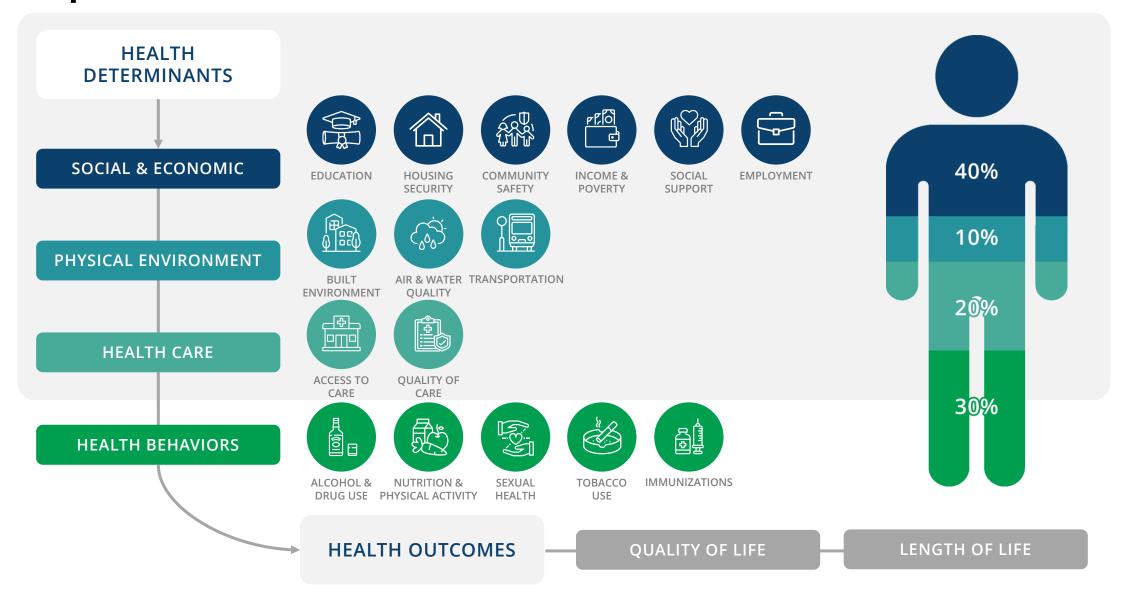
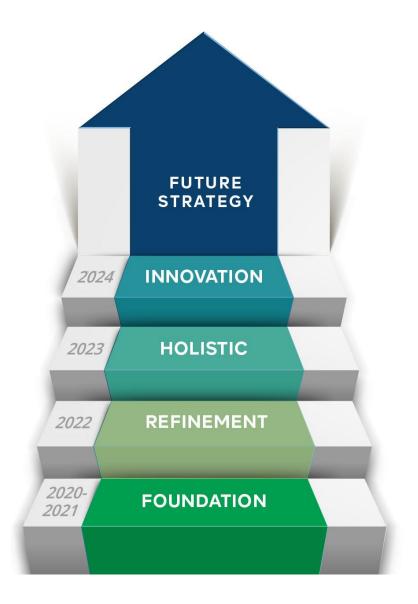




## Population Health Framework: What Goes Into Health?



## Steps to Building the SDOH Strategy



**INNOVATION:** MDHHS develops cross-cutting solutions that support community-driven initiatives. Proposals for Change and grant applications will reflect these efforts.

HOLISTIC: MDHHS continues to build a robust strategy through engagement of stakeholders throughout Michigan. Collaboration will support a holistic approach.

REFINEMENT: MDHHS aligns activities in the 2020 strategy to develop focus areas and strategic objectives. The key is alignment and process improvement.

**FOUNDATION:** MDHHS developed activities to support social determinants of health efforts and COVID-19 response efforts.

## **SDOH Strategy Phases**

Refinement

**PHASE II** 

Holistic

**PHASE III** 

Innovation

**IMPROVEMENT** of internal programs and policies

**ALIGNMENT** of internal initiatives and collated resources

Statewide initiatives to holistically address SDOH and advance health equity:

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

INNOVATIVE, community-driven solutions:

- SDOH Hubs
- Health in All Policies multi-sectoral initiatives
- Rural and Racial Health Equity Roadmaps





# SDOH Hubs: *Incorporating Phase I and Phase II Lessons Learned*

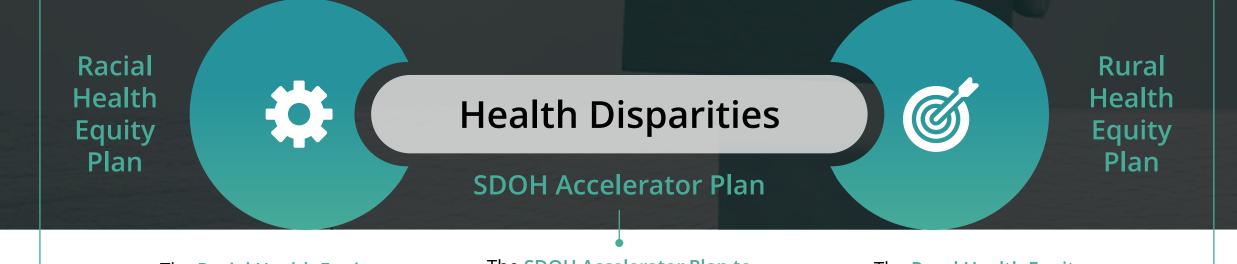
- Community Information Exchange (CIE)
   Recommendations
- Community Health Worker (CHW)
   Recommendations
- Reducing Health Disparity Gap
  - Racial Health Equity Plan
  - Rural Health Equity Plan
- Health in All Policies Framework
  - Food Stability, Housing Security,
     Environmental Health, and Transportation





# Closing the

# **Disparity Gap**



The Racial Health Equity
Plan will look closely at
racially marginalized groups
who have faced longstanding barriers in getting
fair access to good health.

The SDOH Accelerator Plan to
Prevent Chronic Disease
considers the unique challenges
faced by rural communities to
find ways to make things better
for people living in rural areas.

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.



# Rural Health Equity Plan



November 2022-September 2024

**Convene Advisory Group** 



B

September 2024

December 2024

Final Report of Recommendations

Rural Health
Equity Plan/
Written Report





# **Community Engagement Methods**









**Listening Sessions** 



Surveys



Advisory Group Internal Work Sessions



**Emerging Community Engagement Feedback** 

Hillsdale County's Listening Session was one the first sessions conducted.

Most utilized state assistance programs:

- Medicaid and Medicare
- SNAP

Barriers: Awareness, Transportation, and Technology needed to submit and maintain services after enrollment.





# **Local Community Information Exchange**



The Hillsdale County Resource Guide is a valuable digital resources guide dispersed via email and QR code.



2-1-1 is valuable and needs more frequent updates with relevant resources.



Residents prefer to utilize local community guides that are updated more frequently and trustworthy.



# Rural Health Equity Plan Next Steps

Community Engagement

**Data Analysis** 

**Final Report** 

continue community engagement strategy to capture the experience of those with lived experience and service providers.

Review and conduct a data analysis of internal and external programs and policies;
Community engagement feedback;
Listening Sessions,
Surveys, and Focus
Groups.

Submit a final report on recommendations addressing gaps in the SDOH strategy and access to resources by September 30, 2024.





https://bit.ly/CIE-TF-Final-Report

Phase II Structural Intervention: CIE Task Force Recommendations

## Resolutions of the CIE Task Force

01

An equitable strategy needs to meet complex needs of diverse communities. One size does not fit all.

02

Technology alone cannot solve these problems; we need to invest in people and processes.

03

Interoperability
is essential any new
solutions
should enable
existing
systems to
work together.

04

State level action should support – not preclude – systems that work at local levels. 05

The success of CIE is contingent on our ability to build trust and accountability.



## Values and Principles



The task force articulated a set of values and principles to guide all activities associated with the collection, exchange, and use of personal data through social care processes.

## **Values**

- Accessibility
- Accountability
- Equitability
- Responsibility
- Interconnectedness

## **Principles**

- Learn Together
- Center Impacted Parties
- Build and Maintain Trust
- Serve Common Interests
- Anticipate, mitigate, reduce, and redress any possible harms

## **Recommendation Domains**

The CIE Task Force identified the following domains that support effective implementation of Community Information Exchange:



## **Privacy & Confidentiality**

- Privacy and confidentiality are two major concerns that CBOs report hearing from clients
- ~53% report not hearing concerns
- N=633





04

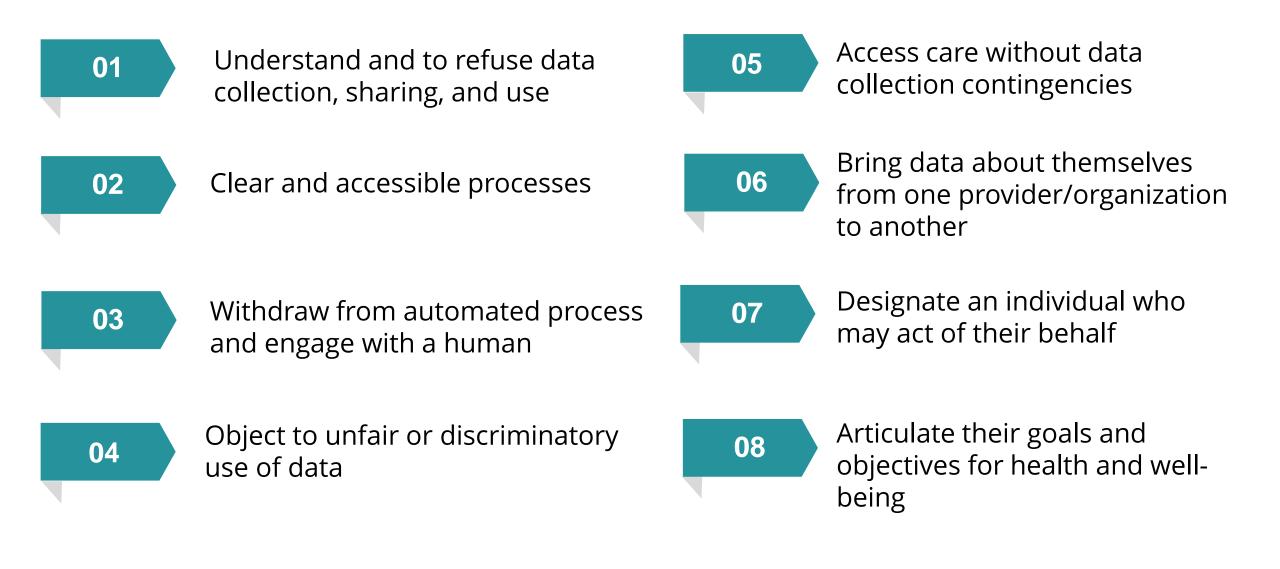
Legal and Ethical Framework Flexible, foundational legal recommendations for social care data exchange aligned with established policies, regulations, and informed consent. MDHHS should:

Establish a baseline policy framework for local communities and Tribes to build upon

Support and fund processes for partnership development and workflow processes

A designated body should review and formalize a "Bill of Rights" for consumers and communities.

## Consumer Bill of Rights: Consumers have the right to...



## Communities should have...

- Established processes through which their members can propose, review, and sanction any uses of data about people within the community
- The right to collectively refuse to be subject to surveillance.
   Technology systems operate with a social license that is revocable

## **CBOs should be able to:**

- Choose the organizations with whom they wish to partner
- Request corrections to directory information about their services
- Respond to grievances raised against them and receive a fair hearing
- Raise grievances about policies or actions that they consider to be inequitable – and propose changes to policies

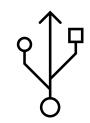
# Survey Finding: Technology is not the foremost barrier to participating in CIE identified by CBOs.

- Funding was the most frequently ranked as both the 1<sup>st</sup> and the 2<sup>nd</sup> barrier to CIE participation
- Staffing and partnerships with other organizations were also identified as critical barriers
- Technology was most often ranked 5<sup>th</sup> out of 6 options









07

Sustainability

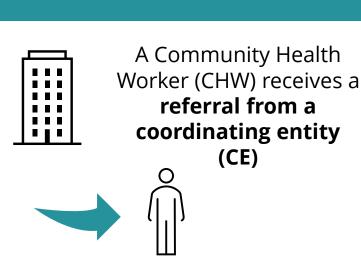
Effective CIE requires additional resources and capacity to support the existing network of social services. MDHHS should:

- Leverage existing funding levers, like Advance Planning
   Documents and Medicaid policies like in-lieu-of services
- Work with payers to support CBOs
- Promote vendor revenue sharing
- Advocate for federal investment in CIE

Health care – hospitals, health systems, and payors - should have established mechanisms for investing in social service delivery and CIE, including reinvestment.

Philanthropic funding can support the startup costs and can help sustain CIE through 'program-related investments.'

## What does CIE look like in a CBO?







The CHW connects with the client to identify needs



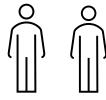
The CHW finds resources from a resource directory and services from a CBO



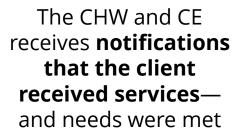




The CHW shares recommendations with the client.



The client agrees to share data with the CBO







The client receives services from the CBO









## **CHW Subcommittee Priorities**

**ALIGN** 



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

**MEASURE** 



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

**ENGAGE** 



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

**SUPPORT** 



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

**TRAINING** 



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



## Next Steps for Recommendations: Workforce













- To support recommendations S-1, S-1.1, and A-2.3, the MDHHS Policy and Planning Office will establish a CHW Advisory Council, comprised primarily of current or former CHWs, to advise on the development of policies impacting the CHW workforce.
- To support recommendations S-1.3 and F-1.4, the Policy and Planning Office is allocating funding to support stipends/compensation for CHW Advisory Council members, acknowledging the value of their contributions.



# Next Steps for Recommendations: Alignment

Community Health Worker Integration to Improve Equity (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.



Assess populations for significant characteristics and needs, evaluating a variety of defining characteristics and SDOH.

Identify and establish partnerships with organizations/agencies working closely with the priority population.

Determine and secure funding and resources needed for the project; define scope and timeline of the project.

Train and integrate CHWs; strengthen their capacity to address the defined SDOH barrier(s) and/or health issue(s). Evaluate health outcomes and impact of the project; make improvements as needed; share best practices.



## Next Steps for Recommendations: Measurement

The CHW Center for Research and Evaluation (CHW-CRE) aims to contribute to the integrity, sustainability, and viability of CHW programs through the collaborative development and adoption of common process and outcome indicators for CHW practice.

CHW Processes	CHW-Mediated Outcomes
Frequency of enactment of the 10 core CHW roles	Participant self-reported physical, mental, and emotional health
CHWs' level of compensation and benefits	Participant (household) access to health and social services
CHW-facilitated connections/referrals at all levels	Participant social support
CHWs' own connections to and engagement with decision- and policymakers	Participant empowerment
Extent to which CHWs are integrated into teams	Policy and system change



## Next Steps for Recommendations: Engagement













- To support recommendations **E-1** through **E-3**, the CHW Advisory Council will engage community leaders and influencers, including members of the MDHHS Social Determinants of Health (SDOH) Community Influencer Program, to help build trust and credibility within communities, making it easier for CHWs to access and engage with community members.
- The Policy and Planning Office has convened the CHW Community Feedback Forum (CHW-CFF) to bring together community members, as well as state and local community partners to provide input on policy and program recommendations to support the CHW workforce in Michigan.



# **Next Steps: Financing**

- The department is developing a policy to formally enroll and recognize CHWs as providers and utilize Medicaid funds to cover CHW and Community Health Representative (CHR) services, leveraging a Medicaid state plan amendment (SPA).
- Additional funding opportunities through partnerships and grants will be pursued.



## Next Steps for Recommendations: Training





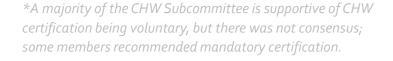








- To support recommendation R-1, the CHW Advisory Council will advise on the development of a CHW certification policy, including the following considerations: CHW definition, core competencies, coordinating bodies, training, experience, applications for CHWs and training providers, renewal, reciprocity, whether certification should be voluntary or mandatory\*, and other certification options.
- Barriers and potential negative outcomes to certification will be considered and solutions to address them will be prioritized.







## What are SDOH Hubs?

- SDOH Hubs are a local or regional entities working at the intersection of health care and social care to advance health equity.
- Structured with a lead organization and diverse network of partners.
- Designed to expand or build foundational capacities.
- Reflect the unique needs and strengths of the communities served.



## **SDOH Hub Key Elements**

SDOH Hubs are centralized resource center with adaptable governance structure based on community that:



evidence-based policies that prioritize health equity and holistic well-being.

# **SDOH Hubs: Transparency and Accountability**

To ensure transparency and accountability, Hubs will include:



1 Data Collection and Analysis



02 Monitoring and Evaluation



O3 Public-facing Dashboards





# **SDOH Funding**

## Funding will support:



O1 CHW training, hiring, and integration



O2 CIE planning and implementation



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



# SDOH P Hub Launch



September/October 2023

Connect with interested partners



December 2023

First cohort launch

January 2024

Second cohort launch



### THE GOAL OF THE MDHHS SDOH STRATEGY IS TO:

Improve the health and social outcomes of all Michigan residents while working to achieve health equity by eliminating disparities and barriers to social and economic opportunity.



# **Engagement Opportunities**

Stay involved with implementation and expansion efforts









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