary prevention programs. These are all programs that are connected within their communities

**• REDI working on reducing cumbersomeness of the application process to allow for smaller organizations with no grant writer to apply more easily. RFP Announcement language is important—standard boilerplate language can be revised. Less application components, etc.**

Group 1

- Balance in funding and continue to utilize efforts that work
- Community benefit spending
- Incentivize CHWs and peer support model through Medicaid Reimbursement
- Balance in continuing efforts that we know work (ex: CHIR model) and new funding
  - Create opportunity for replication and innovation
- For Community Health Centers, we have a patient-leadership mandate in our funding program requirements (51% of Board members must be patients receiving services through the health Center)
- This structure helps ensure that the decision-making table of the FQHC are inclusive of those the health center is intended to serve. It can also provide a leadership development opportunity in the community.
- Could be a consideration for funding: What is the representation in the powerholders of a funded project that will direct the work?
- The state could think through ways in which Michigan can utilize community benefit spending – Michigan is a state that does not use community benefits spending
  - State can leverage this and provide an additional nudge to support partners
- Incentivize Medicaid/Medicare providers to utilize peer support and CHW models
- To incentivize peer support model and CHW, time is billed to Medicaid, however, the current reimbursement is low and not livable
- Look to Medicaid to increase reimbursement rate to support work

**Appendix D:** SDOH Strategy Coordinating Bodies Diagram



**Appendix E:** SDOH Steering Committee Charter

Michigan Department of Health and Human Services (MDHHS)
Social Determinants of Health (SDOH)
**STEERING COMMITTEE CHARTER**

1. PURPOSE

Health begins in our communities, homes, and the places where we live, work, and grow. The conditions within the community we are born into, the home we live in, and our schools and workplaces are some of many factors that are collectively referred to as the social determinants of health (SDOH). These conditions include a wide range of factors, including, but not limited to, income, education, job security, food security, housing, basic amenities, the environment, social inclusion and non-discrimination, and access to quality, affordable healthcare. There is growing acknowledgement that these economic and social factors, rather than individual risk factors, more greatly influence a person's health status and vulnerability to adverse health outcomes.

The Social Determinants of Health Steering Committee is established to provide ongoing strategic direction for the MDHHS Overarching SDOH Strategy.

2. OBJECTIVES

The Steering Committee is charged with the following duties:

a. Provide strategic guidance on the priorities and direction of the MDHHS Overarching SDOH Strategy as well as monitor progress.
b. Provide recommendations for better alignment of SDOH efforts across MDHHS program areas as well as state and local partners.
c. Provide recommendations to strengthen regional capacity building, resource allocation, and community driven SDOH solutions.
d. Determine standards and best practices for data interoperability, based on evaluation of pilots and national best practices, that support community information exchange (CIE). This includes integration of existing data privacy and security policies as well as state and federal program requirements.
e. Develop policy recommendations that reduce disparities and support holistic approaches to upstream prevention based on emerging trends.
f. Engage diverse stakeholders in SDOH strategic planning, implementation, and evaluation processes.

OBJECTIVES, continued

g. Develop policies and procedures for use by State of Michigan (SOM) departments and agencies, including collaborative problem-solving, to assist in assuring that SDOH principles are incorporated into departmental and agency decision-making and practices.
h. Recommend meaningful mechanisms for members of the public, communities, tribal governments, and groups, including disproportionately burdened communities, to inform equity efforts within the SDOH Strategy.

The SDOH Steering Committee will meet on a regular basis as determined by the committee. Initially, these meetings will be bimonthly, every other month, and then progress to quarterly meetings.

3. MEMBERSHIP

The MDHHS SDOH Strategy Steering Committee is an advisory body within the Michigan Department of Health and Human Services (MDHHS), consisting of leadership and subject matter experts from the following Administrations and Offices:

- Policy, Planning, and Operational Support Administration
- Policy and Planning Office
- Strategic Integration Administration
- Legislative, Appropriations and Constituent Services Office
- Behavioral and Physical Health and Aging Services Administration
- Public Health Administration
- Office of Race Equity, Diversity, and Inclusion
- Michigan Children's Services Agency
- Economic Stability Administration
- Legal Affairs Administration

Steering Committee membership will not exceed twenty individuals. The Steering Committee can establish sub-committees that meet more frequently and could include additional subject matter experts.

**Appendix F:** SDOH Interagency Workgroup Charter

Michigan Department of Health and Human Services (MDHHS)
Social Determinants of Health (SDOH)
**INTERGENCY WORK GROUP CHARTER**

1. PURPOSE

Health begins in our communities, homes, and the places where we live, work, and grow. The community we are born into, the home we live in, and our schools and places of work are some of many factors that are collectively referred to as the social determinants of health (SDOH). They include a wide range of factors, including, but not limited to, income, education, job security, food security, housing, basic amenities, the environment, social inclusion and non-discrimination, and access to quality, affordable healthcare. There is growing acknowledgement that these economic and social factors, rather than individual risk factors, more greatly influence a person's health status and vulnerability to adverse health outcomes.

The Social Determinants of Health Interagency Workgroup (SDOH-IW) is established to act in an advisory capacity with the goal of assuring that Michigan residents' benefit from coordinated efforts across state agencies that support the social, economic, and health of Michigan communities.

2. PARTICIPANTS

The Interagency SDOH-W is created as an advisory body within the Michigan Department of Health and Human Services (MDHHS), consisting of the following members:

A. The director of the Department of Health and Human Services (MDHHS), or the director's designee from within the Department.
B. The director of the Department of Agriculture and Rural Development (MDARD), or the director's designee from within that department.
C. The executive director of the Department of Civil Rights, or the executive director's designee from within that department.
D. The director of the Department of Labor and Economic Opportunity (LEO), or the director's designee from within that department.
E. The director of the Department of Natural Resources, or the director's designee within that department.
F. The president of the Michigan Strategic Fund, or the president's designee from within the Michigan Strategic Fund.

G. The director of the Department of Transportation, or the director's designee from within that department.
H. The director of the Michigan State Housing Development Authority, or the director's designee from within that department.
I. The director of the Michigan Department of Education, or the director's designee from within that department.
J. The director of the Michigan Infrastructure office, or the director's designee from within that department.
K. The director of the Michigan Poverty Taskforce, or the director's designee from within that department.
L. The director of the Michigan Racial Disparity Taskforce, or the director's designee from within that department.
M. The commissioner chair of the Michigan Public Service Commission, or the commissioner chair's designee from within that department.

3. OBJECTIVES

A. Ensure the success of Michigan Social Determinants of Health efforts through better alignment across state agency partners.
B. Utilizing a Health in All Policies approach, supporting interagency interoperability, to strengthen regional capacity building and resource allocation.
C. Develop policy recommendations that support holistic approaches to upstream prevention based on emerging trends and existing infrastructure.
D. Encourage coordination and communication, between state agency partners, to ensure that State sponsored initiatives have a health lens and account for impact on well-being of Michigan residents.
E. The SDOH-IW will meet on a regular basis as determined by the committee. Initially, these meetings will be quarterly.
F. Meetings will be conducted in an unclassified environment. When necessary, classified discussion and topics will be taken up in the appropriate interagency forum.
G. Assist the Department in developing, implementing, and regularly updating our statewide Social Determinates of Health Strategy.
H. Identify and make recommendations to address discriminatory public policy that effects state laws, regulations, policies, and activities on Michigan residents, including an examination of disproportionate impacts.
I. Develop policies and procedures for use by state departments and agencies, including collaborative problem-solving, to assist in assuring that SDOH principles are incorporated into departmental and agency decision-making and practices.

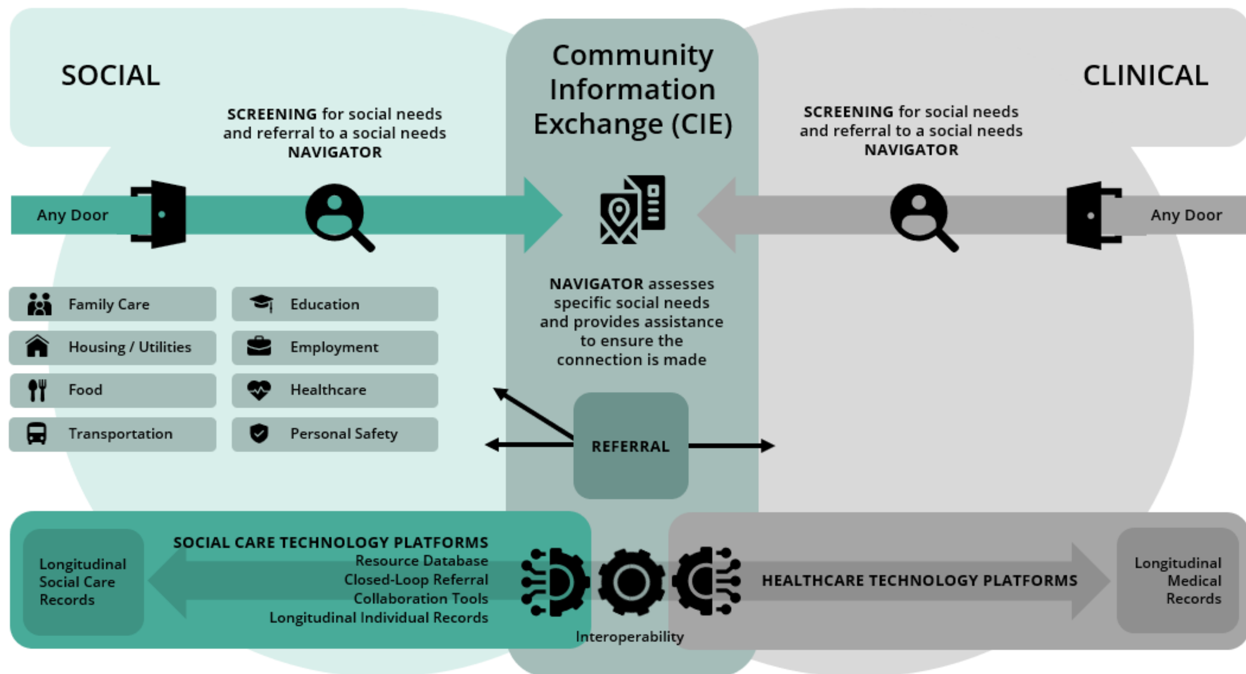
SDOH-IW OBJECTIVES, continued

J. Recommend mechanisms for members of the public, communities, tribal governments, and groups, including disproportionately burdened communities, to assert adverse or disproportionate social, economic, or environmental impact upon a community and request responsive state action.
K. Review best practices to enhance community SDOH quality monitoring.
L. Recommend changes in Michigan law.

4. PERIODIC CHARTER REVIEW

On an annual basis the MDHHS Executive Board will review the adequacy of its charter, nominate steering committee members and make recommendations to the for appropriate changes.

**Appendix G:** Community Information Exchange Diagram



**Appendix H:** Community Information Exchange Task Force Charter

## Community Information Exchange (CIE) Task Force – Charter

**Background:**

This Community Information Exchange Task Force is authorized by the Michigan Health Information Technology Commission's (MHITC) 2022 annual report, as per the Michigan Health IT Roadmap (Bridge to Better Health Feb 2022), referred to as the MHITC Roadmap.

**Purpose:**

MDHHS has resolved to create and sustain state-wide infrastructure to support the collection, exchange, and responsible use of information that can help address the social needs of Michigan's people and communities.

The CIE Task Force brings together community-based organizations (CBOs), heath care organizations, health payers, health IT, and governmental entities whose aligned work and interests are best served by a coordinated approach to Community Information Exchange. The Task Force is an advisory body that will make recommendations to both MHITC and the Michigan Department of Health and Human Services (MDHHS) on the development of capabilities for community information exchange. Should a MHITC CIE sub-committee become necessary, this Task Force will serve in that capacity.

**Goal:**

To promote health and social equity, and improve the well-being of all Michigan residents, Community Information Exchange infrastructure can enhance capabilities for providers of health, human, and social services to coordinate care across sectors and technologies, by enabling information (such as information about people's needs, and the resources available to help them) to effectively and responsibly flow to the right people at the right time in the right context.

**Objectives:**

In service of the stated purpose and goal, the Community Information Exchange (CIE) Task Force will:

- Examine promising state, national, and global strategies, standards, metrics, and best practices that could accelerate, support, and improve CIE in Michigan.
- Examine relevant perspectives from all interested parties and partners, with a focus on the priorities of communities that experience health inequities, the perspectives of community-based organizations that serve them, and the needs of people who have experienced the challenges of navigating these services.
- Create a coordinated knowledge resource in service of:

  - MHITC Roadmap (Bridge to Better Health).
  - SDOH Strategy (Michigan's Roadmap to Healthy Communities).

- Advise the State of Michigan on the development of a CIE strategy, including recommendations as to prioritized capabilities for community information exchange, the appropriate balance between statewide and regional/local capacities and roles, prospective principles, and processes for governance, incentives and adoption support for community-based organizations, guidance for legal agreements, and a roadmap for implementation, among other critical considerations.
- Articulate scenarios for pilot implementations of key use cases that enable cooperation among prioritized stakeholder groups.

**Membership of the Task Force:**

Membership is expected to include 15 representatives of entities or communities with a stake in CIE, up to two designated liaisons from MHITC, and no less than two consumers.

Members of the Task Force can make recommendations for expansions to the membership, for consideration and approval by the MDHHS SDOH Steering Committee.

**Stewardship of the Task Force:**

- The Task Force has been convened and is supported by MDHHS.
- The co-chairs of the Task Force are Ed Worthington and Janée Tyus, as representatives of Community Health Innovation Regions (CHIR).
- The Task Force is co-facilitated by the Michigan Public Health Institute and Greg Bloom of the Open Referral Initiative.

**Meetings:**

- Task force meetings will be held once a month through at least June of 2023. Members are expected to attend all task force meetings.
- Members shall engage with materials and complete necessary preparation in advance of meetings
- Members are expected to engage in discussion during meetings.
- Members are invited to facilitate progress by self-organizing additional ad hoc meetings as necessary and appropriate; outputs from these meetings should be documented in SharePoint and shared with the Executive Committee.
- Members are expected to respect others, recognizing when to lean in and lean out

**Documentation:**

- All documents will be stored in a shared space accessible to all on SharePoint
- When editing documents during discussions, MPHI will document comments, concerns, revisions and provide a revised document for consideration at the following meeting.
- Members may provide feedback and revisions by email to MPHI and MDHHS between meetings
- Members may also suggest edits in shared documents on the SharePoint site
- Revisions will be made by committee and brought back to the group for final approval

**Decision-making:**

Recommendations made in the Task Force's final report will be assumed to represent the opinion of the group. The group will strive to come to consensus on decisions including recommendations; where consensus is not achievable, the group will work toward consent (in which all can accept the outcome, despite disagreements). When we find differing perspectives, we will clarify and document them.

**Appendix I:** Boilerplate Language

Sec. 1616. (1) By September 30 of the current fiscal year, the department shall seek federal authority to formally enroll and recognize community health workers as providers and to utilize Medicaid matching funds for community health worker services, including the potential of leveraging of a Medicaid state plan amendment, waiver authorities, or other means to secure financing for community health worker services. The appropriate federal approval must allow for community health worker services on a statewide basis and must not be a limited geography waiver. The authority should allow the application of community health worker services statewide and maximize their utility by providing financing that includes fee-for-service reimbursement, value-based payment, or a combination of both fee-for-service reimbursement and value-based payment for all services commensurate to their scope of training and abilities as provided by evidence-based research and programs.

(2) By September 30 of the current fiscal year, the department shall report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office on the progress of meeting the requirements in subsection (1).

**Appendix J:** Accelerator Plan Leadership Team

**Leadership Team**

A Leadership Team will advise on the development of the SDOH Accelerator Plan. The Leadership Team will utilize a community-based participatory approach by ensuring shared decision-making and building on identified existing resources.

Members of the Leadership Team will include diverse and inclusive members, consisting of the following, as outlined in the NOFO:

I. At least two (2) members of the community that understand the distinct characteristics and culture of the selected population(s) and are recognized by their peers as trusted voices for the community:
    a. Lorna Elliott-Egan, MDHHS Constituents Services Manager and Tribal Liaison, will provide perspective on the distinct characteristics and culture of the Native American population, and serve as a trusted voice for the tribal communities in the state.
    b. Afton Shavers, MDHHS Office of Equity and Minority Health, will provide perspective on the distinct characteristics and cultures of minority populations in Michigan, as well as expertise on efforts to improve racial equity.

II. A minimum of five (5) additional representatives from different sectors with the expertise and authority to accomplish the development of the implementation ready SDOH Accelerator Plan in the selected SDOH priority areas:
    a. Ninah Sasy, MDHHS Policy and Planning Director, will serve as the primary lead for the development and review of the SDOH Accelerator Plan.
    b. Laura Drayton, MDHHS Policy and Planning, will serve as a secondary lead for the development and review of the SDOH Accelerator Plan.
    c. Linda Scarpetta and Holly Wilson, MDHHS Division of Chronic Disease and Injury Control, will provide their expertise in ensuring the SDOH Accelerator Plan includes strategies to prevent and mitigate the impacts of chronic disease.
    d. Aaron Ferguson and Julia Field, Michigan Climate and Health Adaptation Program (MICHAP), MDHHS Division of Environmental Health, will provide their expertise in ensuring the SDOH Accelerator Plan includes consideration of climate change as a risk multiplier.
    e. Maddy Kamalay, Weatherization Specialist, MDHHS Weatherization Assistance Program, will provide expertise on holistic approaches to healthy housing and an established relationship with Community Action Agencies (CAAs) throughout the state.

f. Norm Hess, Executive Director of the Michigan Association for Local Public Health (MALPH), will provide expertise on local public health efforts within Michigan's 45 city, county, and district health departments.

Brad Banks, Energy Waste Reduction Section, Michigan Public Service Commission, Commission Staff Lead, EWR Low Income Workgroup and, Co-Chair of the Low-Income Energy Policy Board, will ensure an understanding of the intersectionality of housing, energy efficiency, energy equity, and health and safety issues.

**Appendix K:** Community Engagement Strategy and Compensation Policy

### Community Engagement Compensation to Support the MDHHS SDOH Strategy

Building bridges for collaboration is a crucial part of our strategy to establish healthy communities. Community feedback will be incorporated throughout the development and implementation of the 2022-2024 Social Determinants of Health (SDOH) Strategy to ensure that the Strategy supports equitable, community-driven solutions.

Robust community engagement efforts will ensure that residents have the opportunity to provide meaningful input on policies and programs. Utilizing fair compensation practices for community members is necessary in demonstrating our commitment to engaging community voices and recognizing the value those with lived experience add to our work. Valuing residents as experts and compensating them for their time is a crucial facet of our community engagement model.

The Michigan Department of Health & Human Services (MDHHS) SDOH team will clearly define engagement criteria before engaging community members in any activity. These criteria may include, but are not limited to, a person's lived experiences, expertise, and/or skills that are relevant and aligned with the targets of the activity. Criteria for engagement and compensation will be clearly communicated before and during recruiting community members to participate in the activity.

Engagement Strategies:

Mini-Grants to Support Community Engagement: MDHHS Policy and Planning Office may provide mini-grants to community partners to support community-led engagement; funds can be used to organize and facilitate multiple layers of community engagement including stakeholder workshops, community conversations, equity action labs, and action team sprints to access community voice to create ways to use the power of MDHHS to support the priorities identified by the community.

Compensation to Support Community Participation in SDOH Task Forces/ Workgroups: MDHHS Policy and Planning Office may provide compensation to community members and small non-profit organizations to serve on SDOH task forces, workgroups, subcommittees, etc.

Criteria for compensation:

- Compensation is standard in exchange for a community member's time and expertise. Michigan residents over the age of 18 years of age are eligible; additional eligibility guidance provided below.

- MDHHS employees or contractors are NOT eligible as well as individuals who are already receiving compensation from their organization/ company to participate in these efforts within the scope of their role.
- Community member must attend meeting and complete W-9 to receive stipend.
- Non-profit organizations that employ less than 500 individuals may seek a stipend if participation may cause a financial hardship to the organization.

Community Compensation Approach:

We compensate community members by the hour. The rate of compensation is $100.00 per hour for a community member's time and expertise. Multiply the amount of time in hours that the community member will spend on the activity by $100.00 to determine the rate of compensation for the activity. This rate includes what may be needed for transportation, childcare, and other needs during engagement.

Fair compensation for community member participation is not the only thing to consider when engaging community members. The following are expectations for MDHHS Policy and Planning Office to build and maintain community member trust:

1. Establish clear communicating compensation amounts before participation or projects begin is necessary to prevent confusion. MDHHS members should be upfront and transparent about the processes for collecting W9 forms so that both parties can plan accordingly. Additionally, participants should be informed before participation that all compensation can be considered as taxable income from the IRS and that MDHHS cannot provide tax assistance.
2. Compensation should be paid in a timely manner within 3-4 weeks of participation to the community member.
3. It is essential to clarify the role and impact the community members will have in the activity they are engaging in. Items that should be clearly communicated to community members include responsibilities, expected deliverables, and timeline of the project which could be communicated in a verbal or written agreement such as scope of work agreements.
4. Consider the space you're inviting community members into. Create an environment that will value their lived experience and expertise.

*The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.*