MDHHS | Social Determinants of Health
Michigan Department of Health & Human Services

Michigan's Roadmap to Healthy Communities

Phase III: The Innovation 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.

2022-2024

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APPENDICES

Letter to Stakeholders

Dear SDOH Partners,

I am writing to extend my heartfelt gratitude and appreciation to the entire Community Information Exchange (CIE) Task Force, the Community Health Worker (CHW) Subcommittee, the SDOH Accelerator to Prevent Chronic Disease Leadership Team, and all of our invaluable partners who have dedicated their time and expertise towards the development of Phase III of our Social Determinants of Health (SDOH) Strategy.

Your commitment and tireless efforts have been instrumental in shaping and refining our approach to addressing social drivers of health. The diversity of perspectives and experiences brought by each member of these vital groups has been the cornerstone of our strategy's success. Your collective wisdom, innovative ideas, and unwavering commitment to improving community health outcomes have been invaluable.

The decision to release our SDOH Strategy in phases has been deliberate, recognizing the need for agility and adaptability in the face of ever-evolving community needs. We firmly believe that perfection should not be the goal; rather, it's the continuous learning and adaptation that propel us forward. Each phase allows us to incorporate new insights, refine our methodologies, and better align our strategies with the dynamic landscape of social drivers affecting our communities.

As we embark on Phase III, we remain steadfast in our commitment to learning from our experiences and embracing an iterative approach. It is this flexibility and willingness to evolve that will enable us to create impactful interventions that resonate deeply with our communities.

Moreover, we recognize the critical importance of supporting community-led interventions at the local level through the establishment of SDOH Hubs. These hubs serve as beacons of change, empowering communities and amplifying their voices in driving sustainable and impactful solutions.

Your ongoing support and collaboration are essential as we move forward in implementing Phase III. Together, we will continue to champion initiatives that address SDOH and strive to create healthier and more resilient communities.

Once again, I extend my deepest gratitude to each member and partner for their unwavering dedication and contributions to this effort.

Sincerely,

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

Executive Summary

In the pursuit of a healthier and more equitable society, addressing social drivers of health [1] has emerged as a vital component of overall health outcomes. Eliminating health disparities is essential to ensure that all individuals, regardless of their background, have an equal opportunity to lead healthy and fulfilling lives.

To achieve this, the Michigan Department of Health and Human Services (MDHHS) Policy and Planning Office is taking a dynamic and responsive approach to address the diverse and evolving needs of the community by releasing its statewide Social Determinants of Health (SDOH) Strategy, *Michigan's Roadmap to Healthy Communities*, in phased implementations. This strategic decision reflects a commitment to inclusivity and adaptability, recognizing that the landscape of public health is continually changing. By unveiling the SDOH Strategy in stages, MDHHS aims to engage with and incorporate feedback from Michigan's invaluable partners, including community leaders, health care professionals, and stakeholders. This collaborative process ensures that the strategy remains finely tuned and responsive to the specific challenges and opportunities faced by Michigan residents. Through these iterative releases, MDHHS endeavors to build a comprehensive and resilient framework that not only reflects the current state of public health but also evolves with the evolving needs and aspirations of the diverse communities it serves.

Phase III of the SDOH Strategy marks a pivotal juncture where the culmination of Phase I and Phase II converges into a cohesive framework. Building on the foundational achievements of the first phase of the strategy, which prioritized critical areas such as food security, housing stability, and health equity, Phase III represents a progression in our commitment to holistic well-being. The success of the second phase, featuring structural interventions like community information exchange (CIE), the integration of community health workers (CHWs), and fostering strategic partnerships for health equity, forms a robust foundation upon which Phase III expands. This latest phase synthesizes the insights gained from earlier efforts, by incorporating feedback from Michigan's diverse partners, and employs a collaborative, community-driven approach to address emerging challenges.

[1] Phase III of the SDOH Strategy progresses from addressing the social determinants of health (SDOH) to the social drivers that influence health. To learn more about the difference between SDOH and social drivers, see the call out box on page 7.

Phase III, or the 'Innovation' phase, of the SDOH Strategy will launch innovative SDOH Hubs, piloting the infrastructure needed for meaningful collaboration to better identify, understand, and address the root causes of health inequities. Its implementation will also support Health in All Policies (HiAP)[1] multi-sectoral initiatives and build on health equity partnerships to close the gap in health disparities.

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[1] HiAP is an established approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people. For more information about HiAP, please see Chapter 3: *Health in All Policies*.

Social Drivers of Health

In the dynamic landscape of public health, innovation stands as a cornerstone in our collective pursuit of addressing SDOH. Recognizing the intricate web of factors that influence well-being, we are introducing the concept of social drivers to emphasize the dynamic nature of these determinants. Rather than static influencers, social drivers encapsulate the evolving and interactive elements that shape health outcomes [1].

SDOH and Social Drivers of Health

SDOH are the conditions in which people are born, grow, live, work, and age. These factors, like access to education, housing, and economic opportunities, play a pivotal role in shaping an individual's health.

Social drivers of health are the dynamic and interactive forces that constantly influence our well-being. They go beyond fixed conditions and highlight the ongoing, ever-changing aspects of our lives, such as social relationships, community engagement, and cultural influences.

In simpler terms, social determinants are the things that shape our health, while social drivers are the ongoing forces that keep influencing it. Both are essential to understanding how to improve and maintain good health for everyone.

Innovation becomes important in this context, as it empowers us to explore novel approaches, technologies, and collaborative strategies to better understand and address the multifaceted challenges posed by social drivers.

By fostering a culture of creativity and forward-thinking, we can unlock transformative solutions that transcend traditional boundaries. These innovative endeavors not only enhance our ability to identify and intervene in social drivers but also pave the way for adaptive, data-driven, and community-centric interventions.

Through the lens of social drivers, the strategy envisions a future where cutting-edge ideas and inventive, community-driven solutions play a pivotal role in dismantling health disparities and promoting the holistic well-being of communities. This shift from fixed determinants to ever-changing social drivers signifies MDHHS' dedication to embracing innovation as a vehicle for positive change in the realm of SDOH.

Building Healthy Michigan Communities

Recognizing the many factors that influence health, it is paramount that we turn our attention to addressing social drivers of health at the state and local levels. These drivers, which include factors like social relationships, community engagement, and cultural influences, play a crucial role in shaping the well-being of individuals and communities.

State partners are uniquely positioned to champion sustainable solutions that can be tailored to meet the specific needs of diverse communities. By acknowledging and addressing the unique social drivers affecting local populations, state partners can develop frameworks that go beyond a one-size-fits-all approach. State-level collaboration empowers communities to design interventions that resonate with their distinctive challenges and strengths, fostering a sense of ownership and sustainability.

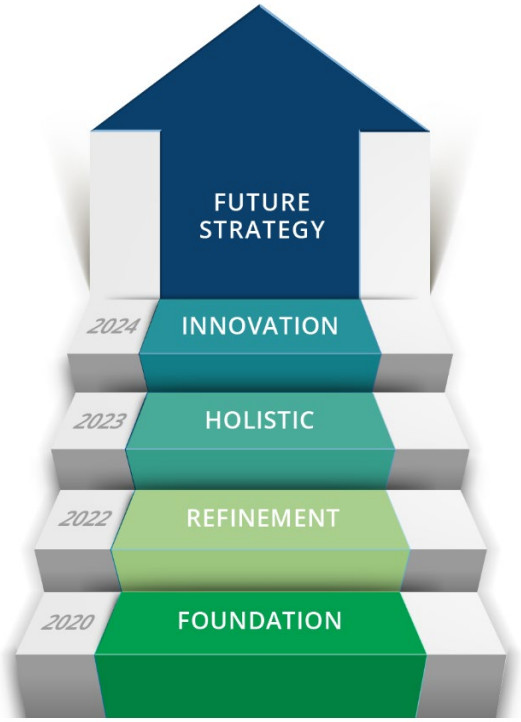
In this collaborative effort, state partners serve as facilitators, providing resources, expertise, and a supportive environment for local initiatives. By building flexible frameworks that can be adapted to the specific needs of each community, it ensures that interventions are not only effective, but also sustainable. This localized approach, guided by state-level support, reflects MDHHS' commitment to promoting health equity and fostering resilient, community-driven solutions. Together, states and local communities can create lasting positive change, addressing social drivers to enhance the health and well-being of all residents. Recommendations throughout Phase III will be framed at opportunities for state and local-level implementation.

Chapter 1: Introduction

Leveraging lessons learned and best practices, Phase III aspires to orchestrate a symphony of initiatives that resonate at both grassroots and institutional levels.

A Glance Back at Phases I and II

Through Phase III, the strategy seeks to harness the collective insights, experiences, and successes garnered through implementation of Phase I and Phase II. These insights will serve as the foundation for innovative strategies that can be implemented at state and local levels. By threading together the accomplishments of preceding phases, MDHHS aims to fortify its SDOH Strategy, ensuring that it remains a dynamic, responsive, and effective framework in the pursuit of equitable health outcomes for all Michiganders.



Phase III / Innovation: MDHHS develops cross-cutting solutions that support community-driven initiatives. Proposals for Change (PFCs) and grant applications will reflect these efforts.

Phase II / Holistic: MDHHS continues to build a robust strategy through engagement of stakeholders throughout Michigan. Collaboration supports a holistic approach.

Phase I / Refinement: MDHHS aligns activities in the strategy to develop focus areas and strategic objectives. The key is alignment and process improvement.

Foundation: MDHHS developed activities to support SDOH efforts and COVID-19 pandemic response efforts.

Figure 1. Steps to Building the SDOH Strategy

Phase I: The 'Refinement' Phase

Phase I of the SDOH Strategy, released in April 2022, 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 – selected to be most impactful and align with existing state of Michigan-sponsored initiatives and task force recommendations.

Phase II: The 'Holistic' Phase

Phase II of the SDOH Strategy, released in January 2023, built on efforts from Phase I, outlining structural interventions to drive the work forward: community information exchange (CIE), community health workers (CHWs), and health equity partnerships. It 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.

Through implementation of Phase II of the SDOH Strategy, convening bodies were established, each charged with developing recommendations supporting Phase II structural interventions. They included a CIE Task Force, which published a report detailing 33 recommendations for the development of statewide CIE capacities and infrastructure, and a CHW Subcommittee, which published a report detailing 24 recommendations to support and strengthen the role of CHWs and promote the expansion, integration, and sustainability of the CHW workforce. These recommendations, along with lessons learned through implementation of Phases I and II, have informed the development of Phase III of the SDOH Strategy, ensuring it continues to be a collaborative and iterative strategy.

Phase III: The 'Innovation' Phase

Phase III of the strategy, released in January 2024, outlines interventions that are a culmination of prior efforts to more effectively support sustainability and advance health equity. These interventions include the launch of innovative SDOH Hubs, implementation of a HiAP framework, and strategies to close the disparity gap.

In the evolution of the SDOH Strategy, the SDOH Hub framework is poised to integrate and build upon key recommendations stemming from the structural interventions outlined in Phase II. Recognizing the pivotal role of collaborative efforts, we are committed to incorporating insights from the CIE Task Force, the CHW Subcommittee, the SDOH Accelerator Plan to Prevent Chronic Disease Leadership Team, and health equity partnerships.

Phase III Priorities

Through the established framework of the SDOH Strategy, which includes *alignment*, *improvement*, and *innovation*, three overarching goals have been established for Phase III:

Launch innovative SDOH Hubs to foster collaboration and innovation and support community-driven initiatives. SDOH Hubs will promote regional, multisector collaboration and provide the infrastructure for a sustainable statewide framework to address health disparities and enhance community well-being. They act as a nexus between local communities and broader state-level initiatives. By leveraging resources, expertise, and tailored approaches, they aim to bridge the gap between social drivers and health outcomes, working towards a more equitable and healthier society.

Align efforts across sectors utilizing a Health in All Policies (HiAP) approach to integrate and articulate health considerations into policymaking. The HiAP framework serves as a powerful strategy at both the state and local levels, fostering collaboration among various sectors to support innovative and sustainable solutions. Through this approach, multisector partners come together to ensure that health considerations are seamlessly integrated into decision-making processes across diverse policy domains.

Build on health equity partnerships to close the gap in disparate health outcomes. Health disparities affect various populations, and the extent and nature of these disparities can vary greatly based on SDOH. While it's important to recognize that health disparities are complex and multifaceted, some populations, identified as priority populations through the SDOH Strategy, consistently face more significant and persistent health disparities than others. To address this, health equity partnerships established in Phase II of the Strategy will be expanded to develop and implement strategies to close the gap, with a focus on priority populations that have been disproportionately burdened by health disparities. Please see Appendix C for a list of SDOH Strategy priority populations.

The HiAP framework will be intricately woven into the fabric of SDOH Hubs, guiding and shaping collaborative initiatives across sectors. Through the HiAP lens, local partners within the hubs will collaboratively develop and implement policies and tailored solutions that address social drivers and ensure that health equity remains at the forefront of decision-making processes.

Through this intentional integration of SDOH Hubs and the HiAP framework, Phase III sets the stage for a future where health disparities are systemically addressed, and communities thrive with resilience and inclusivity at their core.

Chapter 2: A Closer Look at SDOH Hubs

SDOH Hubs will promote regional, multisector collaboration and provide the infrastructure for a sustainable statewide framework that addresses the social drivers of health.

Social drivers of health are interconnected and often reinforce one another. Additionally, many social drivers lie outside of the traditional scope of the health care sector. Addressing these complex and multifaceted factors that impact health require a collaborative, multisectoral, and holistic approach. To achieve this, Phase III of the SDOH Strategy outlines the framework to pilot innovative SDOH Hubs that are designed to bring people and resources together to address SDOH and improve health equity.

A Collaborative, Multi-Faceted Solution: SDOH Hubs

SDOH Hubs include core components to support multisector coalitions with the overarching goal of achieving meaningful and sustainable improvements in health equity. They build on the expansive efforts and investments of MDHHS, SDOH partners, and communities across the state to address SDOH and improve health and well-being. The SDOH Hub framework does not replace existing local collaborative efforts. The design of the SDOH Hub was crafted to harness the strength of established alliances and partnerships within the community while actively fostering new collaborations with unconventional health partners, such as housing, business, and education sectors. By leveraging existing community networks and relationships, hubs seek to capitalize on the strengths and expertise of local organizations, community groups, and health care providers, maximizing their collective impact on addressing social drivers.

The MDHHS Office of Policy and Planning is committed to co-designing SDOH Hubs with community members and local organizations, acknowledging that communities are experts in their own experiences and our role in supporting community-determined priorities. While SDOH Hubs include foundational elements, a fully formed structure will not be imposed. Empowering communities to determine their unique needs will lead to more effective and sustainable outcomes.

Responding to a Federal Call to Action

In November 2023, the White House and the U.S. Department of Health and Human Services (HHS) issued a call to action to, "catalyze efforts at the community level to encourage partnerships across sectors. HHS is calling upon individuals working in health care, social services, public and environmental health, government, and health information technology to partner and work together across silos to address health-related social needs (HRSNs) through community partnerships to improve the health and well-being of every American."

"HHS is calling upon all our partners to collaborate – no single sector can drive this type of change alone – so that together we can achieve a future in which everyone, regardless of social circumstances, has access to aligned, high-quality, person-centered health and social care systems that can improve health and well-being."

The call to action outlines a promising model for aligning health and social care through "hubs", which, "leverage community capacity and expertise to allow for an efficient, scalable approach to health care/CBO (community-based organization) partnerships that can facilitate care coordination and service delivery to address HRSNs."

In response to this call to action, MDHHS' Policy and Planning Office, through its statewide SDOH Strategy, is piloting the promising hub model, launching regional SDOH Hubs to effectively address HRSNs and help facilitate community-led transformation.

To learn more about the Call to Action and efforts of the Biden-Harris administration to improve health and well-being, click on the embedded hyperlinks or find more information in the 'References' section [4].

2.1: Building on Past Insights: Shaping the SDOH Hub Framework

Phase II, or the 'holistic' phase of the SDOH Strategy identifies SDOH Hubs as a strategic imperative for expanding community-led solutions. As stated in the strategy, "these hubs will promote regional, multisector collaboration and provide the infrastructure for a sustainable statewide framework that supports addressing the social determinants of health."

- MICHIGAN'S ROADMAP TO HEALTHY COMMUNITIES, **PHASE II: THE HOLISTIC PHASE** (pages 11, 23, 49)

Regional, Multisector Collaboration

The infrastructure to support regional, multisector collaboration builds on national learning from Medicaid projects across the country, including Michigan's State Innovation Model (SIM) [3, 4].

Sustainable Statewide Framework

The sustainable statewide framework for SDOH Hub development is adapted from the six pillars of the Centers for Disease Control and Prevention's (CDC) work to address SDOH [5], Accountable Health Communities (ACH) findings, Phase II SDOH Strategy activities, including recommendations from the CIE Task Force, CHW Subcommittee, and SDOH planning grants initiatives [6, 7, 8, 9].

SDOH Hubs Exploratory Phase: SDOH Planning Grants with Local Health Departments

In preparation of the launch of the SDOH Hubs, the MDHHS Policy and Planning Office awarded $986,500 in planning grants to 22 local health departments (LHDs) and public health alliances. These grants were awarded to advance the implementation of Community Health Need Assessments (CHNA) and community information exchange (CIE), as well as implement community-driven initiatives to address SDOH priorities. The CHNA and CIE planning grants are part of a larger effort through MDHHS' SDOH Strategy to support and advance SDOH efforts that improve health outcomes and advance equity. The grant period began November 1, 2022, and ended September 30, 2023. These planning grants leveraged ongoing local initiatives to collaboratively establish a sustainable, statewide framework aimed at addressing SDOH.

LHDs were invited to engage with the CIE Task Force to support the development of a statewide CIE model that supports the needs of local stakeholders while also determining statewide standards for the collection and use of social care data to ensure interoperability. LHDs assessed the needs of local stakeholders in their community to support a successful CIE model.

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[3] Accountable Communities of Health: What Are We Learning from Recent Evaluations

[4] Michigan's State Innovation Model

[5] Centers for Disease Control and Prevention (CDC), What is CDC doing to address SDOH?

[6] Community Information Exchange Task Force Final Report

[7] Rising Equitable Community Data Ecosystems (ReCoDE), The Voices We Trust: Building Equity-Centered Community Data Ecosystems That Work for Everyone

[8] CIE recommendations build on Health Information Exchange experiences and advance objectives in Michigan's Health IT Roadmap, "Bridge to Better Health" report.

[9] Community Health Worker Subcommittee Final Report

Additionally, LHDs utilized CHNAs to assess the health needs of a community to identify and prioritize health needs. Funding through this grant could be used to conduct a CHNA or utilize a current CHNA to accelerate SDOH efforts related to housing stability, food security, and/or health equity. Initiatives emphasized building and strengthening relationships with trusted grassroots organizations that have connections with the most vulnerable populations.

By working together, state and local partners not only learned from one another's successes but also identified common barriers and challenges in addressing SDOH. This collaborative learning approach allowed for the identification of best practices, innovative strategies, and effective interventions that have yielded positive outcomes in diverse communities. Additionally, it provided a platform to collectively navigate and address barriers that hinder progress, facilitating a more comprehensive and impactful response to SDOH.

Key Findings

The 22 LHDs that participated in the SDOH planning grants were tasked with investigating identified CHNAs. Each LHD had a distinct approach to using CHNAs in their efforts to plan and execute strategies aimed at addressing SDOH in their respective communities. Some were still in the planning stage, while others were implementing or engaged in learning and evaluation. Despite the varying phases of engagement, every LHD remained steadfast in upholding core values throughout the duration of the grant.

Community engagement, the reinforcement of partnerships, and the formalization of work groups were pivotal components of all grantee activities. Various community outreach initiatives, such as surveys, listening sessions, focus groups, and housing summits, effectively captured the voices of residents. Community members expressed concerns about housing and food insecurity and associated health disparities. LHDs also learned during the community engagement phase that financial incentives are not enough to gain community participation. Service providers and LHDs must build authentic relationships with communities to garner partnerships. It has been noted that participation is at its best when providers lead with the mutual benefit of their participation.

2.2: SDOH Hub Overview

SDOH Hubs serve as a coalition of local partners that align efforts to addresses the various non-medical factors influencing individuals' health outcomes. SDOH Hubs bring together social and health care services to boost health, save costs, and tackle inequalities. They work closely with health care providers, community groups, and government bodies to organize care. These hubs don't just look at medical issues; they also address factors like stable housing, access to good food, jobs, and education. By planning care that covers all these areas, SDOH Hubs provide comprehensive care that goes beyond just medical treatment.

Hubs are comprised of local partners that work together with the aim to mitigate health disparities by addressing the broader social and economic factors that impact people's health and well-being. SDOH Hubs are designed to act as a nexus where various social and health programs come together to synergize their efforts and resources. They bring together these programs through:

RESOURCE SHARING: Hubs facilitate the sharing of resources among different programs. For instance, a housing assistance program might collaborate with a health care provider to ensure individuals have access to stable housing, which in turn positively impacts their health. By sharing information and services, these programs optimize their impact.

FUNDING INTEGRATION (Braided Funding): These hubs often employ a strategy called funding braiding, where multiple funding sources are combined or coordinated to support comprehensive services. This approach allows diverse programs to combine their funding streams, reducing duplication and maximizing the utilization of resources.

TECHNICAL ASSISTANCE: Hubs offer technical support and expertise to participating programs. For instance, a health program might require assistance in understanding the social needs of their patients. By collaborating with social service programs within the hub, they can gain insights and guidance on how to address these needs effectively.

ALIGNED APPROACH: By bringing together different programs, hubs foster a more aligned and coordinated approach to service delivery. For example, a community health clinic might work with local education initiatives to ensure children receive proper health care and nutrition, ultimately enhancing their academic performance.

Bringing partners together for collaboration can be challenging due to differing priorities, methods, and goals. However, obtaining funding and technical assistance from state partners plays a crucial role in overcoming these challenges. MDHHS will provide resources to support the facilitation of these connections by providing resources, guidance, and a framework for collaboration.

2.3: SDOH Hub Operational Framework

SDOH Hubs serve as a centralized resource center, connecting multisectoral partners to address SDOH more effectively and improve the overall health and well-being of a community. Hubs have three core components and six core functions that make up their framework. However, they are designed to be flexible and iterative, adapting to the specific needs, strengths, and priorities of each community.

Figure 2. SDOH Hub Framework

SDOH Hub Core Components

The pursuit of equity serves as the foundation of the framework. Building on this foundation, the hub framework includes three core components: shared decision-making, learning and evaluation, and sustainability:

Shared Decision-Making

Hubs will be guided by community members and local organizations—and will pay special attention to the experiences of people most impacted by hub policies or programs. Hubs may develop steering committees, build on established coalitions, or create new governance structures.

Learning and Evaluation

Hubs will strengthen the skills and practices needed to identify, design, implement, and evaluate policies and programs that support thriving people and places. These capacities will be transferable to any focus area or topic hubs decide to prioritize.

Sustainability

Hubs will leverage funding from multiple sources to address community-identified needs. Hubs will also align with complementary coalitions or networks to reduce duplication of efforts and support shared goals.

EQUITY

SDOH Hub Core Functions

Each SDOH Hub will be comprised of six core functions that support the overarching framework of the SDOH Strategy. To support *alignment*, SDOH Hubs will foster meaningful community engagement across all phases of intervention planning and implementation. Each hub will also have an established governance structure that will establish criteria, actionable steps, and strategies for partnerships, collaborations, and relationships that result in improved health outcomes.

To support *improvement*, hubs will rely on data collection and storytelling to ensure decisions are not only data-driven but informed by communities and the people most impacted. They will embed a consistent SDOH approach to the collection, analysis, and dissemination of qualitative and quantitative data. This information will be leveraged for evaluation and evidence-building to reduce disparities and promote health equity.

To support *innovation*, each hub will be provided with funding and resources to strengthen and sustain infrastructure, including organizational, person-centered, and technological capacities. Additionally, hubs will work to support policy and advocacy, identifying evidence, tools, and resources to enhance communication about policies that affect SDOH with policymakers and other stakeholders.

Community Engagement

Foster meaningful, sustained community engagement across all phases of intervention planning and implementation.

The SDOH Strategy places a strong emphasis on strengthening community engagement and will continue to prioritize efforts to support community-driven solutions. Through the hubs, community engagement efforts will ensure that interventions are responsive to the specific needs of the community, foster collaboration and trust, and promote sustainable, culturally relevant, and effective solutions to improve health outcomes.

Community members are best positioned to identify barriers and facilitators that influence their health, providing valuable insights into the factors that impact health behaviors and outcomes. Hubs will engage in robust and ongoing community engagement through a range of methods to seek out unique insights into the community's needs, strengths, barriers, and priorities.

Communities across Michigan are diverse, and their needs vary. Community engagement allows for tailored, more impactful interventions to address specific social determinants and alleviate barriers that are most relevant to a particular population.

To support community engagement efforts, each hub will have access to a community engagement guide, as well as additional resources that will promote meaningful and culturally responsive engagement.

Governance

Establish criteria, actionable steps, and strategies for partnerships, collaborations, and relationships that result in improved health outcomes over the long term.

SDOH Hub governance will include a lead organization, local or regional networks, and supporting partners.

Lead Organization

All hubs will have an organization that is committed to managing the hub. This organization will be responsible for administering funds, communicating with partners, and ensuring that community members guide the work of the hub.

The importance of diverse SDOH lead organizations cannot be overstated, as different communities require tailored approaches to address their unique needs. In some instances, the lead might be taken by local health departments equipped with resources, infrastructure, and expertise to spearhead initiatives effectively. These departments often bring a systemic understanding of health challenges and have established connections within the community.

Conversely, there are communities where the most effective leaders in addressing SDOH might be community-based organizations (CBOs) or free health clinics. These entities often possess a deep-rooted understanding of the community's specific dynamics, cultural nuances, and challenges. Their closeness to the population they serve enables them to engage directly with individuals, building trust and delivering targeted interventions that resonate with the community's needs.

Recognizing the diversity among communities, the flexibility to designate varied SDOH lead organizations is essential. It allows for a responsive and localized approach that maximizes the effectiveness of interventions. The choice of lead organization should align with the community's characteristics, ensuring that initiatives are culturally responsive, well-received, and impactful. This diversity in lead organizations reflects the adaptability needed to address the multifaceted nature of social determinants and underscores the importance of community-driven solutions for optimal health outcomes.

Local or Regional Networks

Hubs will strengthen relationships across sectors and engage diverse partners, including CBOs. Networks may have a formal relationship with the hub to deliver services or administer programs. Network organizations may also have more informal ways of collaborating to share information or support aligned initiatives.

Collaborative partnerships are the cornerstone of supporting SDOH Hubs, particularly when emphasizing community engagement. These partnerships bring together diverse stakeholders, including health care providers, local government agencies, community-based organizations, residents, and other key players, to collectively address the multifaceted challenges related to social determinants.

To support SDOH Hubs, collaborative partnerships should prioritize inclusivity, valuing the insights and experiences of diverse community members. Leveraging the strengths of each partner, these collaborations can harness collective resources, knowledge, and expertise, amplifying the impact of interventions aimed at addressing social determinants.

The SDOH Hub network may include the following governance structures:

- **STEERING COMMITTEE**: Comprising representatives from key local partners such as health care organizations, local government agencies, CBOs, education institutions, housing authorities and advocates, employers and workforce development, transportation and infrastructure agencies, environmental and sustainability organizations, community and neighborhood associations, and – most importantly – representatives from affected communities. Existing collaborative partnerships, coalitions and alliances should have representation on the steering committee to ensure that existing infrastructure is leveraged. The steering committee provides strategic guidance, sets goals, and oversees the overall direction of the hub.
- **EXECUTIVE DIRECTOR OR HUB COORDINATOR**: Responsible for the day-to-day management and operations of the hub, implementing strategies and decisions made by the steering committee, overseeing staff, and liaising with stakeholders. Provides updates to MDHHS and SDOH Hub Advisory Council. This role may be contracted out to support the hub or the lead organization may have a contact that assumes this role.
- **WORKING GROUPS OR TASK FORCES**: These are specialized groups focused on specific areas of social determinants (e.g., housing, education, employment) or thematic issues. They conduct in-depth research, develop interventions, and provide recommendations to the steering committee for action.

Supporting Partners

SDOH Hub pilots will receive technical assistance and support from the MDHHS Policy and Planning Office as well as the SDOH Interagency Work Group, and the SDOH Hub Advisory Council.

SDOH Hub Advisory Council

The SDOH Advisory Council plays a vital role in fortifying and advancing the SDOH Hub framework by providing guidance, expertise, and strategic direction. This council, comprised of experts from diverse fields such as health care, social services, government, and community advocacy, serves as a bridge between partners and the overarching goals of the SDOH Hub.

In service of this stated purpose, the SDOH Advisory Council will:

- Advise MDHHS on the implementation and evaluation of the SDOH Hubs pilots by elevating best practices and/or sharing relevant resources.
- Support alignment with SDOH Strategy Phase I – III initiatives and complementary efforts at the state and local levels, including the Health Information Technology (HIT) Commission Community Information Exchange Subcommittee, Regional Health Equity Councils, Community Health Worker Advisory Council, and SDOH Steering Committee.
- Provide strategic guidance to SDOH Hub cohorts based on collective expertise and insight within the community to support goals of new and established SDOH Hub sites.
- Facilitate stakeholder engagement among partners, leveraging current networks, including health care professionals, community-based organizations, policymakers, private industry, and community members to determine sustainable strategies to address SDOH through a Health in All Policies (HiAP) approach.
- Advocate for policies and initiatives that address root causes of health disparities and close disparity gaps.
- Provide SDOH Hub performance oversight and develop recommendations for scaling, replicating, and sustaining SDOH Hubs in fiscal year (FY) 2025 and beyond.

By engaging the SDOH Advisory Council in discussions, planning, and decision-making processes, the SDOH Hub gains access to a wealth of knowledge, networks, and perspectives necessary for sustainable operations and strategic expansion. The council's role goes beyond mere advisory—it serves as a catalyst for innovation, collaboration, and inclusive growth towards addressing social drivers at a larger scale.

The advisory council will be convened by the MDHHS Policy and Planning Office. Meetings will be staffed by the MDHHS SDOH Policy Team.

Data Collection and Storytelling

Embed a consistent SDOH approach to the collection, analysis, and dissemination of quantitative and qualitative data.

To ensure transparency and accountability, SDOH Hubs may include data collection and analysis, monitoring and evaluation, and public-facing dashboards.

Data Collection and Analysis

Collecting data on SDOH provides valuable insight into the various factors that influence individuals' well-being and health outcomes. It helps to identify and understand health inequalities and disparities among different populations, which is essential information for addressing the root causes of health disparities and advancing health equity. By collecting data on social determinants, SDOH Hubs can tailor interventions and allocate resources for populations and communities that have been disproportionately impacted by poor health outcomes.

SDOH Hubs will utilize a variety of methods for collecting data to inform interventions, including surveys and questionnaires, census data and vital statistics, community health needs assessments (CHNAs) and asset mapping, and focus groups and interviews. Collecting information from individuals directly regarding their social and economic circumstances in a culturally sensitive and linguistically appropriate way, while ensuring privacy and confidentiality, will allow hubs to identify community priorities.

Additionally, this data will help inform the development of policy recommendations that address SDOH factors and can have a significant impact on improving overall health outcomes.

For more information about how the SDOH Strategy uses data to inform decision-making and close the disparity gap, please see Chapter 4: *Closing the Gap*.

Evaluation and Evidence-Building

Advance evaluation and build evidence for strategies that address SDOH to reduce disparities and promote health equity.

Measuring the Impact of SDOH Hubs: Monitoring and Evaluation

Regularly evaluating the impact of SDOH Hubs is of paramount importance as it provides a continuous feedback loop essential for refining and enhancing their effectiveness. A thorough and ongoing assessment will allow partners to monitor the impact of each SDOH intervention, identify any unforeseen challenges or disparities, and make data-informed adjustments to implementation strategies. Most importantly, it ensures that hubs remain responsive to the evolving needs of the community, adapting to changing circumstances and effectively addressing root causes of health disparities. Regular assessments will not only validate the success of the hub model but also enable a dynamic and iterative approach that maximizes impact and fosters sustained improvements health outcomes.

Stakeholder feedback will be a cornerstone in the continual improvement of the SDOH Hub model, providing invaluable insights that will inform improvements and refine strategies for optimal outcomes. Engaging hub leadership and network partners, community members, service providers, and other partners ensures a diversity of perspectives that will enhance the understanding of each hub's impact and effectiveness. By incorporating input from key stakeholders, hubs and their community-driven interventions to address SDOH can be adjusted to better align with the needs, preferences, and challenges of each community, ultimately maximizing their relevance and positive impact.

Defining Success

Outputs

SDOH Hubs will submit regular reports throughout the project period, including documentation related to process and technical activities. Documentation may include:

- Guiding documents, such as values, principles, vision statements, or charters.
- Governance structure or organizational charts and/or steering committee rosters.
- Legal agreements, Business Associate Agreements, and/or other contractual documents.
- Operational and/or workflow protocols.
- Summarized feedback, reports, and/or meeting minutes.

Outcomes

SDOH Hubs will develop the foundational infrastructure necessary to support additional SDOH activities. Outcomes may include:

- Successful implementation of process and technical activities, as demonstrated by submitted outputs.
- Successful engagement of impacted parties and community partners, as demonstrated by an ongoing commitment to SDOH Hub participation.
- Clear understanding of needs and next steps at close of pilot, as captured in the final project report.

Measuring Success

Measuring the success of SDOH Hubs will involve a comprehensive assessment of various factors to ensure it effectively meets defined objectives and fulfills the needs of the community it serves. Key indicators of success will be determined by the SDOH Hub Advisory Council; however, relevant areas for assessment have been identified and proposed metrics have been developed. Please see Appendix D for a table of proposed metrics and key performance indicators (KPIs) for consideration by the SDOH Hub Advisory Council. Relevant areas for assessment are outlined below:

Health Equity Advancement: *Address persistent health disparities and advance health equity. Success in this regard will be measured through metrics such as reduced disparities in health outcomes and increased access to quality health care services.*

Health and Social Outcomes: *Improve health and social outcomes for people experiencing health disparities and inequities.*

- Measure changes in health disparities across different demographic groups by measuring health outcomes such as disease prevalence, mortality rates, and life expectancy.
- Success will be measured by the extent to which preventive and holistic approaches reduce the prevalence of preventable health conditions, lower health care costs, and improve overall community well-being.
- Implement key recommendations from the SDOH Accelerator Plan to Reduce Chronic Disease through SDOH Hubs at the local level and through MDHHS/state agency partners at a state level. Outreach and education in partnership with the Michigan Department of Environment, Great Lakes, and Energy (EGLE) and with the MDHHS Division of Environmental Health will continue to help support environmental health of communities.

Access to Services: *Increase the utilization rates of health care services, social services, and community resources among underserved populations.*

- Measure utilization rates through regular data collection and reporting.
- Ensure that SDOH Hubs have the necessary resources and outreach programs to support this increase.

Food Security: *Decrease food insecurity by implementing initiatives to improve access to high quality, nutritious food.*

For more information about food security initiatives, please see section 5.1: *Food Security: Holistic Health Strategies*.

Housing Stability: *Decrease housing instability and homelessness by administering the* **Good Housing = Good Health Program** *through the SDOH Hubs.*

- Measure the reduction in homelessness, improved housing stability, and positive impacts on health and well-being associated with stable housing.
- Through partnership with the Michigan State Housing Development Authority (MSHDA), implement key recommendations from the Statewide Housing Plan (SHP) to diversify funding resources allocated to support health and housing.

For more information about the **Good Housing = Good Health Program** and the Statewide Housing Plan, please see section 5.3: *Housing Stability: Holistic Health Strategies*.

Community Health Workers: *Expand the CHW workforce and improve their capacity to support priority populations.*

Community Information Exchange: *Implement regional and statewide CIE to improve interoperability and care coordination.*

SDOH Hub Infrastructure: *Establish governance and infrastructure to implement a SDOH Hub.*

- To ensure lasting improvements, SDOH Hubs are needed to establish sustainable funding mechanisms. Success will be measured by the longevity and stability of funding sources, as well as the impact of sustained investments on health outcomes and disparities reduction.

Health in All Policies Implementation/Cross-Sector Collaboration: *Increase the number of diverse partnerships established and maintained at local and state level to support pooling of funds and resources for sustainable solutions to support healthy communities.*

- Track the level of partnership engagement (including breakdown of grassroot entities, private entities, and government entities engaged), the number of cross-sector initiatives launched, and improvements in community health outcomes resulting from these collaborations.

- Through partnerships with MDHHS Program areas like the Family Resource Centers (FRCs) that support vulnerable children, and increasing the behavioral health workforce, allocation of resources to support workforce development and resource deployment will increase.

Data-Driven Decision Making: *Increase effectiveness of data collection and analysis in guiding resource allocation, the identification of trends in social determinants, and evidence that interventions are tailored based on data insights.*

- Develop and implement data collection standards to support interoperability of systems so that aggregated information can be summarized effectively.
- Develop and implement privacy standards by drafting a "Community Bill of Rights" which articulates consumer protections for the use of an individual's social care data to protect privacy and promote ethical data use.
- Develop public-facing dashboards so that information is available to support resource allocation and implementation of evidence-based interventions.

Community Impact: Expand outreach to priority populations and improve the lives of people and communities.

- Success in community engagement will be measured by the level of community participation in decision-making, the diversity of voices heard, and the extent to which community input influences the design and implementation of interventions.
- Better understand the impact on health and well-being through storytelling.

Success will be measured by the achievement of established health outcome targets, transparency in reporting, and evidence of accountability mechanisms that hold partners in the work responsible for outcomes. Each SDOH Hub will have a dashboard to track information at a county, regional, and statewide level. Annual reports will be developed and disseminated to show impact in the community.

Evidence-Building

Evidentiary support is needed to advocate for resources, garner support from stakeholders, and drive policy changes. This evidence empowers decision-makers to invest strategically, inspires collaboration among health care sectors, and fortifies the sustainability of these initiatives. Efforts directed at evaluation, evidence-building, and data enhancement are ethical imperatives as we strive for health equity. Robust evidence and improved data serve as catalysts in dismantling systemic barriers and improving access to equitable health and social care services.

Infrastructure

Strengthen and sustain infrastructure such as workforce, training, and access to financial resources, including resources required to address SDOH and reduce health disparities.

Sustaining SDOH Hubs requires careful planning and access to various resources, including funding, to build capacities and infrastructure.

ORGANIZATIONAL: *Structures and Interventions to Support Equity*

Organizational capacity considers a hub's ability and readiness to perform the essential functions, achieve its objectives, and adapt to changes. It encompasses various elements that collectively contribute to the hub's overall strength, resilience, and capability to effectively address SDOH and improve equity.

Adequate person-centered and technological infrastructure are also necessary to support hub operations. Hubs will bridge the gap between social and clinical care services by building person-centered capacities through the training and integration of community health workers (CHWs) and by building technological capacities through the planning and implementation of community information exchange (CIE). These connections will better support a coordinated, more holistic approach to care through data sharing, improved cross enrollment, and more targeted, individualized case management.

PERSON-CENTERED: *CHW Training and Integration*

CHWs are a diverse group of professionals who contribute to more equitable health outcomes through their relationships with the communities and patients they work with, and their ability to foster communication and develop understanding of health care systems. Additional research over the past few decades has provided evidence of the value of CHWs, and the positive impacts they can have on individual and community health.

Hubs will be provided with support to expand and sustain the CHW workforce, including investment in recruiting, training, and retention of CHWs throughout the state. Additionally, hubs will collaborate with CHWs to engage with the community, implement interventions, and provide diverse perspectives in decision-making processes.

For more information about SDOH Hub activities, including CHW training and integration, please see Section 2.4: *SDOH Hub Funding Priorities*.

TECHNOLOGICAL: *Facilitating CIE Planning and Implementation*

Community Information Exchange (CIE) facilitates the exchange of information and collaboration among various stakeholders within a community, particularly in the context of health and social care. The benefits of implementing CIE are wide-ranging and contribute to improved community health and well-being.

SDOH Hubs will support the development and sustainability of regional and statewide CIE, including the development of data maps, investments in screening platforms and additional technology, and continued training of community partners.

For more information about CIE planning and implementation activities, please see Section 2.4: *SDOH Hub Funding Priorities*.

Policy and Advocacy

Identify evidence, tools, and resources to enhance communication about policies that affect SDOH with policymakers and other stakeholders.

Advocacy efforts should target policy adjustments aimed at reducing bureaucratic hurdles, enabling smoother coordination between health care and social service entities within the hubs.

At the local level, policies should focus on fostering community engagement and empowerment by ensuring representation from diverse stakeholders in decision-making processes. This can be achieved through SDOH Hub initiatives supporting community-led programs and partnerships with local organizations, enabling tailored interventions that directly address the unique needs of each community. Moreover, advocating for increased funding allocation for SDOH Hubs at the local level is crucial to sustain and expand their initiatives effectively.

On a state level, policy recommendations should revolve around establishing frameworks that facilitate collaboration among various hubs. Creating standardized metrics for data collection and evaluation across hubs can streamline information sharing and enhance the understanding of regional disparities in social determinants. Additionally, advocating for policy changes that support sustainable funding models for SDOH Hubs at the state level is vital. This could involve incentivizing public-private partnerships, allocating resources based on demonstrated impact, and integrating SDOH metrics into broader health policies to underscore their importance in health care delivery.

2.4: SDOH Hub Funding Priorities

As outlined in the 'Infrastructure' section above, SDOH Hubs will expand on technological, person-centered, and organizational infrastructure. These activities will be supported by funding from the MDHHS Policy and Planning Office as available.

Technological: CIE Planning and Implementation

Community information exchange (CIE) capacities enable organizations using different technologies to share information while providing social care to people in need. CIE can also facilitate the aggregation of data about community resources, and communities' needs, to inform policy change that promotes more equitable and effective distribution of resources and programming. According to the 2-1-1 San Diego Community Information Exchange Toolkit, drawn upon by the CIE Task Force, *"A CIE is a community-led ecosystem of multidisciplinary network partners that use a shared language, resource database, and integrated technology platforms to deliver enhanced community care planning. CIE enables communities to shift from a reactive approach to addressing social needs, to an approach that is more proactive, holistic and person-centered. At the very core of a CIE is the community it serves, and with the community as its compass, a CIE seeks to support antiracism and health equity."*

Person-Centered: CHW Training and Integration

CHWs are a diverse group of professionals who contribute to more equitable health outcomes through their relationships with the communities and patients they work with, and their ability to foster communication and care coordination. A growing body of evidence over the past few decades has demonstrated the value of CHWs and the positive impacts they can have on individual and community health.

Organizational: Implementation of holistic interventions that address SDOH utilizing a Health in All Policies framework

Funding will also be prioritized to support community-driven, holistic interventions that align with the Health in All Policies (HiAP) framework. Through these interventions, communities will foster cross-sector collaboration and consider health implications in decision-making to address the root causes of health disparities.

For more information about the Health in All Policies framework and HiAP interventions, please see Chapter 3: *Health in All Policies*.

2.5: SDOH Hub Pilot Implementation

The first cohort of SDOH Hub pilots will launch in January 2024. Each SDOH Hub pilot site has a detailed work plan and budget that has been submitted by the lead organization and approved by the MDHHS Policy and Planning Office.

During the first cohort, many of the SDOH Hub pilots will be led by local health departments (LHDs) that will serve as lead organizations. Establishing a robust governance structure, inclusive of diverse partners, stands as a linchpin for the success of these hubs. While the lead organization may already possess a network of partners, conducting an early assessment of involved stakeholders is pivotal. This assessment ensures the network's capacity to embrace a comprehensive **Health in All Policies** approach while actively addressing disparities in priority populations by collaborating with safety net providers and grassroots entities.

Early and inclusive community engagement remains a top priority, aiming for genuine representation and involvement of community members from the outset. This approach fosters a more authentic and impactful collaboration. To bolster these initial priorities, SDOH Hub pilots may request technical assistance through the MDHHS Policy and Planning Office. This office will serve as a conduit, connecting the pilot projects with additional partners and resources crucial for support and guidance. Moreover, the Policy and Planning Office will offer best practices to further fortify the foundations of these initiatives, ensuring they are well-equipped to navigate and excel in their endeavors.

In alignment with the SDOH Strategy, during the initial launch of the SDOH Hubs, prioritization will be placed on development and implementation of strategies to improve environmental health outcomes, housing stability, and food security. These endeavors will operate within a **Health in All Policies** framework, aiming to address the broader **social drivers** of health and foster sustainable improvements. Additionally, the MDHHS Policy and Planning Office will allocate funding to bolster lasting solutions, backing the training and integration of community health workers (CHWs), investing in community information exchange (CIE), and executing recommendations from the CIE Task Force and CHW Subcommittee.

Further cohorts of SDOH Hub pilots are slated for launch throughout the year to guarantee comprehensive coverage across Michigan's Prosperity Regions. Concurrently, the SDOH Hub Advisory Council will provide guidance, fostering alignment and steering the strategic vision to ensure long-term sustainability.

For more information about the Health in All Policies approach, please see Chapter 3: *Health in All Policies*.

To view a map of Michigan's Prosperity Regions, please see Appendix E.

Community-Driven Solutions

MDHHS recognizes that no one group can solve the complex challenges our communities face alone. Stakeholders across domains and sectors must work together to share resources, assets, and strengths. Hubs provide the infrastructure necessary to make it easier to solve problems and exchange ideas – and to know what's happening in the communities they serve. The core functions of the hub framework are designed to build capacities that will be transferable to any topic that communities want to work on together.

Hubs will look different in different communities. Local organizations and community members will define exactly how to structure their hubs, what to prioritize, and how to allocate their resources. This will allow hubs to effectively address the needs of the communities they serve by tailoring their approaches to the specific challenges and resources present in each region.

Hubs will also be part of different pilot projects. In FY24, lead organizations for some hubs will center their work on CIE and learning more about what it takes to support communities as coordinating entities for CIE. As more hubs are launched, the Policy and Planning Office will adjust recommendations to reflect lessons learned.

2.6: SDOH Hub Anticipated Impact

Hubs will build on the work of local leaders, previous initiatives, and recommendations to help ensure that all Michiganders reach their full potential. In the short-term, each hub will be responsible for specific grant or contract requirements. In the long-term, hubs will be flexible, adaptable initiatives that belong to community members and reflect their needs. Over time, the anticipated impact of SDOH Hubs is:

Development of a foundational infrastructure that can adapt and expand over time. The SDOH Strategy envisions SDOH Hubs in every region of Michigan, supporting every Michigander and working toward health equity. The framework of the hubs will serve as a foundation for communities to build hubs that are reflective of their needs. Hubs will invest in critical infrastructure that is flexible enough to expand and adapt as they secure additional funding sources and/or identify additional priorities.

Aligned efforts at state and local levels. The SDOH Hub approach will help connect state and local efforts, promoting alignment and sharing information and ideas. Hubs will facilitate collaboration among diverse stakeholders, including schools, health care providers, government agencies, community organizations, and private sector partners, serving as vital platforms fostering collaboration among diverse stakeholders to tackle social drivers of health and persistent disparities. SDOH Hubs seek to eliminate ineffective, siloed, program-by-program interventions by catalyzing alignment and providing a new framework for collaboration. SDOH partners will work together to collectively problem solve, identify shared goals, and incubate innovative ideas. Moreover, hubs will be able to rapidly adapt interventions to address emerging issues.

Increased alignment across health and social care. SDOH Hubs will strengthen how health care and social care organizations collaborate to meet the needs of community members by developing and promoting the technological, human, and organizational capacities necessary for a holistic system of care. By providing a shared space and focus, SDOH Hubs encourage stakeholders from different sectors to align efforts toward a common objective: mitigating health disparities. They facilitate cross-sector collaboration, emphasizing the interconnection between health care, education, housing, employment, and policymaking to comprehensively address these drivers. This collaborative environment is community-centric, encouraging direct engagement with local populations, allowing for culturally tailored interventions that resonate with the specific needs of diverse communities. SDOH Hubs also promote the sharing and analysis of data across sectors, enabling a deeper understanding of community needs and disparities, thus informing collaborative strategies and interventions. Through the pooling of resources, expertise, and capacities, these hubs enable stakeholders to implement multifaceted, data-driven solutions that address social determinants and work toward health equity for all.

Improved access to state resources. To address the root causes of health disparities and promote lasting improvements, SDOH Hubs are needed to establish sustainable funding mechanisms through coordinated blending and braiding of funding and resources to support social care. SDOH Hubs establish mechanisms that will facilitate more consistent, aligned, community-driven, and reliable funding for initiatives that address social drivers, reducing the risk of short-term solutions or program cuts. They seek to comprehensively address the multifaceted factors that influence health outcomes, reduce disparities, and ensure that health improvement efforts are sustained over time. SDOH Hubs will be established to serve as catalysts for positive change by fostering collaboration, securing funding, and implementing evidence-based policies that prioritize health equity and holistic well-being.

Reduced health disparities. Hubs will support learning and promote action within and across communities in Michigan, with the aim of advancing health, equity, and well-being through alignment, improvement, and innovation. Its focus on supporting priority populations that have been disproportionately impacted by poor health outcomes will help to address long-standing and unjust health disparities.

For more information about reducing health disparities though implementation of SDOH Hubs, please visit Chapter 4: *Closing the Gap*.

Increased accountability and transparency. Hubs will improve accountability and transparency through data collection and analysis, monitoring and evaluation, and public-facing dashboards. This is crucial for building trust among stakeholders, including community members, service providers, and funders. By fostering a culture of collective accountability and demonstrating their commitment to serving the community, hubs will drive sustainable systems changes and improved outcomes.

Increased commitment to community-driven work. Hubs will center around a commitment to community-driven work, contributing to a more effective, culturally sensitive, and sustainable framework. Incorporating community voices into initiatives and utilizing feedback for continuous improvement of hub infrastructure and implementation is fundamental to their effectiveness. By recognizing and respecting the unique perspectives of communities, SDOH Hubs will be more responsive, inclusive, and successful in improving health and well-being.

Chapter 3: Health in All Policies (HiAP)

Utilizing a Health in All Policies approach to address key drivers of health outcomes and health inequalities.

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 social drivers of health and introduces improved health for all and the closing of health gaps as shared goals.

The **Health in All Policies (HiAP)** approach recognizes how various parts of our lives—like education, transportation, housing, and more—affect our health. Instead of only focusing on health care, it considers how decisions in different areas impact our well-being. The comprehensive approach of HiAP addresses the root causes of health issues, aiming to improve overall well-being rather than merely treating illnesses. By considering health in various policies, it tackles the social drivers of health, such as access to education, safe housing, and healthy environments.

HiAP promotes preventive measures by designing policies that prevent health problems before they occur. For example, improving mobility through walkable neighborhoods encourages physical activity, reducing the risk of obesity and related health issues. Additionally, HiAP can be cost-effective in the long run by reducing health care costs associated with preventable diseases. Investing in health-promoting policies early on can save substantial resources by preventing chronic illnesses later.

Most importantly, it helps address health disparities and promotes equity by focusing on vulnerable populations. HiAP ensures that policies are inclusive and benefit all segments of society, reducing health inequities.

3.1: Michigan's Approach to HiAP

Private and public partnerships play a vital role in making HiAP effective. Public sectors, like governments, develop policies and regulations, while private entities such as businesses, non-profits, and community organizations contribute resources and expertise. Collaborating allows them to combine strengths and address health challenges more comprehensively. These partnerships leverage diverse resources, knowledge, and skills to create sustainable improvements in health across various aspects of society. They facilitate innovation and a broader reach, enabling impactful changes that benefit overall community health and well-being. For example, policies that improve job opportunities, provide affordable housing, and reduce environmental hazards can have a direct impact on the SDOH and, consequently, overall population health. It recognizes the interconnectedness of various sectors and aims to develop and implement policies that promote health and well-being by addressing the underlying conditions that influence health outcomes.

To support this HiAP approach, the SDOH Strategy promotes collaboration and the collation of resources across government departments. It also seeks to make connections across sectors by bringing together partners across SDOH domains, such as housing, food, transportation, and environmental health.

The HiAP framework benefits non-health partners by creating healthier environments, fostering collaboration, and improving outcomes across various sectors, leading to more robust, prosperous, and sustainable communities.

- Education: Schools benefit from improved student health, leading to better attendance and academic performance.
- Transportation: Transport sectors benefit from reduced traffic and emissions, creating healthier environments and encouraging more sustainable travel options.
- Economic Sectors/Businesses: Companies benefit from a healthier workforce, leading to increased productivity and reduced health care costs.
- Community Organizations: Non-profits and community groups benefit by accessing resources, funding, and support to address health and non-health related issues in their communities.

Implementing HiAP at the state and local levels is crucial for fostering healthier communities. By integrating health considerations into various policies, like education, transportation, urban planning, and housing, governments can address the root causes of health issues. This approach allows for tailored solutions that respond to the unique needs and challenges of different communities. Ultimately, integrating health considerations into policies at the state and local levels empowers decision-makers to build environments that support well-being, leading to healthier and more resilient communities.

3.2: HiAP Local Implementation

Local partners, being closer to the residents they serve, can ensure that policies are more responsive and accountable, reflecting local realities and priorities. HiAP optimizes the use of available resources, directing efforts towards preventive measures and innovative pilot programs. Through collaboration with community organizations and stakeholders, these levels of government can create inclusive policies that promote healthy lifestyles, safe environments, and access to health care services.

Implementation of the HiAP framework can occur in many forms at the local level. One mechanism will be through SDOH Hubs, which aim to address the underlying social and economic factors impacting health outcomes.

SDOH Hubs will receive funding and support in FY24 to implement a HiAP approach. For example, through the **Good Housing = Good Health Program**, local health departments received funding in October 2023 to improve access housing resources.

Good Housing = Good Health (GH2) Program

The **Good Housing = Good Health (GH2) Program**, awarded through the Michigan Housing Community Development Fund (HCDF) and Michigan State Housing Development Authority (MSHDA), is a federally funded program utilizing United States Department of the Treasury American Rescue Plan (ARP) Coronavirus State and Local Fiscal Recovery Funds (SLFRF). This program was made possible through a partnership with MSHDA and MDHHS to support a HiAP approach to improve housing stability. Additional opportunities will be available to SDOH Hubs to support addressing social drivers utilizing the HiAP approach. To learn more about the GH2 Program, see page 42.

Another mechanism can occur at an organizational level. HiAP prompts organizations to consciously consider how their decisions impact health, fostering a culture of proactive health promotion and contributing to the creation of healthier environments. The HiAP framework recommendations below can be utilized on new and existing projects to shape decisions:

- **Establish Clear Communication Channels**: Create platforms, meetings, or forums where representatives from different sectors can come together regularly to discuss health-related issues and share information. Clear communication ensures everyone understands the goals and strategies, fostering alignment.
- **Develop Shared Goals and Strategies**: Encourage sectors to identify common health goals and develop strategies that align with their respective missions. When everyone works towards shared objectives, it creates synergy and maximizes impact.
- **Promote Cross-Sector Training and Education**: Offer workshops, training sessions, or educational programs that help professionals from various sectors understand the importance of health considerations in their work. This builds a shared understanding and commitment to integrating health considerations.
- **Encourage Interdisciplinary Collaboration**: Facilitate joint projects or initiatives that involve multiple sectors. For instance, a project might involve urban planners, health professionals, and educators working together to create healthier communities.
- **Incentivize Collaboration**: Offer incentives or rewards for cross-sector collaboration, such as grants, awards, or recognition programs. This encourages active participation and commitment from different sectors.
- **Leverage Technology and Data Sharing**: Encourage the sharing of data and technology platforms to track health-related outcomes. This sharing allows for better-informed decision-making and facilitates coordinated efforts.
- **Advocate For Policy Alignment**: Advocate for policies that promote health across sectors. This might involve advocating for laws or regulations that support healthier environments or lifestyles.
- **Engage Communities**: Involve communities in decision-making processes to ensure their needs and perspectives are considered. Community engagement builds trust and helps tailor initiatives to local needs.
- **Evaluate and Share Success Stories**: Regularly evaluate collaborative efforts, highlighting success stories and lessons learned. Sharing these experiences can inspire other sectors to join in and replicate effective strategies.
- **Establish Leadership and Commitment**: Strong leadership from key stakeholders and a commitment to cross-sector collaboration are essential for sustained efforts. Leaders can set the tone and prioritize health considerations across sectors.

3.3: HiAP State Agency Implementation

The implementation of the HiAP framework at the state level will unfold through various channels, with the SDOH Interagency Work Group (SDOH-IW) serving as a cornerstone. This collaborative platform stands poised to drive the integration of HiAP principles into strategic initiatives by revisiting Phase I priorities such as food security and housing stability.

Through the SDOH-IW, the HiAP framework will be embedded within the fabric of collaborative efforts. This work group will facilitate cross-sectoral collaboration, allowing for the infusion of health considerations into diverse policy domains. By leveraging the collective expertise of participating agencies and stakeholders, this work group will steer the implementation of HiAP, ensuring a comprehensive approach that addresses the multifaceted aspects of health drivers.

The SDOH-IW was established by the Executive Office of the Governor (EOG) in 2022. It acts 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.

For more information about the SDOH-IW, please see the SDOH-IW Charter in Appendix E.

Furthermore, the HiAP framework's implementation will involve a strategic revisit of Phase I priorities, particularly focusing on enhancing strategies related to food security and housing stability. By reexamining these critical areas through the lens of HiAP principles, Michigan aims to refine and amplify existing initiatives, fostering more integrated, impactful, and equitable approaches to address these fundamental drivers of health.

Phase III represents a crucial evolution building upon the groundwork laid in Phase I, aiming to craft innovative and sustainable solutions that address not only the immediate challenges but also the systemic root causes of food security, housing stability, and health equity. It prioritizes a holistic approach that addresses the intricate web of social drivers, aiming not just to mitigate immediate challenges but to reshape systems, promoting equity and resilience in food security, housing stability, and overall health outcomes.

Through these concerted efforts within the SDOH-IW and the inclusion of the HiAP framework within Phase I priorities, Michigan endeavors to forge a path towards more cohesive, cross-cutting, and health-centric policies. This approach ensures that considerations of health are intricately woven into various policy domains, fostering a more comprehensive and equitable approach to addressing the social drivers of health.

Embracing HiAP Approaches to Support Food and Nutrition Security

By utilizing the HiAP framework, efforts in food and nutrition security are elevated beyond the immediate need of nutritional support. This approach acknowledges the intricate interplay between access to nutritious food and broader societal factors. It recognizes that housing stability, transportation and mobility, income disparities, educational opportunities, and employment significantly impact individuals' abilities to secure and maintain adequate nutrition. Thus, adopting policies that address these interconnected social drivers becomes fundamental in fostering sustainable food and nutrition security.

In the realm of food and nutrition security, Phase III explores innovative models that merge agriculture, urban development – including mobility – and economic policies to create sustainable food systems. By integrating these diverse fields, Phase III aims to foster local food production, enhance access to nutritious options, and address disparities in food distribution. This innovative approach ensures a more resilient and equitable food ecosystem.

For a closer look at food and nutrition security efforts, please see Section 6.1: *Food and Nutrition Security: Holistic Health Strategies*.

HiAP serves as a unifying force, bringing together stakeholders from food, transportation, and environmental health sectors. This collaborative approach aims to address the multifaceted natural and built environmental factors that impede access to healthy and affordable foods.

Recognizing transportation and mobility as fundamental components, vital for broader access to essential services such as health care, education, and employment, HiAP underscores the pivotal role of transportation in enabling access to healthy food options. As Phase III unfolds, transportation emerges as a pivotal cross-cutting initiative, acknowledging its significance in shaping equitable access to essential resources. This approach of bridging food security and transportation efforts aligns with Healthy People 2030, a federal initiative that sets data-driven national objectives to improve health and well-being over the next decade.

One notable HiAP approach to supporting food security within Phase III includes the establishment of the **Michigan Coordinating Council on Access and Mobility (MICCAM)**. By September 30, 2024, MICCAM will have engaged diverse transportation and food security stakeholders to develop a workplan for FY25 activities.

Establishing a Michigan Coordinating Council on Access and Mobility (MICCAM)

The final report of the Michigan Food Security Council highlighted a pivotal recommendation: the establishment of a **Michigan Coordinating Council on Access and Mobility**. This recommendation represents a concerted effort to address the complexities of food security by proposing a model council approach, drawing inspiration from the well-established Michigan Interagency Migrant Services Committee.

Outlined within this recommendation is a structured council approach designed to optimize coordination and collaboration among diverse stakeholders. Much like the long-standing Michigan Interagency Migrant Services Committee, the proposed MICCAM aims to foster a cohesive council structure. This structure will facilitate effective communication, joint planning, and seamless coordination between various agencies and partners involved in addressing access and mobility issues pertaining to food security.

By drawing from the successful framework of the Michigan Interagency Migrant Services Committee, the envisioned MICCAM intends to create a similar, well-structured council. This approach not only seeks to streamline efforts but also aims to leverage collective expertise and resources towards enhancing access to food resources and mobility solutions. Through the proposed model council, Michigan endeavors to fortify interagency collaboration, ultimately fostering a more unified and effective approach to addressing the complex challenges of food security.

Embracing HiAP Approaches to Support Housing Stability

In integrating HiAP principles, Phase III prioritizes innovative policies that intertwine housing initiatives with energy security and the provision of housing-supportive resources to our most vulnerable populations.

By crafting and implementing policies geared towards promoting affordable housing, preventing homelessness, and establishing supportive environments, Phase III aims to foster sustainable housing solutions that holistically impact health and overall well-being.

Additionally, Phase III incorporates innovative policies that connect housing initiatives with energy security and facilitate the delivery of supportive resources. Through the design and implementation of policies aimed at promoting affordable housing, preventing homelessness, and fostering supportive environments, Phase III strives to nurture lasting housing solutions.

Good Housing = Good Health (GH2) Program

The Good Housing = Good Health Program embodies a HiAP approach by establishing a robust partnership between MDHHS and MSHDA. This collaboration will implement a program that effectively links populations most impacted by housing insecurity to vital housing resources. The GH2 initiative strategically complements the Michigan Statewide Housing Plan, which fosters collaboration among diverse sectors to enhance access to affordable housing statewide. By aligning with this broader housing strategy, the GH2 Program seeks to bridge gaps and connect vulnerable communities to housing resources, acknowledging the intrinsic link between stable housing and overall health outcomes.

Administered by local health departments across Michigan, this program capitalizes on their existing relationships with priority populations. Leveraging these established connections allows for targeted and culturally sensitive outreach to communities in need. Through these partnerships, the program aims to provide essential housing support, fostering stability and improved living conditions.

By intertwining health care and housing initiatives through collaborative efforts, the GH2 Program exemplifies the HiAP approach. By recognizing the synergy between housing and health, this program acknowledges that stable housing is fundamental to fostering good health. It embodies a comprehensive strategy that not only provides housing resources but also addresses the broader social drivers impacting health, ultimately contributing to a more equitable and healthier Michigan.

For a closer look at food and nutrition security efforts, please see Section 6.3: *Housing Stability: Holistic Health Strategies*.

Chapter 4: Closing the Gap

Understanding Disparities

The gap in health outcomes refers to the disparities in health status and well-being that exist between different population groups. This gap is often observed in terms of differences in rates of illness, life expectancy, access to programs and resources, and overall quality of health. There are several factors that contribute to the gap in health outcomes, including SDOH.

One stark illustration of health disparities is evident in life expectancy variations across different populations. According to the Robert Wood Johnson Foundation, life expectancy can significantly differ among various communities, sometimes varying by more than a decade between neighborhoods just a few miles apart. Factors contributing to these disparities can stem from socioeconomic inequalities, lack of access to nutritious food, limited educational opportunities, inadequate health care infrastructure, cultural barriers, discrimination, and systemic injustices.

Upstream and Midstream Strategies

Addressing health disparities requires a comprehensive approach that encompasses both immediate support for SDOH and the eradication of systemic inequities at their roots. This entails a two-pronged strategy: midstream interventions for immediate SDOH needs and upstream initiatives to dismantle systemic barriers.

Midstream interventions target the immediate and tangible needs that impact health outcomes. These include access to health care, nutritious food, stable and safe housing , education, and employment opportunities. By addressing these factors, we can mitigate the immediate effects of SDOH. Within the SDOH Strategy, communities can effectively target and address immediate needs related to food security and housing stability. This approach not only enhances individuals' health outcomes but also contributes to building more resilient and supportive communities by leveraging local resources and fostering collaboration.

However, the sustainability of these midstream interventions relies heavily on addressing upstream systemic inequities. Upstream interventions involve identifying and rectifying the structural and systemic issues embedded in policies, institutions, and societal norms that perpetuate disparities. This means tackling issues like racial discrimination, economic inequality, unequal access to education, and inadequate health care infrastructure. It requires policy changes, advocacy for equitable laws, reforms in health care delivery systems, and a commitment to inclusive practices across all sectors.

Through the Racial Health Equity Plan and the Rural Health Equity Plan, as well as lessons learned from the COVID-19 Racial Disparities Task Force (RDTF) Final Report, midstream and upstream interventions will be identified and implemented to close the disparity gap.

These plans and the RDTF report are detailed further below.

By integrating both midstream and upstream approaches, we can create a more holistic and effective strategy to close the disparity gap in health outcomes. A robust and comprehensive approach acknowledges the immediate needs of individuals and communities, while simultaneously working to dismantle the systemic barriers that perpetuate health inequities. This not only ensures immediate relief but also establishes sustainable, long-term solutions that foster healthier and more equitable societies for generations to come.

Addressing Socioeconomic Factors

Michigan's Roadmap to Healthy Communities serves as a strategic blueprint that integrates multiple approaches, stakeholders, and resources to address SDOH systematically. Through its multifaceted approach, it aims to create a more equitable landscape where all residents have the opportunity to live healthier lives, regardless of their socioeconomic status, race, or background.

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

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

As implementation of the SDOH Strategy progresses, supporting people made vulnerable to poor health outcomes remains a key strategy. To achieve this, Phase III of the SDOH Strategy takes a more focused approach to supporting **priority populations**.

> A **priority population** refers to a group or community that is specifically identified as needing targeted attention, resources, or interventions due to certain characteristics or circumstances that increase their risk of facing health disparities of challenges in accessing health care and social resources.

Identifying Priority Populations

Identifying priority populations requires a comprehensive and nuanced approach that considers the multifaceted nature of disadvantage to effectively address their unique needs and ensure equitable support and resources. To identify priority populations, the Policy and Planning SDOH Team reviewed a variety of data sources, including the 2021 Health Equity Report, to assess populations for significant disparities and needs and evaluate a variety of defining characteristics and SDOH. Based on this information, a list of priority populations was developed to inform interventions, optimize outcomes important to addressing disparities, and maximizing impact. For a list of priority populations identified by the SDOH Strategy, please see Appendix C.

It is important to note that this list is variable and will be updated as additional populations are identified.

Supporting Priority Populations

The SDOH Strategy seeks to close the disparity gap in health outcomes and promote equity in opportunity by prioritizing the needs of populations disproportionately impacted by poor economic, social, and health outcomes to give everyone the opportunity to live a healthy life.

It's essential to recognize that the disparities experienced by priority populations are not inherent traits of these communities but are instead outcomes of systemic inequities. These disparities are not defining characteristics of the people within these groups; rather, they are a result of historical, social, economic, and structural factors that have created barriers to equal access, opportunities, and resources. It is also crucial to recognize that identified priority populations are not mutually exclusive, and individuals often belong to multiple intersecting groups that can compound health disparities. Efforts to address health disparities require a comprehensive and intersectional approach that considers the complex interplay of factors impacting diverse populations.

4.1: Initiatives to Support Priority Populations

Phase III of the SDOH Strategy is poised to employ structural interventions, including the integration of community health workers (CHWs) and community information exchange (CIE) to bolster support for priority populations. Additionally, the Policy and Planning SDOH team will work with partners across MDHHS to implement additional interventions that focus on a wide range of priority populations.

CITIE INITIATIVE

To support recommendations developed by the CHW Subcommittee, the MDHHS Policy and Planning SDOH team developed a framework and will support pilot projects for the Community Health Worker Integration to Improve Equity (CITIE) initiative. CITIE is an innovative, collaborative initiative that aims to address health disparities by training and integrating CHWs in communities that have been disproportionately burdened by health inequities. Implementation of CITIE will begin in early 2024, with efforts to establish partnerships and secure funding underway.

CITIE Pilot Project: Supporting the Refugee Community

One of the first CITIE pilot projects to launch in FY24 is a partnership between the Policy and Planning Office, the Michigan Department of Labor and Economic Opportunity (LEO) Refugee Services, clinical care partners, and community-based organizations. The pilot aims to support refugee populations by providing the resources needed to train and integrate CHWs into refugee communities. CHWs will help to address the cultural, linguistic, and transitional challenges that they face and act as cultural navigators, assisting refugees in accessing health care services, social support networks, and employment opportunities.

MDHHS EMPHASIS ON BEHAVIORAL HEALTH AND CHILD WELL-BEING

MDHHS emphasizes behavioral health and the well-being of children through initiatives like MI Kids Now and efforts led by the Children's Services Administration. MI Kids Now focuses on early intervention and support for children's mental health by expanding access to behavioral health services and resources. This initiative aims to identify and address behavioral health concerns early, promoting overall well-being for children and families. The Children's Services Administration oversees various programs aimed at supporting children, ensuring access to health care, mental health services, and support for families. By prioritizing behavioral health and children's well-being, MDHHS aims to create a nurturing environment that fosters healthy development and resilience among Michigan's youth.

Community Engagement and Empowerment

Community engagement fosters relationships, helps build trust, and ensures that interventions are culturally sensitive and respectful of the community's values and beliefs. Promoting the development of relationships beyond the scope of a specific project can foster a sustainable foundation for long-term commitment and collaboration. Additionally, community involvement in advocacy efforts can lead to policies that address social determinants at a higher level, promoting sustainable improvements in health outcomes.

Community engagement will also serve as a foundational pillar for the SDOH Hubs in Phase III. The SDOH Hub acts as a central coordinating entity that collaborates with local communities, stakeholders, and organizations. It facilitates and promotes community engagement strategies within the framework's initiatives, ensuring that interventions are not imposed from the top down but rather developed in partnership with the communities they aim to serve.

ELEVATING COMMUNITY VOICES: THE COMMUNITY INFLUENCER PROGRAM

A strategy that has been employed to support robust community engagement is the establishment of the Community Influencer Program (CIP). Community influencers are individuals who have a deep understanding of their communities' unique needs, challenges, and strengths. They are trusted figures within their community and serve as a vital link between MDHHS and the communities they represent. Community influencers are champions of the SDOH Strategy, working diligently to address SDOH within their communities. They play a crucial role in providing feedback on initiatives and bridge the gap between policy and action. By engaging SDOH Community influencers, the strategy not only reaches a wider audience but also becomes more attuned to the lived experiences, preferences, and needs of diverse communities. Their involvement ensures that the strategy remains dynamic, relevant, and effective in addressing the multifaceted challenges related to SDOH. Moreover, their role in amplifying messaging and providing feedback helps in fostering a more inclusive and community-centered approach to improving health outcomes.

4.2: Phase III Health Equity Priorities

The Health Equity focus area remains foundational to this work and is integrated throughout the strategy and its implementation. The strategy takes both a macro- and micro-level approach to advance health equity and connect efforts across MDHHS, state agencies, and with community stakeholder groups. At the macro-level, the strategy will address policies, programs, and systems that impact the entire state. At the micro-level, MDHHS will support community- and regional-specific priorities that address social and health needs of community residents in a coordinated and culturally appropriate way. This approach allows MDHHS to implement a comprehensive SDOH Strategy, focused on ensuring Michigan's families have the opportunity to live full and healthy lives.

To advance health equity, the SDOH Strategy outlined three priorities for Phase I: support populations made vulnerable to adverse health outcomes, improve MDHHS-driven equity programs and policies, and strengthen community engagement to support community-driven solutions. Phase II of the strategy expands on the priorities outlined in Phase I to include: aligning efforts with statewide entities and health equity partners to take collective and coordinated action toward advancing health equity, developing policy recommendations that address the SDOH and advance health equity, and enhancing care coordination and connection to services by providing communities with the guidance and resources needed to establish SDOH Hubs.

The SDOH Strategy will continue to align efforts with statewide entities and health equity partners to take collective and coordinated action toward advancing health equity through convening SDOH partners. During Phase II, the development of policy recommendations within Michigan's SDOH initiatives, including the CIE Task Force, CHW Subcommittee, and the SDOH Accelerator Plan to Prevent Chronic Disease, embodied a commitment to diverse perspectives and inclusive practices. To achieve this, an open nomination period welcomed participation from all Michigan partners, fostering diverse voices comprising community-based organizations, health care providers, advocacy groups, and residents from varied backgrounds. Furthermore, these initiatives prioritized inclusivity by implementing a compensation policy, ensuring that community residents contributing their time and expertise are fairly compensated. This compensation acknowledges the invaluable insights and lived experiences of residents impacted by the issues under consideration, removing barriers to participation and fostering a more diverse and representative decision-making process. The composition of these bodies deliberately incorporates representatives from various sectors and communities. This inclusivity ensures that policy recommendations benefit from a breadth of perspectives, enhancing their effectiveness in addressing the multifaceted needs of diverse populations across Michigan. These same strategies will be employed during Phase III to establish a CIE Advisory Committee and a CHW Advisory Committee.

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

ALIGNMENT: Expand health equity partnerships to develop and implement health equity plans that support populations disproportionately impacted by health disparities.

IMPROVEMENT: Strengthen existing policies and implement new policy recommendations that support SDOH and health equity.

INNOVATION: Pilot SDOH Hubs to support a holistic system of care and implement community-led solutions.

Pursuing Health Equity: A Vital Commitment for Michigan's Diverse Communities

Michigan stands at a pivotal juncture, where the imperative to prioritize health equity for all communities has never been more critical. Recognizing the unique and diverse needs spanning racial, rural, and urban landscapes is foundational to bridging the gap in health care access and outcomes across the state.

- **Racial Health Equity**: Prioritizing racial health equity isn't merely an aspiration; it's an ethical obligation. Michigan's diverse population demands a concerted effort to dismantle systemic barriers that have perpetuated disparities in health care access and outcomes. Addressing these disparities is not just about equity; it's about justice and the well-being of every individual and community.
- **Rural Health Equity**: Rural communities form the backbone of Michigan's identity. Yet, these areas often face distinct challenges in accessing quality health care. Prioritizing rural health equity entails ensuring that these communities have equitable access to health care services, resources, and infrastructure, regardless of geographical barriers.
- **Chronic Disease Prevalence**: Chronic diseases cast a long shadow over the health of Michigan's residents. Prioritizing the reduction of chronic disease prevalence aligns with the goal of fostering healthier, more resilient communities. By addressing these conditions, we can significantly enhance the quality of life for Michiganders across the state.

Closing the gap in health disparities requires a collective effort. It necessitates collaboration among policymakers, health care providers, community leaders, and advocates. Michigan's strength lies in its diverse tapestry of communities, each with its own set of needs and challenges. Prioritizing health equity acknowledges and embraces this diversity, striving to ensure that every Michigander can lead a healthy and fulfilling life. By prioritizing racial health equity, rural health equity, and addressing chronic disease prevalence, Michigan sets the stage for a healthier, more equitable future for all.

Priority: Expand health equity partnerships to develop and implement health equity plans that support priority populations disproportionately impacted by health disparities.

The MDHHS Policy and Planning SDOH Team is partnering with entities working to advance health equity to develop and implement health equity plans. These health equity plans include a Racial Health Equity Strategies, a Rural Health Equity Strategies, and a SDOH Accelerator Plan to Prevent Chronic Disease.

- The Racial Health Equity Plan will look closely at racially marginalized groups who have faced long-standing barriers in getting fair access to good health.
- The Rural Health Equity Plan considers the unique challenges faced by rural communities to find ways to make things better for people living in rural areas.
- The SDOH Accelerator Plan to Prevent Chronic Disease aims to reduce disparities in health outcomes related to chronic disease, with a focus on preventing chronic disease by addressing social drivers.

Racial Health Equity Strategies: Investing in Lasting Change to Transform Communities Through Equity and Health

After early reports of significant disparities in outcomes related to the COVID-19 pandemic among Black residents, Michigan established the Racial Disparities Task Force (RDTF). The RDTF was charged with developing recommendations to reduce disparities and improve outcomes for communities of color. In 2023, funding was allocated to implement these recommendations. The transformative power of strategic investments in the recommendations put forth by the RDTF cannot be overstated. These investments pave the way for enduring change, addressing the root causes of inequity and reshaping the landscape of community health and wellness.

Equity Impact Assessment and Training: Initiating an Equity Impact Assessment coupled with comprehensive training acts as the cornerstone for sustainable change. It fosters a culture of awareness, sensitivity, and inclusivity within MDHHS and other state agencies ensuring that every decision made considers its impact on priority populations.

Neighborhood Health Grant Program: Expanding community-driven health services within comprehensive wellness centers represents a fundamental shift towards proactive health care. Offering essential screenings, immunizations, testing, and counseling creates accessible pathways to care, particularly for underserved populations.

Mobile Health Units: Meeting individuals where they are, both geographically and socioeconomically, is a hallmark of these investments. Mobile health units act as beacons of hope, bridging the gap for communities facing barriers to traditional health care access.

To read more about how MDHHS is expanding access to care through mobile health units, please see page 60.

Local Healthy Community Zones: Designed to tackle the leading causes of health disparities, these zones represent targeted efforts to address systemic issues like food deserts or limited fitness opportunities. Concentrating resources amplifies the potential for tangible, community-wide lifestyle improvements.

IT and Data Collection: The bedrock of progress lies in robust IT infrastructure and data collection. These investments propel us towards health equity by providing the necessary insights to tailor interventions, understand community needs, and create a more inclusive health and social service ecosystem. The urgency to address disparities arising from Social Determinants of Health (SDOH) mandates a strategic deployment of resources. By fortifying IT systems, building community capacity to participate in data exchange, and enhancing data collection processes, we take a pivotal step towards dismantling systemic barriers and fostering a more equitable, healthier future for all.

These investments are not mere transactions; they represent a commitment to the long-term well-being and prosperity of our communities, forging a path towards lasting health equity and social justice. Review the full report and list of recommendations here.

As Michigan advances its commitment to holistic community health, the integration of mobile health units, the Neighborhood Health Grant Program, and Local Healthy Community Zones with regional SDOH Hubs marks a pivotal stride towards comprehensive wellness.

Rural Health Equity Strategies

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 [2]. These disparities are often driven by factors such as geographic isolation, lower socioeconomic status, limited access to health care and other resources, and limited job opportunities. This inequality is intensified as rural residents are less likely to have employer-provided health insurance coverage. Through community engagement efforts and ongoing data analysis, frequent barriers to health have been identified:

- In rural communities, Michiganders struggle to find access to child care, affordable housing options, and access to broadband, which burdens families and affects health (LEO, Poverty Task Force).
- Rural areas in Michigan have aging populations, housing shortages, needs for costly infrastructure improvements, and limited high-speed internet access (Office of Rural Prosperity, 2023).
- According to Feeding America, 2.2 million households in rural communities across Michigan face hunger, and rural communities make up 87% of counties with the highest rates of overall food insecurity.
- According to a national analysis by Navigant, Michigan has the ninth highest percentage of rural hospitals at risk of closing in the nation. The risk of rural hospital closures represents less access to essential health care services in Michigan as many rural hospitals continue to cut services that they can no longer afford, including obstetric care such as labor and delivery services.

Based on the 2020 Michigan Primary Care Needs Assessment:

- The main health priorities for rural Michigan are access to care, substance abuse/behavioral health, infectious/chronic disease, socioeconomic factors, obesity, and maternal and child health.
- The population in the state is getting older, while the percentage of children under the age of 18 is decreasing. In 2018, more than 83% of Michigan counties had higher percentages of elderly people than the state, particularly in rural Michigan.
- The areas with the worst SDOH outcomes were rural counties.

Building Partnerships to Support Rural Health Equity

To better support rural communities, the MDHHS SDOH Team continues to partner 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 health care providers, transportation, and broadband internet.

Implementation of the Rural Health Equity Plan

Implementation of the Rural Health Equity Plan requires a multifaceted approach that addresses the unique challenges faced by these communities. At a local level, comprehensive needs assessments – or Community Health Needs Assessments (CHNAs) – will help identify health disparities and challenges specific to the community. It will also help assess health care infrastructure (or lack thereof), the workforce, and available resources. Community assets, challenges, and priorities will also be determined through community engagement efforts. As needs and priorities are identified, SDOH Hubs in rural areas will implement community-driven solutions to reduce disparities in health outcomes.

At a state level, efforts will focus on enhancing access to health care by investing in broadband internet access and telehealth expansion, supporting workforce development through recruitment and retention in rural areas, addressing social determinants through policy and programmatic interventions, continuing robust community engagement efforts, and supporting community-driven health initiatives.

Improving Access to Broadband

The Department of Labor and Economic Opportunity's (LEO) Michigan High Speed Internet Office (MIHI), with funding from the Broadband Equity, Access, and Deployment Program, will work to expand high-speed internet access and digital equity to more than 200,000 Michiganders in unserved and underserved areas across the state.

You can find the full MIHI Michigan Broadband Roadmap online.

The SDOH Accelerator Plan to Prevent Chronic Disease

As part of Phase II implementation, the MDHHS Policy and Planning SDOH Team partnered with the Chronic Disease and Injury Control Division and the Division of Environmental Health for the development of a CDC-funded SDOH Accelerator Plan.

The **SDOH Accelerator Plan to Prevent Chronic Disease** aims to reduce disparities in health outcomes related to chronic disease by addressing underlying social determinants. This comprehensive plan integrates community-level interventions, policy changes, and collaborations across sectors to target factors contributing to chronic illnesses. It prioritizes access to food security, housing stability, environmental health, and mobility to address social factors that influence chronic disease. By tackling these determinants, the plan will reduce the incidence and impact of chronic diseases among priority populations.

Though broad strategies will be implemented to 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 Accelerator Plan places an emphasis on supporting populations that have been historically disadvantaged by policies, practices, and systems, leading to persistent health disparities and inequities.

One of the key outcomes of the Accelerator Plan includes increased collaboration and engagement across multisectoral partners. This was achieved through community engagement efforts, including regional listening sessions, the establishment of a leadership team to guide the development of the Accelerator Plan, and a promising policies and practices scan that included an inventory of MDHHS programs and services.

The goals of the Accelerator Plan are:

1. To reduce the incidence and impact of chronic disease through a multi-faceted approach that utilizes a community-based participatory approach, ensuring shared decision-making and building on identified existing resources.
2. To address root causes of chronic disease by addressing the social, economic, and environmental factors that contribute to these diseases.

Implementation of the Accelerator Plan aims to promote change at the policy, systems, and environmental (PSE) levels and to support a more holistic system of care and expand partnerships and advocacy to improve health equity.

You can find an in-depth summary of the SDOH Accelerator Plan to Prevent Chronic Disease on the SDOH website.

Priority: Strengthen existing policies and implement new policy recommendations that support SDOH and health equity.

Consumer-Centric Policies and the Impact of CIE and CHW Initiatives

The fresh perspectives and innovative solutions offered by the CIE Taskforce and CHW Subcommittee recommendations herald a new era of proactive health care. Implementation of these recommendations translates into tangible actions, amplifying the voices of Michigan communities, and strategically addressing gaps in health care access and quality. The composition of the CIE Taskforce and CHW Subcommittee embodies diversity, ensuring comprehensive representation and an understanding of Michigan's varied needs. These groups comprise individuals from multifaceted backgrounds, including health care professionals, community leaders, representatives from marginalized communities, policymakers, and advocates. This diversity ensures that a spectrum of perspectives, experiences, and expertise converges to inform decision-making and policy recommendations. The inclusion of voices from grassroots organizations, community health workers, and individuals directly impacted by health care disparities adds authenticity and validity to the recommendations put forth.

Community Information Exchange (CIE) Task Force Recommendations

The Michigan CIE Task Force, in addition to being a core pillar of Phase II of the MDHHS SDOH Strategy, was authorized by the Michigan Health Information Technology Commission's (MHITC) 2022 annual report, as a key step toward the implementation of the Michigan Health IT Roadmap (Bridge to Better Health, February 2022). MDHHS has resolved to create and sustain statewide infrastructure to support the collection, exchange, and responsible use of information that can help address the social needs of Michigan's people and communities, moving the state toward health equity. The CIE Task Force brought together health care organizations, health payers, health IT, and governmental entities to promote health and social equity, and improve the well-being of all Michigan residents. CIE 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 flow to the right people effectively and responsibly at the right time in the right context. Information about social needs and services is essential to effectively addressing systemic inequities which result in health disparities.

The task force has put forth a set of recommendations with strong consensus alongside a high-level roadmap for implementation. These recommendations include:

- Establish core technical capacities necessary to enable interoperability at a statewide scale – including standards for data exchange and identity management services.
- Establish a reliable supply of resource directory information to be provisioned as a public good.
- Establish a statewide framework for legal agreements that aligns with existing regulatory frameworks while addressing data collection in contexts that are not otherwise regulated; and establish an ethical framework in the form of a "Bill of Rights" for consumers and communities.
- Ensure that aggregation of longitudinal data about people and populations can occur with the informed consent of data subjects.
- Designate and support 'coordinating entities' in the process of facilitating activity among CBOs, government agencies, and health care institutions – and ensure that these entities uphold fiduciary responsibilities for the people and organizations that they serve.
- Establish federated systems of governance through which standards and policies are set statewide, while priorities and implementations can be decided and evaluated locally.
- Leverage a variety of financing mechanisms to build and sustain these capacities, including the capacity to provide more social services.

While there is broad consensus across health care, payors, government, and communities on the need for better data and information sharing to adequately address **social drivers** of health, in the absence of federal guidance and dedicated funding for states to promote CIE it is critical that Michiganders coalesce around core values and principles to promote equitable, effective, and interoperable social care data exchange. The CIE Task Force Final Report establishes a roadmap for Michigan to develop state-wide CIE infrastructure driven by the goal of health equity.

Please see Appendix F for a more detailed overview of CIE Task Force recommendations.

Community Health Worker (CHW) Subcommittee Recommendations

To better advance health equity, the MDHHS SDOH Strategy identifies the expansion and sustainability of the CHW workforce as a strategic imperative. In January 2023, MDHHS announced the convening of the CHW Subcommittee to bring together state and local community partners, including CBOs, health care, and governmental entities whose aligned work and interests are best served by a coordinated approach to support CHW workforce expansion and sustainability efforts. The CHW Subcommittee met monthly, from January 2023 through September 2023, to establish priorities and develop recommendations. Through iterative and collaborative convenings, the subcommittee has put forth a set of 24 recommendations, with a number of supporting sub-recommendations**,** as to their established priorities:

1. Create a supportive environment for the CHW workforce to thrive and make a significant impact on improving health equity and enhancing community well-being.
2. Better align CHW efforts by consistently sharing best practices and coordinating approaches to mitigation of efforts.
3. Identify meaningful measures of CHW work to demonstrate value and illustrate impacts.
4. Build a community engagement strategy to raise awareness of the importance and impacts of CHW work.
5. Identify and prioritize existing and potential mechanisms through Medicaid, other MDHHS programs, and other approaches to assure sustainable financing of CHW programs.
6. Create recommendations to support standards for CHW core-competency based training and mechanisms for certifying that training programs meet them.

Please see Appendix G for a more detailed overview of CHW Subcommittee recommendations.

Implementation of CIE and CHW Recommendations

The implementation of Community Health Worker (CHW) and Community Information Exchange (CIE) recommendations occurs on two crucial fronts: the local level through SDOH Hubs and at the statewide level, fostering a comprehensive and coordinated approach to address health disparities.

At the local level, SDOH Hubs serve as vital connectors between communities and health care resources. CHW and CIE recommendations are operationalized within these hubs, leveraging their community-driven approach. CHWs, embedded within these hubs, facilitate the translation of recommendations into actionable strategies. They bridge cultural and linguistic gaps, ensuring that community needs are accurately assessed and addressed.

At the statewide level, CHW and CIE recommendations inform policy discussions and development. The insights and success stories from SDOH Hubs are crucial in shaping broader policies that promote health equity statewide. This integration ensures that policies reflect the ground-level realities and needs of diverse communities across Michigan.

Priority: Pilot SDOH Hubs to support a holistic system of care and implement community-led solutions.

Utilizing SDOH Hubs to Support Cross Enrollment and Holistic Care

The integral role of free clinics and primary care clinics within SDOH Hubs cannot be overstated. These clinics form the cornerstone of equitable health care access, serving as essential pillars within communities facing socio-economic challenges. Free clinics offer a vital lifeline, extending medical services to those without insurance or financial means. Simultaneously, primary care clinics act as the first point of contact for a broader demographic, offering comprehensive health care services. Mobile health units (MHUs) stand as dynamic vehicles of health care delivery, embodying adaptability and responsiveness. Within the framework of SDOH Hubs, these units emerge as crucial assets in bridging the gap between communities and comprehensive health care services. Together, they ensure inclusivity, breaking down barriers that often hinder individuals from seeking necessary medical care.

SDOH Hubs will leverage the community trust, accessibility, and outreach capabilities of free clinics and primary care clinics so that cross-enrollment and Medicaid enrollment efforts can be greatly enhanced. This collaboration ensures that individuals who rely on these clinics for care are informed about and able to access the health coverage they are eligible for, ultimately improving health care access and outcomes for vulnerable populations.

Moreover, within the framework of the hubs, these clinics champion a holistic approach to health care. Beyond addressing immediate medical needs, they recognize and address the broader social determinants impacting health outcomes. By providing resources, education, and support, they empower individuals to navigate complex socio-economic factors affecting their health. This approach not only treats ailments but fosters a community-centered ethos, promoting proactive health practices and overall well-being.

These clinics also play a pivotal role in fostering community engagement and collaboration. They serve as trusted community anchors, creating spaces where individuals feel valued and supported. By actively involving the community in health care decisions and outreach initiatives, they build strong bonds that extend beyond medical treatment. Furthermore, these clinics work collaboratively with various community organizations, social services, and health care providers to create a robust network. This collaborative effort allows for a comprehensive approach to addressing the underlying social determinants affecting health outcomes.

In essence, the integration of free clinics and primary care clinics within SDOH Hubs signifies more than just medical treatment. They represent a commitment to inclusive health care, embodying a broader vision of well-being that extends into the fabric of communities. Their role transcends mere health care provision; they are the linchpin of a system that strives for equity, engagement, and holistic health.

Health Care Access and Equity

In the pursuit of health equity, the SDOH Strategy draws from the comprehensive recommendations outlined in the MDHHS 2021 Health Equity Report, a guiding document that has steered initiatives toward inclusivity and fairness. Additionally, the Policy and Planning SDOH team has closely examined the insights gleaned from the COVID-19 Racial Disparities Task Force (RDTF) Report, which underscores a critical and urgent need to improve health care access and utilization among racial and ethnic groups. The RDTF Task Force highlights the historical barriers that have systematically hindered these communities from accessing and fully engaging with the health care system. Their findings underscore the imperative to address entrenched inequalities, ensuring equitable access to health care for all, regardless of race or ethnicity. These reports serve as guiding lights, directing efforts toward dismantling barriers and fostering a health care landscape that embraces and serves every individual equitably.

Additionally, *Michigan's Roadmap to Healthy Communities* closely adheres to the Healthy People 2030 SDOH recommendations, particularly in enhancing access to care. The strategy strongly advocates for bolstering support to free clinics and primary care facilities, recognizing their pivotal role in addressing health care disparities. By fostering partnerships, allocating resources, and implementing targeted interventions, the roadmap aims to fortify these essential health care avenues, ensuring equitable access to quality care for underserved communities. This alignment signifies a concerted effort within the strategy to advance the shared goal of promoting accessible health care services as a cornerstone of improved societal health outcomes.

Through the Policy and Planning Workforce/Access and Grants Management Section, funding is provided to support primary care clinics and free health clinics. Enhancing access to primary care is pivotal, especially through free clinics and primary care facilities, which serve as vital resources for individuals facing barriers to health care access. These clinics primarily cater to the uninsured, underinsured, Medicaid recipients, immigrants, and refugees. Often grappling with chronic health conditions, these patients, due to their vulnerable circumstances, frequently lack adequate preventive or supportive care, leading to their reliance on these clinics for more complex medical needs.

Primary Care Clinics

In the fiscal year 2022, October 1, 2021, to September 30, 2022, primary care clinics experienced a blend of achievements and obstacles. These clinics encountered both successes and challenges, notably affected by ongoing issues due to the COVID-19 pandemic. Staffing emerged as a significant concern across all clinics. However, amid these challenges, notable successes were observed in testing and vaccination efforts. Many clinics expanded their services by introducing drive-thru testing and vaccination clinics, augmenting their in-clinic initiatives.

Free Clinics

A free clinic refers to a health care facility primarily staffed by volunteers, offering various medical, dental, pharmacy, and behavioral health services to individuals facing economic challenges. These clinics operate as nonprofit organizations, relying on either volunteer or paid health care professionals to deliver cost-free or affordable medical assistance. They specifically cater to uninsured or medically underserved individuals lacking access to health care services.

In fiscal year 2022, $400,000 was allocated to MDHHS for equal distribution among free clinic organizations serving Michigan's indigent population. An additional $250,000 was also allocated to free clinics and formed the MDHHS Free Clinic Additional Funding Program. In 2022:

- Forty-three organizations operating in 23 Michigan counties were funded.
- Free health care was provided for approximately 48,360 uninsured patient visits throughout the year.
- On average, 2,318 volunteer services hours were donated to the clinics each week.
- Sixteen of the funded free clinics only provided care to patients with incomes at or below two times the federal poverty level. Twenty-nine of the 43 awarded clinics only provided care to those without insurance.

Mobile Health Units

During the COVID-19 pandemic, Michigan established a mobile health unit initiative to address critical disparities in health care access and delivery, addressing both urban and rural health inequities. These units capitalized on an initial pilot with Ford Motor Company, Wayne State University and ACCESS. Success in demonstrating the need and ability to administer health services and social support services leveraged existing partnerships and forged new partnerships with local health departments, community-based organizations, employers, schools and health care organizations. The aim was to specifically serve populations living in areas that lack needed infrastructure and resources, pinpoint gaps in services, and orchestrate a cohesive, deployment strategy. This comprehensive approach ensured the delivery of mobile health services tailored to meet the diverse needs of communities in various areas within the state. MDHHS was recently appropriated $7 million to continue Michigan's national leadership in the deployment of mobile health units and filling important gaps in access and care delivery that improves health outcomes. This effort is currently being implemented by the MDHHS Race Equity, Diversity and Inclusion (REDI) Office.

MDHHS remains steadfast in its commitment to closing the disparity gap through the highlighted initiatives in the SDOH Strategy. These efforts are just a part of the collective endeavors undertaken by MDHHS, working in collaboration with various partners, to guarantee that every Michigander has equitable access to health care.

4.3: Using Data to Advance Heath Equity

Improving information technology (IT) and refining data collection processes stand as linchpins in the quest to address health inequities and bridge the disparity gap. By bolstering IT infrastructure, it enables a more comprehensive and accurate collection of data, delving deeper into demographic, socioeconomic, and health-related information. This expanded scope highlights disparities across various populations and regions, revealing critical insights into their underlying causes.

With advanced data analytics, identifying these disparities becomes more precise, empowering health care providers, policymakers, and organizations to tailor interventions to the most affected communities. This customization vastly improves the efficacy of strategies aimed at mitigating disparities. Moreover, the seamless integration of IT systems allows for real-time monitoring and evaluation of interventions, enabling swift adjustments and ensuring dynamic responsiveness. These enhanced capabilities not only measure the impact of interventions but also serve as robust tools for policy advocacy and resource allocation, guiding informed decision-making and advancing the collective goal of achieving health equity.

Data Bridge for Equity

Building Interoperable Data Capacity to Address Health Disparities

Utilizing RDTF funding to support IT and data collection, MDHHS will launch an initiative that aims to create a comprehensive statewide infrastructure facilitating data exchange among diverse entities, including health care providers, schools, carceral settings, community-based organizations (CBOs), and local public health agencies.

The planning phase emphasizes the establishment of statewide standards and an implementation plan. Success during this phase will be measured by the formulation of robust standards aligned with the Office of Management and Budget (OMB) and the Race Equity, Diversity, and Inclusion (REDI) Office, ensuring standardized data collection practices to address health inequities and disparities. Additionally, the establishment of regional Technical Assistance (TA) centers will aid in executing the plan.

During the implementation phase, success will be measured through several key metrics:

- **Onboarding CBOs to CIE**: The number of CBOs engaging in electronic data sharing and closed loop referrals will gauge the initiative's reach and engagement across community-based entities, ensuring comprehensive data inclusion.
- **Updated Racial Data Collection Standards**: Successful implementation of updated racial data collection standards, aligning with OMB and REDI office guidelines, will signify progress in achieving standardized and equitable data collection practices across various institutions.

- **Utilization of Shared Screening Tools:** Implementing shared screening tools and social need identification practices based on the Gravity Project (a national standard) will demonstrate the integration of consistent methods for identifying SDOH. This integration allows for a more holistic understanding of community needs and disparities.

By measuring the number of CBOs onboarded, implementing updated racial data collection standards, and adopting shared screening tools, the initiative aims to create a cohesive and standardized approach to data exchange. This holistic infrastructure fosters collaboration among diverse stakeholders, ensuring a more comprehensive understanding of community health needs and disparities while working towards equitable and effective interventions.

Chapter 5: Learning Forward: Phase III's Approach to Addressing Social Drivers of Health

Continued learning from the preceding phases of the SDOH Strategy is pivotal in shaping and refining ongoing efforts while charting a sustainable trajectory forward. This commitment to learning extends to the utilization of advisory councils, task forces, and other convening bodies. These platforms serve as invaluable forums for collaboration, pooling together expertise and diverse viewpoints. They provide a structured space for ongoing dialogue, enabling us to glean insights, refine strategies, and ensure that our approaches resonate with the communities we serve. Furthermore, initiatives like the SDOH Community Influencer Program play a pivotal role in amplifying community voices, facilitating meaningful engagement, and fostering partnerships that are instrumental in co-creating sustainable solutions.

In essence, this learning journey is intricately tied to an inclusive approach that values community voices and partnerships. By leveraging advisory councils, task forces, and community programs, we ensure that our strategies remain dynamic, responsive, and inclusive. This ongoing engagement empowers us to build a truly comprehensive strategy – one that not only supports the needs but also harnesses the strengths and assets of diverse communities in our pursuit of addressing the social drivers of health.

5.1: Food and Nutrition Security: Holistic Health Strategies

To facilitate collaboration among key stakeholders, the MDHHS Policy and Planning Office convened partners around SDOH domains, including food security, housing stability, and environmental health. By leveraging the expertise and resources of diverse sectors, these work groups seek to develop comprehensive and effective strategies to address SDOH. Building upon the foundations laid in Phase I, the ongoing efforts related to food security continue to evolve and enhance, showcasing a commitment to further improvements.

Food and Nutrition Security

In Phase I of the SDOH Strategy, food security was identified as a focus area. However, it is important to acknowledge that food security goes beyond ensuring an adequate quantity of food; it also involves providing nutritionally adequate and diverse food. Adequate nutrition is fundamental for overall health and well-being, supporting physical and mental development and preventing malnutrition-related illnesses.

Food Insecurity in Michigan

In 2021, nearly 1.2 million Michiganders, or 11.7%, faced food insecurity [3]. Food insecurity continues to disproportionately impact communities of color. Feeding America recently reported that 26% of Black households and 16% of Hispanic households were food insecure. In contrast, just 10% of white households experienced food insecurity. Additionally, food insecurity continues to impact children and older adults at higher rates than other age groups. In 2021, 13%, or more than 280,000 children under the age of 18, were food insecure and 8.7%, or more than 108,000 adults over the age of 60, were food insecure.

Building Partnerships to Support Food and Nutrition Security in Michigan

Collaborating across sectors is crucial to improving food and nutrition security because it addresses the multifaceted and interconnected nature of the challenges associated with food production, distribution, and access. The food system is intricate and involves various stages, including production, processing, distribution, and consumption. Additionally, food security is linked to agricultural, economic, social, and environmental factors.

Consideration of these interdependences is important to ensure a holistic approach. Collaboration also enables the efficient use of resources and can lead to more sustainable and efficient agricultural practices.

Most importantly, involving local communities in the collaboration process ensures that solutions are context-specific and take into account the unique challenges and opportunities present in different regions. This participatory approach will be achieved through the implementation of SDOH Hubs and will enhance the sustainability and effectiveness of food and nutrition security initiatives.

To promote a comprehensive, sustainable, and inclusive approach to ensuring that everyone has access to safe, nutritious, and sufficient food, the Policy and Planning SDOH team is working to build partnerships to support food and nutrition security.

Food Security Partner Meeting

In July 2023, the MDHHS Policy and Planning SDOH team convened a partner meeting focused on food security efforts. During the meeting, more than 175 participants engaged in meaningful discussion relating to engagement with marginalized or underserved communities, policy or legislative changes, challenges or barriers, collaboration and coordination, the role of state government, and metrics, indicators, and benchmarks.

To read more about the key themes that emerged from the partner meeting and additional initiatives that support food and nutrition security, please see Appendix I.

Food Security Internal Alignment Work Group

The Food Security Internal Alignment Work Group was tasked with guiding the Policy and Planning Office in identifying priorities and recommendations for Phase III of the SDOH Strategy. The recommendations will span across agencies and include policy and programmatic strategies with measurable outcomes.

The work group is comprised of 18 members, with representation from the Supplemental Nutrition Assistance Program (SNAP)/Food Assistance Program (FAP), the Women, Infants and Children (WIC) Program, MI Bridges, the Economic Stability Administration (ESA), the Behavioral and Physical Health and Aging Services Administration (BPHASA)/Medicaid, the Farmworker Outreach Services Division, and the MDHHS Tribal Government Services and Policy Director.

Alignment Across State Departments

Food and Nutrition Security work within the state of Michigan is primarily implemented through three departments: MDHHS, the Michigan Department of Agriculture and Rural Development (MDARD), and the Michigan Department of Education (MDE).

Additional alignment across state department programs includes emerging partnerships with the Michigan Department of Environment, Great Lakes, and Energy (EGLE) and the Michigan Department of Transportation (MDOT).

- MDARD supports farmers and farmers markets through a range of initiatives. FY24 appropriations will also support the launch of the Minority Food and Ag Venture Fund, outlined in further detail in the next section. To support a HiAP approach, the Policy and Planning Office is also working to expand on its partnership with MDARD to promote the development of policies that support sustainable agricultural practices and promote diversified and resilient food systems that prioritize the production of nutritious foods.
- MDE manages school food programs, like school meals and the Summer Food Service Program, as well as adult nutrition programs, like the Commodity Supplemental Food Program.
- EGLE is working to support food security through food waste and recovery efforts, detailed further on the next page.
- MDOT is currently exploring a framework that improves access to essential destinations, including food-related locations (e.g., grocery stores, food banks). The Policy and Planning SDOH team is working to expand its partnership with MDOT to integrate a HiAP approach to future transportation and mobility planning efforts.

Food Waste and Recovery

Each day in the U.S., approximately one pound of food per person is wasted.

Today, it is estimated that one-third of all the food produced in the world goes to waste. This equals 103 million tons (81.4 billion pounds) of food waste generated in America in 2017, or between 30-40% of the food supply, according to the United States Department of Agriculture (USDA). This means that either these products never leave the farm, get lost or spoiled during distribution, or are thrown away once purchased. This could be enough to feed every undernourished person on the planet. Reducing food waste would reduce the impact of human-caused greenhouse gas emissions. Michigan has a goal of carbon neutrality by 2050 and reducing food waste would help Michiganders reach this goal.

To learn more about food waste and recovery efforts, visit: https://bit.ly/MI-Food-Waste-Roadmap.

Across MDHHS, there exists a range of programs and services that support food and nutrition security, including SNAP/FAP and WIC. The department also works to improve food access and affordability through improved navigation and inbound client services and provide food and nutrition education.

- The **Supplemental Nutrition Assistance Program (SNAP)**, also known as the **Food Assistance Program (FAP)**, provides benefits to buy or grow food for low-income households.
- The **Women, Infants and Children (WIC)** program is a federally funded special Supplemental Nutrition Program, serving low- and moderate-income pregnant, breastfeeding, and postpartum adults, infants, and children up to age 5 who are found to be at nutritional risk. It provides a combination of nutrition education, supplemental foods, breastfeeding promotion and support, and referrals to health care and other community supports tailored to families' needs.
- **MI Bridges** is an online site where residents can explore potential eligibility, apply for Food Assistance benefits, apply for emergency relief, view their case information, or report changes to their specialist. It enables residents to identify their needs and connect to community resources that meet those needs to improve stability over time. These resources include community programs and organizations through a partnership with Michigan 2-1-1.

Several strategies continue to represent a concerted effort to not only sustain but also amplify the impact of food security initiatives:

MDHHS BPHASA Programming

The **Behavioral and Physical Health and Aging Services Administration (BPHASA)** administers nutrition programming for older adults and adults with disabilities through its provider network. Meals and other nutrition services are provided in a variety of group settings such as senior centers, faith-based settings, and schools, as well as in the homes of older adults and adults with disabilities. In addition to nutritious meals, the programs offer opportunities for social interaction and help decrease feelings of isolation. Nutrition programs provide a vital link to other supportive services available in local communities.

Home-Delivered Meals

Home-delivered meals have provided an essential benefit to communities for decades. Various programs like the **Program of All-inclusive Care for the Elderly (PACE)**, the **MI-Choice Waiver program**, and **MI Health Link** ensure that vulnerable populations have access to nutritious meals in the comfort of their homes, addressing both food security and health and safety needs concurrently.

Food and Nutrition Security Initiatives to Support Priority Populations

EXPANSION OF SENIOR PROJECT FRESH

To extend the reach and impact of nutritional support, there's a concerted effort to expand the **Senior Project Fresh** program into new regions. By reaching out to older adults in previously underserved areas, this expansion aims to provide access to fresh produce and nutrition education, promoting healthier dietary habits among this demographic.

DIVERSIFYING FARMERS MARKETS

To address food disparities, plans are underway to expand farmers markets into at least one additional underrepresented area in Michigan. This expansion targets areas characterized as low-income, food deserts, or areas associated with Native American or tribal organizations. By establishing farmers markets in these regions, the initiative aims to increase access to fresh and healthy food choices, fostering community health and economic development.

PRESCRIPTION PRODUCE PILOT PROGRAM (P4): ADDRESSING FOOD AND NUTRITION SECURITY WITH CULTURAL COMPETENCY

Within *Michigan's Roadmap to Healthy Communities*, ongoing efforts to combat food insecurity and reduce disparities requires cultural competency and the promotion of culturally appropriate foods. These fundamental elements are central to the strategy of MDHHS as it allocated $240,000 in planning grants to support the endeavors of four Michigan tribes.

The awarded grants represent a vital step in expediting preparations for the innovative Produce Prescription Pilot Program (P4) that took place from July 1, 2023, to September 30, 2023. Aligning seamlessly with MDHHS' comprehensive SDOH Strategy, these grants are pivotal in amplifying SDOH initiatives, fostering improved health outcomes, and advancing equity. Additional funding has been secured to support this work through September 2025.

At the heart of the P4 project lie core objectives, including:

- Mitigating food insecurity by addressing cultural barriers and promoting access to culturally relevant foods.
- Elevating dietary practices through the encouragement of increased consumption of culturally appropriate fruits, vegetables, and traditional foods.
- Enhancing health outcomes within tribal communities situated in Michigan through culturally sensitive approaches.

The P4 Bridge funding grantees, forming the core of the **P4 Inter-Tribal Consortium**, include Bay Mills Chippewa Indian Community, Grand Traverse Band of Ottawa and Chippewa Indians, Hannahville Indian Community, and Nottawaseppi Huron Band of Potawatomi.

By strategically utilizing nutrition programs, expanding outreach, and targeting underserved areas, these efforts aim to create a more equitable and healthier food landscape across Michigan.

For additional information about aligned food and nutrition security initiatives and reports, see Appendix I.

5.2: Phase III Food and Nutrition Security Priorities

The overarching food security goal from Phase I of the SDOH Strategy continues in Phase III:

Reduce food insecurity in Michigan and promote health equity by increasing access to good quality, nutritious food and implementing food system changes.

To tackle identified challenges and align efforts to support food and nutrition security in Michigan, Phase III of the SDOH Strategy includes four priorities for the Food and Nutrition Security Focus Area:

Reducing disparities: Ensuring that food resources reach people disproportionately impacted by food insecurity.

Improving food access: Supporting community development efforts that improve food access through public and private partnerships.

Supporting agricultural development: Implementing policies and programs that support and maintain local agriculture development in rural and urban communities.

Addressing negative environmental factors: Addressing natural and built environment factors that limit access to healthy and affordable foods.

These strategies, developed through the collaborative efforts of the Internal Alignment Food Security Work Group, represents a concerted approach to address these critical facets of food security. This coordinated approach within MDHHS and collaborating agencies underscore a collective commitment to combating food insecurity comprehensively.

Priority: Ensuring that food resources reach people disproportionately impacted by food insecurity.

Phase III strategic objectives to ensure food resources reach people disproportionately impacted by food insecurity:

Strategy FS-1: Collaborate with non-traditional partners to leverage resources to reduce food insecurity for disproportionately impacted populations.

Strategy FS-1: Collaborate with non-traditional partners to leverage resources to reduce food insecurity for disproportionately impacted populations.

Objective FS-1.1: By September 30, 2024, establish or strengthen at least three partnerships with partners that are working to improve food security.

- **Initiative FS-1.1.1:** Pilot a partnership with the Michigan State Police (MSP) and county jails to complete SNAP applications for future returning citizens before release.
- **Initiative FS-1.1.2:** Pilot a partnership with Children's Protective Services to connect food supports to families who have been reported for potential investigation but are not in need of investigation.
- **Initiative FS-1.1.3:** Strengthen the partnership between the Economic Stability Administration (ESA) and the Children's Services Administration (CSA) to increase food security for youth aging out of foster care by reducing procedural denials.

Strategy FS-2: Design and implement policy, systems, and environmental (PSE) changes to support community-driven food security strategies.

Policy, Systems, and Environmental (PSE) Changes

PSE changes refer to a comprehensive approach to promoting health and well-being by influencing policies, systems, and the environment. PSE changes aim to create supportive environments and structures that facilitate healthy choices and lifestyles. Policy changes involve modifications to rules, regulations, laws, or guidelines at various levels, including government, organizational, or community policies. System changes focus on modifying the structures and processes within organizations, institutions, and communities to better support health and equity. Environmental changes involve altering the physical surroundings in which people live to encourage healthier behaviors. This approach acknowledges the broader context in which people live, and by positively impacting this context, it becomes easier for individuals to achieve good health.

Strategy FS-2: Design and implement policy, systems, and environmental (PSE) changes to support community-driven food security strategies.

Objective FS-2.1: By September 30, 2025, implement at least three PSE changes to support community-driven food security strategies.

- **Initiative FS-2.1.1:** Develop food security plans with Michigan's Local Food Council Network.
- **Initiative FS-2.1.2:** Release a request for proposals (RFP) for community-based strategies to increase physical activity and nutrition.
- **Initiative FS-2.1.3:** Invest in evidence-informed insights that can guide policy decisions and improve the integration of nutrition and health care for Medicaid beneficiaries, ultimately enhancing their overall health and well-being.

Priority: Supporting community development efforts that improve food access through public and private partnerships.

Supporting community development efforts that improve food access includes initiatives and strategies that expand best practices, explore innovations, or leverage technology to make it easier for people to access food.

Phase III strategic objectives to support community development efforts that improve food access through public and private partnerships:

Strategy FS-3: Increase food access and availability through community-directed strategies.

Communities possess unique knowledge about their local environment, agricultural practices, and food preferences. Community-directed initiative leverages this indigenous knowledge, ensuring that interventions are culturally sensitive, contextually relevant, and align with local practices.

Strategy FS-3: Increase food access and availability through community-directed strategies.

- **Initiative FS-3.0.1:** Improve WIC shopping experiences through data collection and integration of user experience feedback.

Objective FS-3.1: By September 30, 2028, invest $5 million in Kent and Wayne counties to meet food delivery gaps.

- **Initiative FS-3.1.1:** Develop a food delivery service program with community members to meet delivery gaps in Kent and Wayne counties.

Objective FS-3.2: By September 30, 2024, the Detroit Food Policy Council will provide technical assistance and implementation support to replicate the Great Grocer Program with the Flint Food Policy Council.

Strategy FS-4: Modernize the website interface to make it easier for community members to access resources.

An outdated website interface can create significant barriers to accessing programs and resources by impeding navigation, hindering readability, lacking accessibility features, and presenting outdated or confusing information. Addressing these issues through thoughtful web design is essential to ensuring that websites effectively serve their intended audience and provide equitable access to information and services.

Strategy FS-4: Modernize the website interface to make it easier for community members to access resources.

- **Initiative FS-4.0.1:** Leverage existing technology solutions to identify an electronic solution for Senior Project Fresh.
- **Initiative FS-4.0.2:** Strengthen the existing interface to ensure participants in the FAP are able to access employment and training services.

Strategy FS-5: Increase food availability by decreasing food waste.

Strategy FS-5: Increase food availability by decreasing food waste.

Objective FS-5.1: By September 30, 2024, publish user-friendly statewide food donation standards on multiple state platforms.

- **Initiative FS-5.1.1:** Develop statewide food donation standards for public and private partners.

Priority: Implementing policies and programs that support and maintain local agriculture development in rural and urban communities.

Phase III strategic objectives to support the implementation of policies and programs that support and maintain local agriculture development in rural and urban areas:

Strategy FS-6: Increase comprehensive support for farmers, farmworkers, and agricultural businesses.

Farmers, farmworkers, and agricultural businesses play a pivot role in supporting food security by contributing to the production, distribution, and accessibility of a diverse range of food products. Together, these interconnected components form the foundation of a sustainable and resilient food system, influencing the nutritional well-being and economic prosperity of communities. Recognizing the significance of these stakeholders underscores the importance of supporting the agricultural sector to address the complex challenges and opportunities associated with food security in Michigan.

Strategy FS-6: Increase comprehensive support for farmers, farmworkers, and agricultural businesses.

- **Initiative FS-6.0.1:** Implement Fresh Food Connection to connect minority farmers to community members and create an online shopping market.
- **Initiative FS-6.0.2:** Expand outreach services to previously unserved areas of the state, assisting farmworkers to apply for the Food Assistance Program (FAP) and Medicaid.

Objective FS-6.1: By September 30, 2028, invest $2.9 million in under-resourced minority-owned farms and urban gardens.

- **Initiative FS-6.1.1:** Increase funding for minority-owned farms and agricultural businesses through MDARD's implementation of the **Minority Food and Ag Venture Fund**.

Priority: Addressing natural and built environment factors that limit access to healthy and affordable foods.

Strategy FS-7: Increase transportation and mobility options for rural and urban community members to improve access to essential destinations, including food.

Transportation is essential to increasing access to essential services, like health care, going to school, and going to work. Transportation will be a cross-cutting domain in Phase III. Long-term opportunities to strengthen alignment between transportation and food security include integrating food security considerations into local and regional planning projects and expanding opportunities for multi-modal design to increase walkability and/or alternative modes of transportation.

Strategy FS-7: Increase transportation and mobility options for rural and urban community members to improve access to essential destinations, including food.

The following recommendation is included in the Food Security Council's final report:

FSC Recommendation 3: Improve food access through increased transportation options including home delivery.

The recommendation outlines a model-council approach, including detail related to council structure, based on the long-standing Michigan Interagency Migrant Services Committee.

Objective FS-7.1: By June 30, 2024, establish a Michigan Coordinating Council on Access and Mobility (MICCAM).

To learn more about MICCAM, please see page 41.

Objective FS-7.2: By September 30, 2024, engage diverse transportation and food security stakeholders to develop a workplan for MICCAM FY25 activities.

5.3: Housing Stability: Holistic Health Strategies

With limited options for affordable, healthy housing, many Michigan residents face instability, poor health outcomes, and homelessness. Housing instability and homelessness are inextricably linked with health, and many homes have hazards (such as lead) that can increase risk for injury, illness, and chronic disease.

Housing instability can also perpetuate a cycle of vulnerability, in which an individual's health problems can lead to a person's homelessness and homelessness can lead to health problems. New and existing health problems can also be further exacerbated by the experience. Ensuring equitable access to healthy, affordable housing is key to improving health and social outcomes of people experiencing housing instability.

Affordability is a crucial component of housing stability because it directly influences whether individuals and families can maintain consistent, secure housing. When housing is affordable, it means that people can comfortably cover their housing expenses, which may include rent or mortgage payments, utilities, and related cost, without it taking an overwhelming portion of their income. If housing costs consume too much of a household's income, it can lead to financial strain, forcing tough choices between paying for housing and other essentials like food, health care, or education. High housing costs can also lead to housing instability, causing individuals or families to move frequently, live in overcrowded or inadequate conditions, or face the risk of eviction or homelessness.

Building upon the foundations laid in Phase I, the ongoing efforts related to housing stability continue to evolve and enhance, showcasing a commitment to further improvements.

Housing Stability

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.

Housing instability includes problems like not being able to pay rent, moving a lot, living in places that aren't safe, or being homeless.

Housing Instability in Michigan

Housing is affordable when individuals spend no more than 30% of their monthly income towards housing expenses. Severe housing cost burden occurs when households spend 50% or more of their monthly income on housing expenses.

From 2017-2021, **12.1%** of Michigan households spent more than 50% or more of their household income on housing.

Source: County Health Rankings

In 2019, **48%** of people who are homeless are Black, despite being only 14% of Michigan's overall population.

Source: Statewide Housing Plan

From January 2013 to October 2021, the average sale price of a home in Michigan increased by **84%**.

Source: Statewide Housing Plan

Consistent with SDOH disparities in Michigan, severe housing cost burden varies significantly. The map below displays the variation between counties:

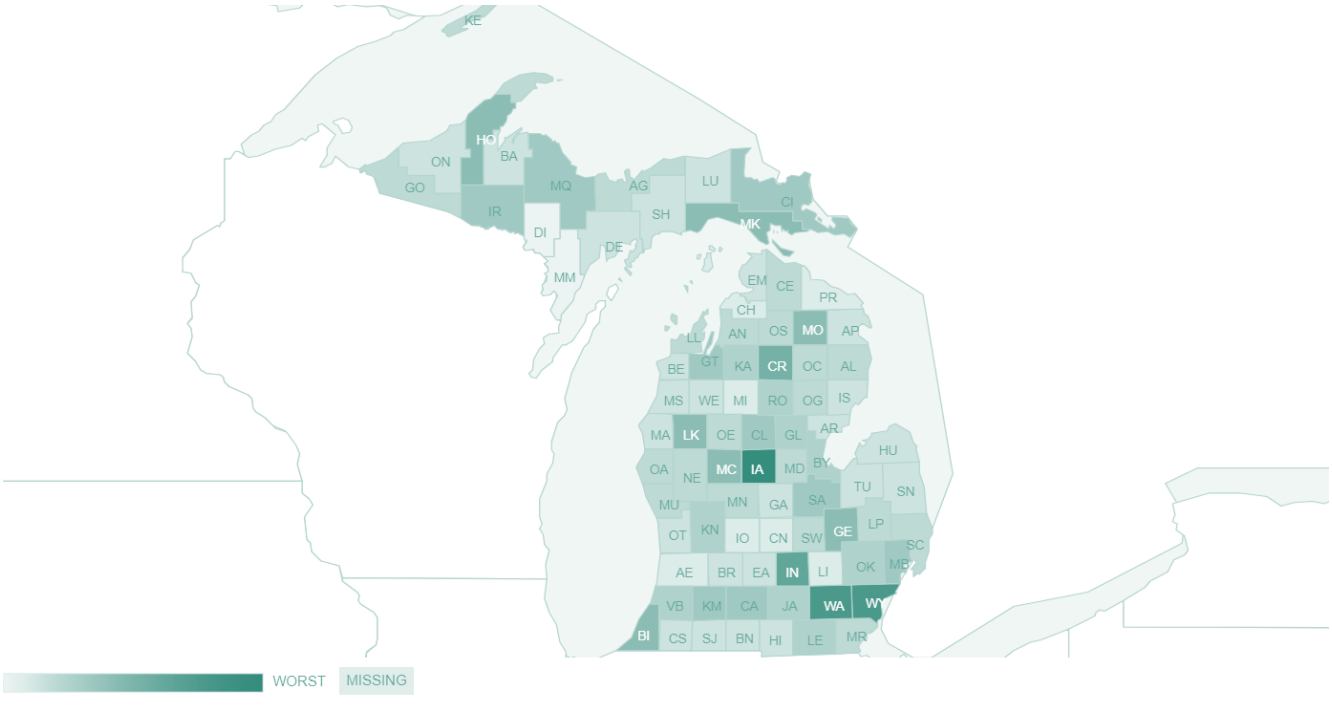

Figure 2. Severe Housing Cost Burden in Michigan, 2017-2021, County Health Rankings

For more data insights on housing in Michigan, visit *https://mihousingdata.org/data_portal*.

Building Partnerships to Support Housing Stability in Michigan

The Housing Stability Internal Alignment Work Group

The Housing Stability Internal Alignment Work Group was tasked with guiding the Policy and Planning Office in identifying priorities and recommendations for Phase III of the SDOH Strategy. The recommendations will span across agencies and include policy and programmatic strategies with measurable outcomes.

The Work Group is comprised of 10 members, with representation from MDHHS Housing and Homeless Services, MI Bridges, Medicaid/the Behavioral and Physical Health and Aging Services Administration (BPHASA), the Michigan State Housing Development Authority (MSHDA), the Weatherization program, the Division of Environmental Health, the Michigan Public Service Commission, the Low-Income Energy Policy Board, and Energy Waste Reduction.

Alignment Across State Departments

Housing stability work within the state of Michigan is primarily implemented through the **Michigan State Housing Development Authority (MSHDA)**. MSHDA provides financial and technical assistance through public and private partnerships to create and preserve safe and decent housing, engage in community economic development activities, develop vibrant cities, towns, and villages, and address homeless issues.

MSHDA recently released Michigan's first Statewide Housing Plan. The plan will help identify the causes of housing issues and what must be done to address them equitably, inclusively, and in a way that best leverages all available resources. MDHHS will identify additional opportunities to align with the plan to support vulnerable populations, including the promotion of universal and barrier-free housing accessibility and reducing barriers to recovery housing.

Holistic Approaches to Healthy Housing

Thinking about housing stability more holistically is crucial in understanding its intricate connections with various facets of well-being and overall quality of life. Housing stability extends far beyond merely having a roof overhead; it encompasses the safety, affordability, and suitability of living conditions. Recognizing housing as a fundamental driver of health and social outcomes underscores the need for holistic approaches to address this issue.

Creating space for innovative collaboration acknowledges that addressing housing stability requires multifaceted solutions that go beyond traditional approaches. Collaboration between sectors such as health care, housing, social services, and community development can foster innovative strategies that tackle the root causes of housing instability.

By bringing together diverse stakeholders, innovative collaborations can harness collective expertise, resources, and perspectives to devise comprehensive and sustainable solutions.

MDHHS' participation on the Michigan Public Service Commission's Low Income Energy Policy (LIEP) Board plays a pivotal role in indirectly addressing both energy security and housing stability. The LIEP Board's primary objective is to comprehensively evaluate energy affordability and accessibility, offering a holistic approach that intricately links energy waste reduction services with energy assistance programs.

Low Income Energy Policy Board

Addressing housing stability through energy efficiency.

As energy security is fundamental to achieving housing stability, the following recommendations may be developed into initiatives in an effort to reduce unsustainable energy burdens for those experiencing energy insecurity:

- Increase home energy security for Michigan's residents most vulnerable to energy insecurity, acknowledging that energy insecurity is driven by factors including, but not limited to, those that can be addressed through energy assistance programs: energy affordability, energy arrearages, and predictability of changes.
- Improve coordination and accessibility of energy assistance programs by ensuring that access to assistance for energy security does not hinge on crisis, by broadening access, tailoring solutions to customer needs, reducing duplication of efforts, and streamlining renewal of enrollments.
- Strengthen collaboration for energy efficiency improvements with landlords accepting housing choice vouchers.

Holistic Approaches to Housing: Addressing Energy Insecurity

The connection between housing security and energy security is multifaceted and crucial in understanding the broader impact on health and well-being. Housing security, ensuring stable and adequate housing, is intrinsically linked to energy security, which refers to reliable access to affordable energy sources.

Chronic energy insecurity pertains to long-term inadequate access to reliable and affordable energy sources, including electricity and heating, essential for maintaining a suitable living environment. Energy insecurity directly impacts housing stability. For instance, inadequate heating can lead to substandard living conditions, posing risks to health, particularly for vulnerable populations.

Acute energy insecurity refers to short-term energy disruptions or unaffordability, often resulting from sudden events like extreme weather or economic crises. These acute energy insecurities can swiftly escalate into housing instability, such as missed utility payments leading to disconnection of services or inability to maintain a habitable living environment due to sudden energy unavailability.

The connection between housing and energy security is paramount when considering health impacts. Chronic energy insecurity in homes can lead to suboptimal living conditions, exacerbating health issues such as respiratory problems, cardiovascular diseases, and mental health conditions. For instance, inadequate heating or poor insulation in homes can contribute to respiratory ailments or worsen existing chronic conditions. Similarly, acute energy insecurities, when persistent, can lead to stress and anxiety, impacting mental health.

Understanding and addressing the link between housing and energy security is vital in mitigating health risks associated with inadequate living conditions. Policies and interventions targeting both stable housing and reliable energy access are crucial not only in fostering housing stability but also in safeguarding the health and well-being of individuals and communities.

5.4: Phase III Housing Stability Priorities

Tackling housing instability stands as a critical mission in ensuring healthier and more equitable communities. Local SDOH Hubs and state-level initiatives employing a Health in All Policies approach serve as powerful tools in combating this pressing issue. This dual-pronged approach, in alignment with the Statewide Housing Plan, will support housing stability in Michigan. By uniting local action with statewide policies and fostering collaborations, we pave the way for sustainable change, ensuring that every Michigander has access to safe, stable, and affordable housing.

To tackle identified challenges and align efforts to support housing stability in Michigan, Phase III of the SDOH Strategy includes three priorities for the Housing Stability Focus Area:

Reducing disparities: Ensuring that housing support programs and services reach people disproportionately impacted by housing instability.

Improving housing factors that influence health: Addressing the threat and safety concerns posed by lead, contaminants, and other environmental health hazards to ensure healthy housing.

Improving housing access: Supporting community development efforts that improve access to healthy and affordable housing through public and private partnerships.

These strategies were developed through the collaborative efforts of the Housing Stability Internal Alignment Work Group, illustrating a synergetic approach to addressing key factors contributing to housing stability.

Priority: Ensuring that housing support programs and services reach people disproportionately impacted by housing instability.

Phase III strategic objectives to ensure housing support programs and services reach people disproportionately impacted by housing instability:

Strategy HS-1: Expand collaboration with non-traditional partners to better utilize resources that reduce housing stability in disproportionately impacted communities.

Strategy HS-1: Collaborate with non-traditional partners to better utilize resources that reduce housing instability for disproportionately impacted communities.

Objective HS-1.1: By September 30, 2024, implement the GH2 Program in partnership with 19 local health partners to connect community residents to housing stabilization resources and increase housing access.

Objective HS-1.2: By December 30, 2024, implement at least two Policy, Systems, and Environmental (PSE) changes that encourage community-driven strategies and reduce housing barriers for populations disproportionately burdened by housing instability.

- **Initiative HS-1.2.1:** Implement the **Newcomer Rental Subsidy Program** with the Office of Global Michigan to provide rental assistance to refugees and newcomers in order to increase access to affordable housing.
- **Initiative HS-1.2.2:** Implement evidence-based practices that improve and expand access to recuperative care programs for Medicaid beneficiaries to reduce hospital re-admissions and increase access to stable housing post-discharge.

Objective HS-1.3: By March 31, 2024, deliver housing resource trainings to local partners participating in the GH2 program to promote awareness and educate on housing programs and services.

- **Initiative HS-1.3.1:** Coordinate with MSHDA to examine and incorporate trainings on housing resources, the homeless response system, and connecting residents to proactive, emergent, and permanent housing.

Objective HS-1.4: Integrate the Medical Vulnerability Index tool in five counties to better understand real-time data between health and homelessness.

Priority: Addressing the threat and safety concerns posed by lead, contaminants, and other environmental health hazards to ensure healthy housing.

Phase III strategic objectives to support healthy housing:

Strategy HS-2: Promote energy-efficient housing to reduce long-term energy costs and increase the number of safe, weatherized homes.

Strategy HS-2: Promote energy-efficient and sustainable housing to reduce long-term housing and energy costs and increase the number of safe, weatherized homes.

- **Initiative HS-2.0.1:** Strengthen collaboration and referral networks between energy assistance and home weatherization services.
- **Initiative HS-2.0.2:** Enhance energy efficiency and reduce energy costs for low-income families through the **Weatherization Assistance Program (WAP)** and utility health and safety programs.

Strategy HS-3: Improve and streamline processes to identify and address home health and safety hazards and explore opportunities for collaboration between sectors.

Strategy HS-3: Improve and streamline processes to identify and address home health and safety hazards and explore opportunities for collaboration between sectors.

- **Initiative HS-3.0.1:** Collaborate with MSHDA and other partners to promote lead abatement work among existing contractors and grow additional workforce specific to lead to help eliminate a critical backlog of properties waiting for lead abatement work statewide.
- **Initiative HS-3.0.2:** Prioritize lead impacted families who must leave the residence that poisoned them with housing vouchers, a safe house, or other supports to fast-track families in crisis to safe, affordable, healthy housing on a temporary or permanent basis, as needed.

Strategy HS-3: Improve and streamline processes to identify and address home health and safety hazards and explore opportunities for collaboration between sectors.

- **Initiative HS-3.0.3:** Elevate a statewide water assistance program for low-income communities, integrating financial support, conservation promotion, and community outreach, with an added focus on enhancing public health outcomes for low-income communities.

Priority: Supporting community development efforts that improve access to healthy and affordable housing through public and private partnerships.

Phase III strategic objectives to support community development efforts that improve access to healthy and affordable housing through public and private partnerships:

Strategy HS-4: Improve the availability of wrap-around services to individuals receiving housing assistance including household budgeting, home maintenance and repair, and other resources to ensure sustainability once housed.

Strategy HS-4: Improve the availability of wrap-around services to individuals receiving housing assistance including household budgeting, home maintenance and repair, and other resources to ensure sustainability once housed.

- **Initiative HS-4.0.1:** Connect weatherization programs to job training and placement programs to help address both employment barriers and staffing limitations.
- **Initiative HS-4.0.2:** Pair housing resources with educational and job development programs for young adults, ages 18-25.

Strategy HS-5: Establish and sustain multi-sector partnerships to strengthen housing efforts, improve housing development and supportive services, and reduce barriers to existing resources and services across the state.

Strategy HS-5: Establish and sustain multi-sector partnerships to strengthen housing efforts, improve housing development and supportive services, and reduce barriers to existing resources and services across the state.

- **Initiative HS-5.0.1:** Increase communication with MSHDA and other housing partners to effectively disseminate best practices, explore partnership opportunities, and align with the Michigan Statewide Housing Plan.
- **Initiative HS-5.0.2:** Expand the current network of housing navigators statewide to assist individuals and families seeking housing resources with enrolling in housing programs, financial assistance, and locating secure, safe, healthy, and affordable housing.

Chapter 6: Implementing Phase III: **A Call to Action**

Momentum for Phase III

Phase III of the strategy will sustain a commitment to address both the midstream and upstream factors that influence health. Through the establishment of SDOH Hubs, a Health in All Policies approach, and implementation of strategies to close the disparity gap, Phase III seeks to comprehensively and sustainably improve health and equity.

Through the current investments in workforce training and education, the expansion of housing options, support from farmers and food production partners, to the leadership of our health care and social services sectors, these efforts collectively produce a healthier, more prosperous Michigan. The true strength of our journey lies in collaborative endeavors. As we navigate towards progress, it's vital to champion collaboration, fostering an environment where diverse expertise converges, experiences merge, and innovations flourish.

We extend a call to all partners, from every sector, to unite in the pursuit of sustaining healthy, prosperous Michigan communities. Let us harness the strength of collaboration to magnify the impact of our collective efforts. Together, we accelerate the pace of change, crafting a future where every Michigander thrives, where opportunities abound, and where well-being is a shared reality.

United Call to Action

The state of Michigan stands at a critical juncture in its collective pursuit of a healthier, more equitable place to live and grow. There is significant opportunity to align efforts and support the implementation of the SDOH Strategy, recognizing and tackling the root causes of health disparities.

The strategy serves as a call to action – calling on partners across the state, including policymakers, health care providers, advocates, and communities – to work together to create resilient and thriving communities by addressing the root causes of health disparities through a holistic approach. The establishment of SDOH Hubs aims to foster a collaborative environment that transcends traditional health care boundaries, recognizing that health is profoundly influenced by social drivers. Through the hubs, partners will collaborate to empower individuals and communities through targeted, tailored interventions that address SDOH. By providing comprehensive support, they will work to break down systemic barriers, reduce inequalities, and enhance overall well-being. Partners across Michigan can work together to build a healthier, more equitable future where every Michigander has the opportunity to live their best and healthiest life.

Priority Areas

Enhancing SDOH Hubs: As vital anchors of support, SDOH Hubs serve as multifaceted platforms. We implore our partners across sectors to strengthen these hubs, ensuring they become robust conduits for comprehensive services, resources, and interventions that address the diverse needs of vulnerable populations.

HiAP Integration: Embracing the principles of Health in All Policies requires a collective effort. Our call to transportation partners, housing advocates, and food distributors is to embed SDOH considerations within their realms, fostering equitable access, affordability, and availability that promote health and well-being. Invite health and social care partners to the table to support alignment of efforts and equitable solutions for all.

Disparity Reduction Strategies: Targeted strategies are imperative to dismantle systemic barriers. Collaborators specializing in behavioral health and those supporting children's welfare, disabled individuals, refugees, immigrants, and BIPOC communities are urged to join forces, contributing their expertise to craft interventions that address nuanced challenges and foster inclusive health outcomes.

Call to Action

For Transportation Partners: Your role in ensuring equitable access is unparalleled. Collaborate with us to improve transportation options, bridging gaps that hinder access to health care, education, and employment. Together, let's create a transport network that promotes health and opportunity for all.

For Housing Partners: Stable housing is foundational to health. Join us in advocating for affordable, safe housing, supporting initiatives that prevent homelessness, and innovating housing solutions that cater to diverse community needs.

For Food Distribution Partners and Farmers: Nutrition is a cornerstone of well-being. Partner with us to ensure food security, support local agriculture, and champion access to nutritious food in underserved areas, nurturing communities' health from the ground up.

For Behavioral Health Partners: Mental health is integral to holistic well-being. Collaborate with us to integrate mental health services seamlessly into communities, destigmatize access to care, and address the intersectionality of mental health and social determinants.

For Partners Supporting Vulnerable Populations: Your dedication to the well-being of children, disabled individuals, refugees, immigrants, and BIPOC communities is invaluable. Let us combine our efforts to tailor interventions that address their unique needs, ensuring inclusivity and equity in health outcomes.

For Philanthropy: Your generosity fuels innovation and progress. Join us in strategically investing in SDOH Hubs, supporting grassroots efforts, and pioneering new approaches to address the root causes of health disparities. Your partnership is instrumental in catalyzing sustainable change.

For Health Plans and Payors: Your influence spans far beyond health care provision. Collaborate with us in integrating SDOH into care models, incentivizing community-based interventions, and fostering partnerships to create comprehensive, patient-centric approaches. Your commitment can redefine health care.

For Other Critical Partners: Your unique expertise and resources are indispensable. Stand with us in advocating for policy changes, dedicating resources to amplify SDOH initiatives, and leveraging your spheres of influence to champion equity. Together, we can create a domino effect of change.

Measuring Success and Continuous Improvement

In our quest to support healthy, prosperous Michigan communities, the journey doesn't end with the launch of initiatives. Measuring success and continuous improvement are necessary to ensure sustainability of efforts. To effectively demonstrate the impact of these efforts, SDOH Hubs will publish annual reports and share information through a dashboard. The dashboard will include key metrics and indicators related to various health and social outcomes. By collecting, analyzing, and sharing data on these indicators, the SDOH Hub can quantify changes over time and demonstrate the effectiveness of its approach. Visualization tools, including graphs and maps, will aim to make complex data more accessible to stakeholders, policymakers, and communities, fostering transparency and accountability. Regularly updating and disseminating these dashboards will ensure ongoing evaluation and adjustment of strategies to reinforce the hub's commitment to addressing and reducing health disparities.

Annual reports will also include qualitative data to showcase the impact of hubs on individuals and families. These reports will include success stories and best practices to inspire change in communities across the state.

As we navigate this path of continuous improvement, we look forward to continuing our partnerships. Together, we will build upon our successes, learn from each other's experiences, and forge a path toward an even stronger Michigan – a Michigan where every community thrives, and every individual's well-being is cherished.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

References

Most sources are cited in text; however, a few references are listed below:

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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 first-line 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

CBO – Community Based Organization
CDC – Centers for Disease Control and Prevention
CHNA – Community Health Needs Assessment
CHW – Community Health Worker
CIE – Community Information Exchange
CSA – Children's Services Administration, or Community-Supported Agriculture
EGLE – (Michigan Department of) Environment, Great Lakes, and Energy
EIA – Equity Impact Assessment
FRC – Family Resource Center
FY – Fiscal Year (e.g., FY24 is the period between October 1, 2023, and September 30, 2024)
HHS – (United States Department of) Health and Human Services
HiAP – Health in All Policies
HIT – Health Information Technology
HRSN – Health Related Social Needs
LHD – Local Health Department
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
MHU – Mobile Health Unit
MiCHWA – Michigan Community Health Worker Alliance
MIHI – Michigan High Speed Internet Office
MPHI – Michigan Public Health Institute
MSHDA – Michigan State Housing Development Authority
OEMH – (MDHHS) Office of Equity and Minority Health
OMB – Office of Management and Budget
PFC – Proposal for Change
REDI – (MDHHS Office of) Race Equity, Diversity, and Inclusion
SDOH – Social Determinants of Health
SHP – Statewide Housing Plan
SIM – State Innovation Model
TA – Technical Assistance

Appendix C: SDOH Strategy Priority Populations

- Children and infants
- Older Adults
- People with physical and/or mental disabilities
- LGBTQ+
- People experiencing homelessness or housing instability
- Immigrants
- Migrant workers
- People who are justice-involved
- People with lower incomes
- People enrolled in Medicaid
- People with behavioral addictions or disorders
- Refugees
- People from racial and/or ethnic minority groups
- Residents of rural areas
- Residents in geographic areas that have been underserved by health and social services
- Veterans
- People with Limited English Proficiency (LEP)
- Youth in foster care, or aging out of foster care
- People who are pregnant and parenting
- People with chronic disease(s)
- Tribal communities
- Communities at higher risk of experiencing the adverse effects of climate change

Appendix D: Proposed Metrics for SDOH Hub Evaluation

Proposed Metrics and Key Performance Indicators (KPIs)

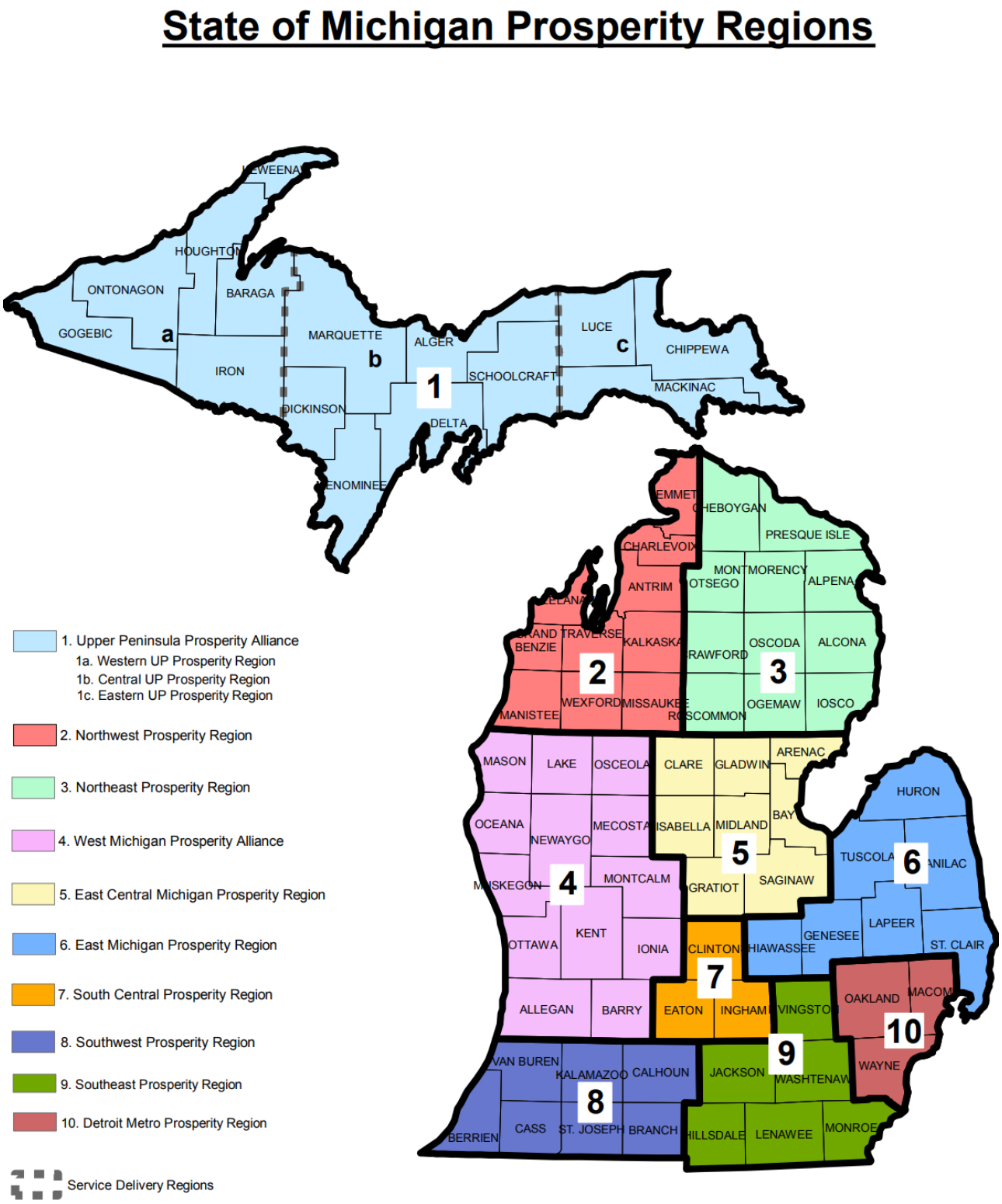
**Note that these are proposed metrics for consideration. These proposed metrics will be presented to the SDOH Hub Pilot sites and the SDOH Hub Advisory Council for consideration to determine which measures will be most meaningful to demonstrate progress. It is especially important to acknowledge that this pilot period will not include long-term measures, as the duration of these pilot projects will not be sufficient to measure long-term impact.*

Outcome	Performance Indicators (Measures)
Health Equity Advancement	
Policy and systems change: Increased adoption of new policies and/or strengthening of existing policies.	▪ Number and type of policies and system changes at the *state level* that address SDOH. ▪ (CHW-CRE #11) Number and type of policies and system changes at the *state level* that address CHW workforce development and sustainability (e.g., training, payment, etc.).
Health Outcomes	
Health and Social Outcomes: Improved health and social outcomes for people experiencing health disparities and inequities.	▪ Individual performance metrics for selected initiatives. ▪ Number of priority populations served through targeted interventions.
Chronic Disease Outcomes: Reduced disparities in chronic disease outcomes.	▪ Change in disparities related to chronic disease prevalence across demographic groups. ▪ Change in disparities related to chronic disease mortality rates and life expectancy. ▪ Number of PSE interventions (as outlined in the SDOH Accelerator Plan to Prevent Chronic Disease) implemented.
Access to Services	
Improved availability and accessibility of health and social services: Increased utilization of health care services, social	▪ Change in utilization rates for health care services, social services, and community resources.

services, and community resources.	▪ Change in geographical coverage of services (by county). ▪ Number and percentage of population served within SDOH pilot hub catchment area. ▪ Change in number of users for websites connecting people to health or social services (digital accessibility). ▪ Change in social media engagement metrics for accounts promoting health and social services. ▪ Number of languages that program materials are translated into.
SDOH Strategy Implementation	
Housing Stability: Decreased housing stability and homelessness by administering the Good Housing = Good Health program through the SDOH Hubs.	▪ Change in the rate of homelessness and housing insecurity. ▪ Number of key recommendations from the Statewide Housing Plan that are implemented.
Community Health Workers: Increased integration of CHWs into a holistic system of care.	▪ Number of CHWs trained and integrated into communities through the CITIE Initiative. ▪ (CHW-CRE #5) **CHW integration into teams** (PROCESS): The extent to which CHWs are members of a collaborative and communicative team/holistic system of care with other providers (i.e., doctors, nurses, social workers, health educators, pharmacists, etc.) ▪ (CHW-CRE #3) **CHW-facilitated referrals** (PROCESS): Number of completed referrals facilitated by CHWs, through which the participant successfully receives services, care, and/or resources from a clinic, other health care or social service agency (break down by housing, food transportation), or public service.
Community Information Exchange: Improved CIE implementation and ongoing participation	▪ Number of contracts with CBOs with the intent of increasing connectivity to facilitate electronic, cross-sector, interoperable referrals.

	▪ Number of community workshops, training sessions, or informational campaigns conducted to improve awareness of CIE.
SDOH Hub Infrastructure: Establishment of infrastructure and funding to support SDOH Hub pilot implementation	▪ Established SDOH Hub lead organization (PROCESS). ▪ Amount of funding allocated to support CHWs. ▪ Amount of funding allocated to support CIE. ▪ Amount of funding allocated to specific SDOH interventions through HiAP approach (breakdown by food, housing, and transportation). ▪ Longevity of funding sources (amount of time that funding sources are available and stable).
Improved client satisfaction with MDHHS-led programs	▪ Number of client feedback surveys administered. ▪ Number of client feedback surveys received. ▪ Change in client satisfaction ratings.
Cross-Sector Collaboration	
Collaboration and Partnerships: Increased collaboration and engagement across multisectoral partners	▪ Number and type of network partner organizations. ▪ Number of meetings and partner attendance. ▪ Number of people participating in the Community Influencer Program.
Data-Driven Decision Making	
Data collection: Development of data collection standards to support interoperability of systems.	▪ Completed data collection standards. ▪ Number of organizations formally adopting data collection standards.
Privacy Standards: Development of privacy standards to protect privacy and promote ethical data use.	▪ Completed *Community Bill of Rights*. ▪ Number of organizations formally adopting the Community Bill of Rights as standard practice.
Public-facing dashboards:	▪ Completed public-facing dashboard published for each hub.

Appendix E: Michigan's Prosperity Regions Map



Appendix F: Community Information Exchange (CIE) Task Force Recommendations

The Michigan Community Information Exchange (CIE) Task Force was authorized by the Michigan Health Information Technology Commission's (MHITC) 2022 annual report, as per the Michigan Health IT Roadmap (Bridge to Better Health, February 2022), referred to as the MHITC Roadmap. MDHHS has resolved to create and sustain statewide 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 brought together health care organizations, health payers, health IT, and governmental entities to promote health and social equity, and improve the well-being of all Michigan residents, CIE 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 flow to the right people effectively and responsibly at the right time in the right context.

The following table summarizes the 33 final recommendations developed by the task force. Recommendations are organized into seven domains:

Capacities for Data Exchange
1. Adopt standards for data exchange to enable interoperability among many technology systems to ensure basic infrastructural capacities can be used by any compliant software system.
2. Establish affordable and ethical statewide identity management services to enable information about people to be effectively shared across different systems.
3. Establish shared terminology and translation capacities to ensure that different vocabularies used in different contexts can be effectively aligned.
4. Establish a process of addressing these technical interoperability concerns over time.
Resource Directory Information Capacities
5. Ensure that a reliable supply of resource directory information will be sustainably provisioned as a key component of CIE infrastructure.

6. The CIE's resource directory information should be provided by a federated network of stewards, each of which have clearly defined areas of responsibility that accord with their respective expertise.
7. Resource directory information must be provisioned as a public good.
8. Service providers can be encouraged to ensure their own information remains up-to-date, through policy levers that incentivize such responsibilities.
Longitudinal Data Aggregation Capacities
9. Enable collection of longitudinal data about clients' social needs, risks, service-related activities and results – contingent upon their informed consent.
10. General standards for data collection, retention, and use should be set statewide; specific decisions over implementation and policies for usage should be made at the most locally appropriate level (in harmony with the statewide framework).
11. Enable the longitudinal aggregation of anonymized data for sanctioned uses, subject to individuals' choice to opt-out of such aggregation when legally and technically possible.
12. Leverage already-existing assets for data infrastructure when possible, and establish appropriate systems of governance for operation of any such infrastructure in contexts which aren't already regulated by HIPAA.
Legal and Ethical Framework
13. MDHHS should establish a baseline policy framework and common structure for legal agreements for collection, exchange, and use of data in contexts not already governed by HIPAA, FERPA, or 42 CFR p2.
14. The CIE task force will recommend a "Bill of Rights" for consumers and communities to be reviewed and formalized by a designated governing body.

15. In all contexts not subject to existing regulatory frameworks, entities conducting CIE activities should ensure that data collection and use is subject to consumers' informed consent.
16. Local communities and tribal nations should be able to build upon the baseline statewide legal framework with additional policies that address their specific needs and concerns.
17. MDHHS should support and fund, where possible, processes for partnership development, workflow change management, auditing, and compliance with all of the above.
Coordinating Entities Capacities
18. Activities associated with community information exchange can be conducted by "coordinating entities" that assume fiduciary responsibilities for their partners in the community and for the consumers they serve.
19. MDHHS can set standards and establish sustainable funding streams to support coordinating entities.
20. Coordinating entities should both reflect the priorities of their communities and be designed to facilitate collaboration across networks.
21. Coordinating entities can formally represent their partners' and consumers' interests through equitable decision-making processes.
22. Coordinating entities can be established within specific service domains, as appropriate on a local or statewide basis, to facilitate engagement of providers across their sectors.
Governance
23. CIE activities should be conducted by accountably governed bodies that are responsible for acting in the best interests of the people they serve.

24. CIE governance should formally represent the interests of affected parties, especially those of consumers and service providers, in transparent and inclusive decision-making processes.
25. CIE governance processes should clearly establish what use cases are permitted under which conditions, and should establish processes for monitoring, compliance, and conflict resolution to ensure equitable outcomes.
26. Local CIE activities should operate as part of a federated network, with local representatives participating in the governance of a statewide entity that establishes baseline policy, standards, core infrastructure and conflict resolution processes.
Sustainability
27. MDHHS should expand the availability of funding for social services through Medicaid, by leveraging policies such as an 1115 waiver to examine the true cost of care for health-related social needs social care interventions, taking advantage of the support recently signaled by CMS for "In-lieu of Services," and Community Health Worker reimbursement mechanisms that can include CBOs as Medicaid providers.
28. MDHHS and commercial payers should create mechanisms to fund CBOs by leveraging existing use case participation incentive programs, like Physician Group Incentive Program (PGIP), Patient Centered Medical Home (PCMH), Pay for Performance (P4P), etc., to support tools, workflows, technical assistance, staff and other costs related to CIE.
29. MDHHS should leverage Advance Planning Documents (APDs) where possible to offset the costs of information technology implementation and enhancements with federal matching funds. Medicaid Advance Planning Documents outline experimental, pilot, or demonstration projects related to health IT which are submitted by MDHHS to CMS to secure up to 90% federal match.
30. Recognizing the importance of social care as an essential component of holistic health and well-being, health systems, health plans, and hospitals should have established mechanisms for investing in social service delivery.

31. The state should promote an equitable method of revenue-sharing among technology vendors who provide services in the CIE market, by which vendors collectively reinvest a percentage of revenue into core infrastructural services that support CBO activity in CIE processes, such as infrastructure maintenance and/or consumer engagement in governance processes.
32. In the short-term, philanthropic funding can support the startup costs of CIE for CBOs, while in the long-term philanthropies can help sustain CIE by making "program-related investments" in CIE services that support their grantees' programs and inform their grantmaking processes.
33. The state and key partners should advocate at the federal level for systematic investment in CIE, similar to the Meaningful Use Incentive program governed by the Office of the National Coordinator which incentivized providers to implement electronic health records and use them meaningfully. The criteria and stages of the Meaningful EHR Incentive program were essential to promoting interoperability and data sharing among health care providers. This guidance and support from the federal level is necessary to effectuate all of the recommendations.

For more information and an in-depth overview of recommendations, please see the CIE Task Force Final Report.

Appendix G: Community Health Worker (CHW) Subcommittee Recommendations

The CHW Subcommittee has put forth a set of 24 recommendations, with a number of supporting sub-recommendations, with strong consensus on a path forward for implementation. These recommendations are organized under a set of six priorities, including:

Priority: Create a supportive environment for the CHW workforce to thrive and make a significant impact on improving health equity and enhancing community well-being.

- Ensure self-determination through CHW participation in all workforce-related decision-making processes, including policy development and advocacy efforts.
- Develop policies to provide fair compensation, benefits, and incentives for CHWs. This can include stipends, salaries, health insurance, paid sick leave, hazard pay, transportation reimbursement, and performance-based rewards to recognize their valuable contributions and encourage retention.
- Create opportunities for career advancement within the CHW field.
- Connect CHWs to supportive networks or platforms to share experiences, seek guidance, and access resources.
- Develop policies ensuring high-quality supervision and mentorship for CHWs to enhance their confidence, job satisfaction, and effectiveness.
- Implement policies to ensure the safety and security of CHWs working in varied and sometimes challenging environments.

Priority: Better align CHW efforts by consistently sharing best practices and coordinating approaches to mitigation of barriers.

- Integrate CHWs into organizations and multidisciplinary care teams.
- Promote collaboration between CHWs, health care providers, community-based organizations, and other partners to enhance the effectiveness of CHW programs.
- Establish partnerships to implement pilot projects through **CHW Integration to Improve Equity (CITIE)**, an innovative, collaborative initiative to train and integrate CHWs in communities disproportionately burdened by health inequities.

Priority: Identify meaningful measures of CHW work to demonstrate value and illustrate impacts.

- CHW programs in Michigan, including programs through community based organizations (CBOs), FQHCs, local health departments, and other health agencies should endorse and adopt the CHW Center for Research and Evaluation (CHW-CRE, formerly known as the Common Indicators Project) indicators to systematically assess the work and impacts of CHWs in Michigan.
- Support the CHW-CRE goal to, "develop infrastructure to collect data and report results on CHW-CRE indicators, optimizing CHW contributions through standardized monitoring and quality improvement, while centering CHWs as experts and leaders."

- Utilize data and results from the CHW-CRE to inform policy development at the state level and contribute to evidence-based decision making for CHW programs.
- Establish a framework for monitoring health and economic outcomes of pilot programs implemented through the CITIE Initiative to demonstrate progress on reducing health disparities and return on investment, contributing to program sustainability.

Priority: Build a community engagement strategy to raise awareness of the importance and impacts of CHW work.

- Encourage meaningful community engagement in the recruitment, training, and evaluation of CHWs to help tailor CHW programs to local needs and ensure their acceptance and effectiveness.
- Engage community leaders and influencers, including members of the MDHHS SDOH Community Influencer Program, to help build trust and credibility within communities, making it easier for CHWs to access and engage with community members.
- Ensure CHW training programs provide comprehensive training on effective community engagement techniques, cultural competency, and communication skills.

Priority: Identify and prioritize existing and potential mechanisms through Medicaid, other MDHHS programs, and other approaches to assure sustainable financing of CHW programs.

Medicaid CHW Policy

Starting January 1, 2024, a new policy establishes coverage criteria for CHW services as a component of Medicaid services. The policy, achieved through the development of a State Plan Amendment (SPA), will cover preventative services including health system navigation and resource coordination, health promotion and education, and screening and assessment. To learn more about the policy, please visit https://bit.ly/MI-Medicaid-CHW-Policy-Bulletin.

CIE Task Force members have observed that a key component of ensuring that this policy is leveraged for maximal effect in promoting social service delivery, and by extension, CIE is to allow CBOs to enroll as Medicaid providers to support the reimbursement of CHWs in community-based settings. While a CHW's primary role is to engage individuals in their community, they are often a key conduit for collecting and communicating data on social needs, providing capacity to CBOs to participate in CIE.

Priority: Identify and prioritize existing and potential mechanisms through Medicaid, other MDHHS programs, and other approaches to assure sustainable financing of CHW programs.

- Allocate sustainable funding for CHW programs to ensure their long-term viability. Policies should prioritize budgeting for training, supervision, and operational costs.
- Develop a Proposal for Change (PFC) that emphasizes the value and impact of CHWs to secure sustainable state funding for CHW programs.
- Allocate dedicated funding to support CHW training organizations to ensure they have the necessary resources to expand training capacity, enhance curriculum development, improve access to training, provide continuing education, meet CHW certification standards (should Michigan become a CHW certification state), and promote evaluation and quality assurance.

Priority: Create recommendations to support standards for CHW core competency-based training and mechanisms for certifying that training programs meet them.

- Develop a statewide policy for CHW certification that recognizes and supports the role of CHWs, ensuring barriers to becoming certified are addressed.
- Define and clarify the CHW scope of practice, outlining their responsibilities and limitations, delineating boundaries that distinguish CHWs from other health professions, and acknowledging the community-based nature of the CHW profession.
- CHW training programs in Michigan should align with the CHW Core Consensus Project's (C3 Project) CHW core competencies.
- Recommendation R-4: Enhance CHW programs to offer specialization and/or supplementary training to address specific health and SDOH issues.
- Emphasize cultural competency and diversity for CHWs to effectively serve diverse populations and address health disparities.

For more information and an in-depth overview of recommendations, please see the CHW Subcommittee Final Report.

Appendix H: SDOH Interagency Work Group (SDOH-IW) Draft Charter

Michigan Social Determinants of Health Interagency Work Group (SDOH-IW) Charter

1. BACKGROUND

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 health care. 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.

2. PURPOSE

The Social Determinants of Health Interagency Work Group (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. This work group was established by the Executive Office of the Governor in 2022.

3. GOALS

- Ensure the success of Michigan Social Determinants of Health efforts through better alignment across state agency partners.
- Utilize a Health in All Policies approach to strengthen regional capacity building and resource allocation.
- 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.
- 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.
- 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.
- Through targeted initiatives and projects led by Interagency Work Group subcommittees with the support of MDHHS Policy and Planning Team, develop annual report and dashboard with measurable goals to track impact of our policy and programmatic changes to support the health and well-being of Michigan communities.

4. 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.
N. The director of the Office of Global Michigan, or the director's designee from within that department.

4. MEETINGS

The SDOH-IW will meet on a regular basis as determined by the committee. Initially, these meetings will be quarterly. Meetings will be conducted in an unclassified environment. When necessary, classified discussion and topics will be taken up in the appropriate interagency forum.

Appendix I: Initiatives that Support Food and Nutrition Security

Food Security Partner Meeting

In July 2023, the MDHHS Policy and Planning SDOH team convened a partner meeting focused on food security efforts. During the meeting, more than 175 participants engaged in meaningful discussion relating to engagement with marginalized or underserved communities, policy or legislative changes, challenges or barriers, collaboration and coordination, the role of state government, and metrics, indicators, and benchmarks.

Key themes from the partner meeting were outlined based on the Healthy People 2030 infographic categories: availability, cost, transportation, and programs.

Availability: **The availability nutritious food is limited, particularly in rural areas.**

> **Counties with the highest rates of food insecurity are disproportionately rural** [3].

Suggested strategies to improve food availability included:

- Encouraging statewide implementation of existing programs.
- Providing culturally relevant options.
- Making it easier to stay connected by maintaining a resource directory with updated contact information and leveraging Michigan Health Information Network (MiHIN) pilot and CIE opportunities.

Cost: *The cost of food is high, consuming a significant proportion of household budgets.*

> **According to the June 2022 consumer price index (CPI) report, food comprised of 13.4% of consumer expenditures and accounted for 15.4% of the overall U.S. CPI rate of 9.1%** [4].

Suggested strategies to address high food costs included:

- Increasing the minimum wage.
- Fully funding care workers, including care managers, CHWs, and other direct care workers.
- Using Medicaid funding to: support food and housing through In Lieu of Services (ILOS) waivers, provide payments for Health-Related Social Needs (HRSN), and reimburse for medically tailored meals.

Transportation: **Transportation is challenging, particularly in rural areas.**

> **Rural residents who lack reliable transportation face additional barriers to accessing food, given the distance to the grocery store in rural communities and lack of public transportation options [2].**

Suggested strategies to improve access to transportation include:

- Expand transportation options.
- Leverage Medicaid and Medicare dollars.
- Serve older adults and adults with disabilities.
- Partner with the Michigan Department of Transportation (MDOT).

Programs: **Community and government-implemented programs help, but stronger alignment, coordination, and expansion are needed.**

> **On a federal level, one in three people facing hunger are unlikely to qualify for the Supplemental Nutrition Assistance Program (SNAP), and not everyone who qualifies for SNAP is enrolled and receiving benefits [3].**

Suggested strategies to improve programs supporting food and nutrition security included:

- Expand Supplemental Nutrition Assistance Program (SNAP)/Food Assistance Program (FAP) benefits and address income limits.
- Allow flexibility in program delivery.
- Expand Children's Services Administration (CSA) programs and universal school meals.
- Consider additional program-related assets, such as the Local Food Council Network, the Good Food Charter, and MDHHS offices.

Additionally, partners highlighted significant barriers to improving health outcomes and advancing health equity, including:

- The interdependence of social drivers.
- A lack of trust with organizations distributing food.
- Language barriers.
- Unsustainable programs that depend on volunteers.
- Systemic racism.

Aligned Initiatives Supporting Food and Nutrition Security

The work outlined in Phase III of the SDOH Strategy is part of a larger food and nutrition security ecosystem in Michigan. The Policy and Planning SDOH team will continue to align with nonprofit partners across the state that share a commitment to reducing food security and advancing health equity. The following food security programs and services were identified during the July 2023 SDOH partner meeting. This is not a comprehensive list but captures resources partners currently leverage and/or hope to expand.

Baby Pantries: Partners identified baby pantries. These programs offer a range of baby supplies—including clothes, diapers, and formula—to assist infants, children, pregnant individuals, families, single parents, and those facing emergency situations.

Basic Needs Investments: Partners identified the Federal Emergency Management Agency's (FEMA) Emergency Food and Shelter Program as an important resource for social service providers.

Partners also identified the importance of additional basic needs investments in the form of gift cards and food boxes from local food banks, famers markets, and community programs.

Blue Cross Complete of Michigan: Partners identified the Blue Cross Complete of Michigan managed care health plan as an important that provides assessment, referral, follow-up, and food delivery for Medicaid members.

Blue Cross Blue Shield of Michigan: Partners identified the funding collaboration between Blue Cross Blue Shield of Michigan and the United Dairy Industry of Michigan to support nonprofit organizations.

Community Health Worker: SDOH Assessments: Partners identified the importance of community health workers (CHW) in screening and assessing SDOH needs. Please see the CHW Final Report for SDOH Strategy recommendations related to CHW hiring, training, and integration.

Double-Up Food Bucks: Partners identified Double Up Food Bucks, a program that enhances access to healthy food for SNAP beneficiaries by matching spending on fruits and vegetables.

Diabetes Prevention Program: Partners identified diabetes prevention programs as important resources, including the National Diabetes Prevention Program (National DPP). The National DPP is a collaborative effort involving both public and private organizations dedicated to preventing or delaying the onset of type 2 diabetes.

The Detroit Abloom Outdoor Wellness Garden: Partners identified the Detroit Abloom Outdoor Wellness Garden as an important resource for supporting a healthy and nourishing plant-based diet. The garden educates individuals about whole food plant-based lifestyles.

The Midland Fresh Initiative: Partners identified the Midland Fresh Initiative, a program that offers free produce and food to residents in need within the Midland area. This initiative reflects an ongoing commitment to alleviating food-related struggles and fostering a healthier, more resilient community.

The Trinity Health Food Prescription Program: Partners identified the Prescription for Health initiative as a holistic approach to improving health outcomes through better nutrition and education. Doctors issue patients a prescription that includes personalized health goals, an emphasis on increasing fresh fruits and vegetable intake, and participation in educational events on health, food, and nutrition.

SNAP (Supplemental Nutrition Assistance Program): Partners identified SNAP as an essential resource for low-incomes families by provides food benefits that supplement grocery budgets.

Food Security Reports

The following reports provided key insights to the Food Security Work Group. These reports share a commitment to the HiAP approach, emphasizing cross-sector and multisector approaches. They also hold the complexity of the food system and center people most impacted by programs and policies designed to reduce food insecurity.

MICHIGAN GOOD FOOD CHARTER

The Good Food Charter is "a vision and a roadmap to advance Michigan's food and agricultural contributions to the economy, protect our natural resource base, improve our residents' health, and enable generations of Michigan youth to thrive."

Food Security Council

The Food Security Council, established through Executive Order 2020-167 in August 2020, published a final report that provides a comprehensive assessment and analysis of the causes of food insecurity and outlines 11 recommendations to address it.

Food Security Networks

Food security organizations and initiatives are strengthened through ongoing partnerships. Michigan is home to many established networks to link communities to resources and strengthen how food security organizations implement their work. The following list of networks is far from exhaustive, but it highlights a portion of the great work happening across the state:

- Michigan State University (MSU) is a land grant university with a strong history in agricultural development and food security, particularly in rural counties. Its Center for Regional Food Systems houses the Good Food Charter, the Michigan Local Food Council Network, and the Michigan Farm to Institution Network. MSU Extension Offices are located in every county of the state and offer programming and educational opportunities.
- The Fair Food Network was piloted in 2009. Their Double Up Food Bucks program now serves as a national model for nutrition incentives. Double Up matches SNAP (or food stamp) purchases of fruits and vegetables, helping families with low income bring home more healthy food, while boosting business for farmers and retailers. The Fair Food Network continues to receive support from the state of Michigan for ongoing implementation of the Double Up Food Bucks program.

- The Michigan Farmers Market Association was established in 2006 as a statewide association to promote local food consumption in Michigan by connecting more farmers to consumers through farmers markets. It places equity at the forefront of supporting the viability of community-driven marketplaces so that they can connect all consumers to local farms and businesses.
- The Food Bank Council of Michigan was created in 1984 to implement a unified strategy to address and alleviate hunger statewide by increasing emergency food resources and advocating on behalf of the hunger relief network. Its mission is to *create a food secure state through advocacy, resource management, and collaboration among stakeholders and Michigan's unified food bank network.*
- Since 1995, the Groundwork Center for Resilient Communities has empowered people who want to be part of creating a better Michigan with innovative, local-based solutions that create a clean environment, strong economy, and healthy community.
- Michigan Food and Farming Systems' (MIFFS) work supports entrepreneurial farm business development and resilient food systems by serving as the bridge between the resources of USDA service providers, knowledge of subject matter experts, and wisdom from diverse farming communities throughout Michigan.

Appendix J: Links to Supplemental Materials and Aligned Reports

- Community Information Exchange (CIE) Task Force Final Report with recommendations
- Michigan Health Information Technology Commission (MHITC) Bridge to Better Health/Health IT Roadmap
- Community Health Worker (CHW) Subcommittee Final Report with Recommendations
- SDOH Accelerator Plan to Prevent Chronic Disease Summary
- Racial Disparities Task Force (RDTF) Final Report
- MDHHS 2021 Health Equity Report
- Michigan State Housing Development Authority (MSHDA) Statewide Housing Plan