MDHHS

Social Determinants of Health Strategy

Michigan's Roadmap to Healthy Communities

SDOH Strategy Framework

Alignment

MDHHS partners with state agencies and other partners on existing initiatives related to focus areas to connect programs and for a greater impact in communities

Improvement

MDHHS program areas utilize an equity screen to improve current policies/ programs, prioritizing items that are connected to focus areas- process and qualitative improvements

Innovation

New innovative initiatives and cross-cutting policies are proposed that would involve collaboration across MDHHS administrations, state agencies, and with local partners to address upstream prevention

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SDOH Strategy Phases

PHASE I
Refinement

IMPROVEMENT of internal programs and policies

ALIGNMENT of internal initiatives and collated resources

PHASE II
Holistic

Statewide initiatives to holistically address SDOH and advance health equity:

- CIE
- CHW
- SDOH Accelerator Plan
- Health Equity Partnerships

PHASE III
Innovation

INNOVATIVE, community-driven solutions:

- LHD SDOH Hubs
- Health in All Policies multi-sectoral initiatives
- Health Equity Roadmap

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THE SOCIAL DETERMINANTS OF HEALTH STRATEGY:

Phase I

REFINEMENT

Phase I of the SDOH Strategy promotes the **alignment** of efforts at the state, local, and community level and the **improvement** of programs and policies through an in-depth internal review.

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SDOH Strategy Phase I Focus Areas

HEALTH EQUITY means that everyone has a fair and just opportunity to be as healthy as possible.

- Robert Wood Johnson Foundation

HOUSING STABILITY means that all people, at all times, have physical, social, and economic access to safe, sufficient, and secure housing that meets their needs for a healthy life.

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 for an active and healthy life.

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THE SOCIAL DETERMINANTS OF HEALTH STRATEGY:

Phase II

HOLISTIC

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

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SDOH Strategy Phase II Focus Areas

1

Community Information Exchange (CIE)

2

Community Health Workers (CHW)

3

SDOH Chronic Disease Accelerator Plan

4

Partnerships to Advance Health Equity

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Partner Spotlight: CHIRs

- Community Health Innovation Regions (CHIRs) are cross-sector collaboratives aimed at improving community health by meeting the social needs of individuals and moving upstream to improve community conditions.
- The CHIRs focus on developing and strengthening connections between providers of clinical care and community-based organizations that address SDOH.

SDOH Strategy Phase II Focus Area

Partnerships to Advance Health Equity

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

Northern CHIR: Advancing Health Equity

Presented by Jane Sundmacher

NORTHWEST COMMUNITY HEALTH INNOVATION REGION

Healthy People in Equitable Communities

Our VISION

Our NETWORK

- Steering Committee
- Clinical Linkages Workgroup
- MiThrive Workgroup
- Learning Community
- Residents
- Community Partners

Our TOOLS

- mithrive
- COMMUNITY connections
- SYSTEMS change

Our OUTCOMES

- HEALTH equity
- ACCESS
- ALIGNMENT
- COORDINATION

Our BACKBONE

NORTHERN MICHIGAN PUBLIC HEALTH ALLIANCE

SDOH Strategy Phase II Focus Area

SDOH Chronic Disease Accelerator Plan

Led by: MDHHS Policy and Planning Social Determinants of Health (SDOH) Team

Muskegon CHIR: Establishing a System that Ensures Livability

Presented by Samantha Cornell

MUSKEGON CHIR
COMMUNITY HEALTH INNOVATION REGION

Vision: The people of Muskegon County will be empowered to continuously create an equitable and thriving community.

Mission: Contribute to building a healthy community through inclusive assessment of strengths and opportunities; alignment of collaborative wellness efforts; and support of innovative strategies for a better tomorrow.

Livability Lab
Multi-Sector SDoH Action

Place-Based Engagement
Health Equity Focus

Economic Opportunity Initiative
Community-Led SDoH and Equity Action

Community Wellness Report
Community Assessment and Priority Setting

Community Clinical Linkages
Aligning and Strengthening Interventions

Closed Loop Referrals
Broad CBO Engagement and Alignment

LIVABILITY LAB

MUSKEGON'S 100-DAY CHALLENGE

Muskegon's Livability Framework

Developed Annually Through:

- 450+ Neighbor to Neighbor Surveys (50 Spanish language)
- CBO and cross-sector surveys
- Multi-Sector Stakeholder Advisory Team
- Neighborhood Associations
- Grassroots and CBO Partnerships
- Consolidated CHNA Data Team
- Ongoing root-cause analysis

LIVABILITY LAB

MUSKEGON'S 100-DAY CHALLENGE

IMPACT HIGHLIGHTS

- Increased Grassroots CBO Capacity
  Annual Cohort of Trained Facilitators / Coaches
- Enhanced Multi-Sector Collaboration
  Largest Team = 40+ Organizations + Residents
- Tri Share Childcare
  Livability Lab Action Team → Statewide Initiative
- Case Management Platform + Common Eligibility
  CBO-led initiative to enhance community impact
- Muskegon Heights Neighborhood Association Council
  Resident Leadership in Resilience Zone

SDOH Strategy Phase II Focus Area

Community Information Exchange (CIE)

Led by: MDHHS Policy, Planning, and Operational Support Administration

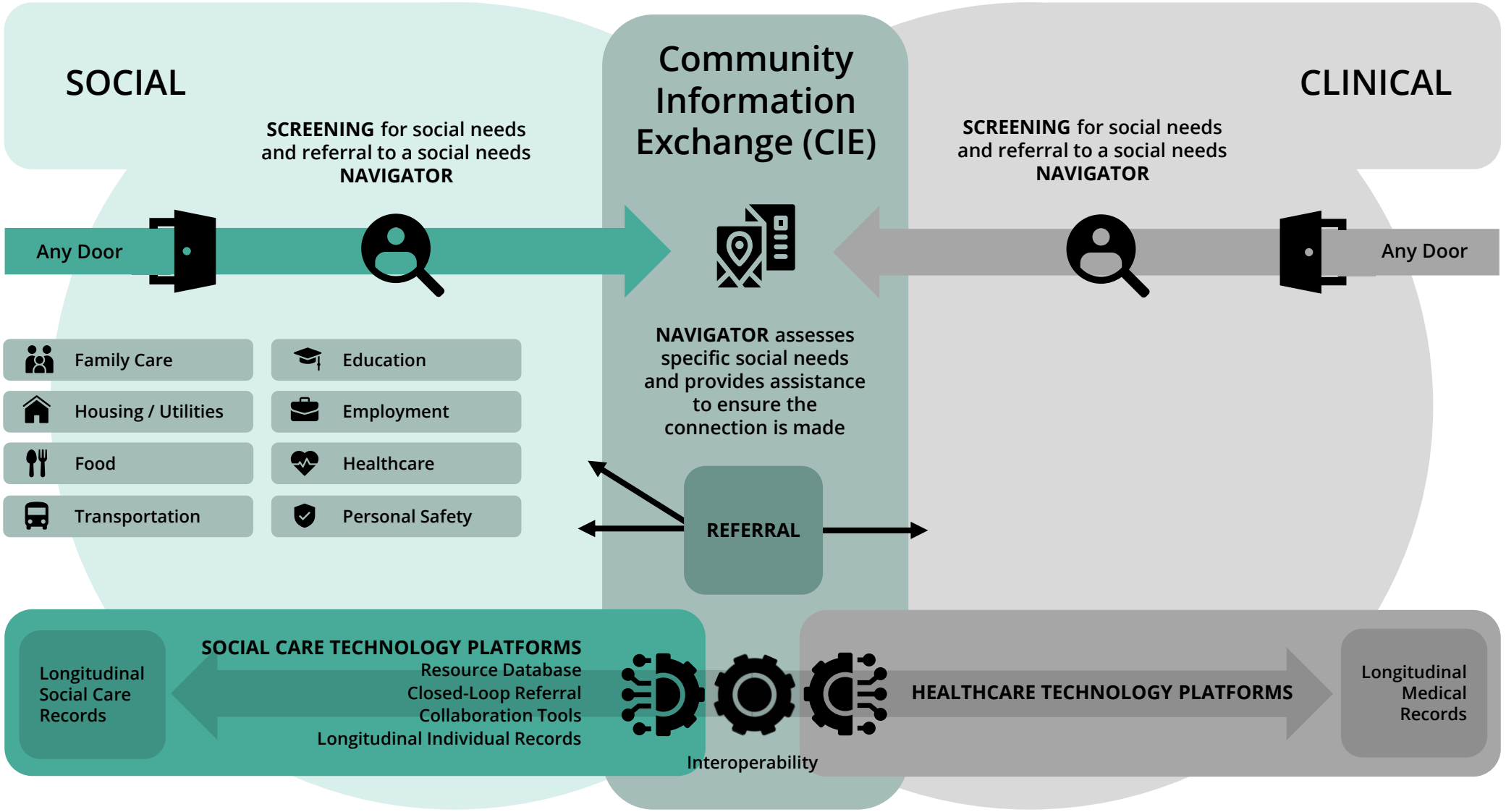
What is Community Information Exchange (CIE)?

Community Information Exchanges (CIEs) build technology and relationships to address social needs

Partners in a CIE can include a broad range of community resources, such as:

Stages of Data Sharing:

1. No formal integration or coordination
2. Referrals but no formal coordination and data sharing
3. Coordinated team with informal but regular data sharing
4. Formalized cross-sector data integration


SOCIAL
Community Information Exchange (CIE)
CLINICAL
SCREENING for social needs and referral to a social needs NAVIGATOR
SCREENING for social needs and referral to a social needs NAVIGATOR
Any Door
Any Door
NAVIGATOR assesses specific social needs and provides assistance to ensure the connection is made
Family Care
Education
Housing / Utilities
Employment
Food
Healthcare
Transportation
Personal Safety
REFERRAL
Longitudinal Social Care Records
SOCIAL CARE TECHNOLOGY PLATFORMS
Resource Database
Closed-Loop Referral
Collaboration Tools
Longitudinal Individual Records
Interoperability
HEALTHCARE TECHNOLOGY PLATFORMS
Longitudinal Medical Records

Genesee CHIR: Addressing Social Needs through Community Information Exchange (CIE) Efforts

Presented by Janée Tyus,
Senior Program Director, Genesee Community Health Access Program (CHAP)
Greater Flint Health Coalition

Genesee CHIR Updates

- The Greater Flint Health Coalition is addressing health equity in a variety of ways:
  - Seeking to improve childhood immunization rates for the underserved through community outreach, education and systems change
  - Improving Racial, Ethnic and Language (REaL Data) Collection among provider and community partners

CHIR
Genesee Community Health Innovation Region

GENESEE CHAP
COMMUNITY HEALTH ACCESS PROGRAM
A Program of the Greater Flint Health Coalition

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Genesee CHIR Updates

- Genesee CHAP is expanding the **community information exchange** among behavioral health providers in the region, outside of Genesee County using the established CCL framework.
- Genesee CHAP also is piloting the use of CHWs in addressing the social determinants of health needs for those with chronic conditions such as obesity and other forms of insurance such as Commercial plans.

CHIR
Genesee Community Health Innovation Region

GENESEE CHAP
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SDOH Strategy Phase II Focus Area

Community Health Worker (CHW) Strategy

Led by: MDHHS Policy and Planning Social Determinants of Health (SDOH) Team

CHW Barriers According to National Academies of Sciences, Engineering, and Medicine

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

CHW Barriers Identified in August 2022 SDOH Partner Meeting Breakout Sessions

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

Source: National Academies of Sciences, Engineering, and Medicine 2019. Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health. Washington, DC: The National Academies Press. https://doi.org/10.17226/25467 (pp 67-68).

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Livingston/Washtenaw CHIR: Integrating CHWs into Cross-sector Community Care Coordination

Presented by Ayse G. Buyuktur
on behalf of the MI Community Care (MiCC) regional collaborative

MiCC Community Care Coordination Program

- Focuses on serving Livingston and Washtenaw residents who need cross-sector care coordination to manage multiple chronic medical conditions and social needs
- Each participant is assigned a lead care coordinator at one of the program's participating organizations—including local medical providers, public behavioral health agencies, and social service organizations
- Community Health Workers serve as a lead or support coordinator depending on the participant's needs
  - CHWs not only help with care coordination, but have also unique roles: conducting home visits, connecting residents to social support, accompaniment to medical and social service appointments, working alongside residents to complete steps to access benefits and resources

CHW Structure

- CHWs are based at community agencies but serve all MiCC agencies
  - Emphasizes embeddedness in community
  - Prevents getting pulled into medical administrative work
  - Allows for better hands-on training about community resources
  - Provides community-clinical linkages
  - Fosters understanding of different organizational cultures

- Training of other partners
  - How to refer to CHWs
  - CHW roles and how they can fill gaps for agencies

CHW Structure

- Peer support and mentorship
  - Hiring more than 1 CHW allows for peer support and collaborative troubleshooting
  - Enables valuable, consistent supervision for managing CHW roles (e.g., “boundary work”) and high caseloads
- Building a CHW Regional Coalition across the L/W CHIR
  - Organized collaboratively by staff from the Washtenaw Health Plan, Michigan Medicine, Trinity Health, Health Departments, and MICHWA
  - The purpose is to bring together local CHWs and their agencies to develop relationships, coordinate services, compare program implementation models, identify shared challenges, collaborate on CHW financing, and coordinate advocacy for local and system changes
- The MiCC CHW Supervisor is currently serving as a member of the State CIE Taskforce

Engagement Opportunities

Stay involved with implementation and expansion efforts

Sign up for the SDOH newsletter

Join ongoing partner meetings

Register to attend the SDOH Summit

Visit the website

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Thank you!

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SAVE THE DATE: Virtual SDOH Summit Jan 24th-26th

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