MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Social Determinants of Health Strategy

Michigan's Roadmap to Healthy Communities

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

MDHHS

Last updated: April 04, 2022

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Executive Summary

The conditions and circumstances of peoples' lives, also known as the **social determinants of health** (SDOH), are known to greatly influence health outcomes. The Michigan Department of Health and Human Services (MDHHS), along with many other private and public partners across the state and nationally, continue to develop and implement initiatives to improve social and health outcomes. The 2022-2024 MDHHS Social Determinants of Health Strategy, *Michigan's Roadmap to Healthy Communities*, takes a focused approach to align efforts at the state and local level for a greater impact in communities.

The strategy was developed through a collaborative process of engagement with social determinants of health stakeholders throughout MDHHS, state agency partners, and local community partners, as well as an assessment of current SDOH efforts. Three focus areas establish the foundation for the 2022 Overarching Social Determinants of Health Strategy: health equity, housing stability, and food security. MDHHS will continue to administer and support SDOH efforts in all domains; however, a focused effort on health equity, housing stability, and food security will allow Michigan to align efforts at the state, local, and community level for a greater impact as well as allow for more in-depth policy and program review.

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.

Figure 1. Focus Areas for Michigan's Roadmap to Healthy Communities.

In 2023 and beyond, the Social Determinants of Health Strategy will maintain *improvement* and *alignment* efforts, while broadening its approach to make space for *innovation* as new initiatives and cross-cutting policies to address upstream prevention will be explored and implemented. MDHHS will continue to support **Health in All Policies** efforts and will serve as a bridge to remove barriers and leverage opportunities to ensure that a health lens is applied.

Introduction

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 [1]**. 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.

The **social determinants of health** can be grouped into five domains:

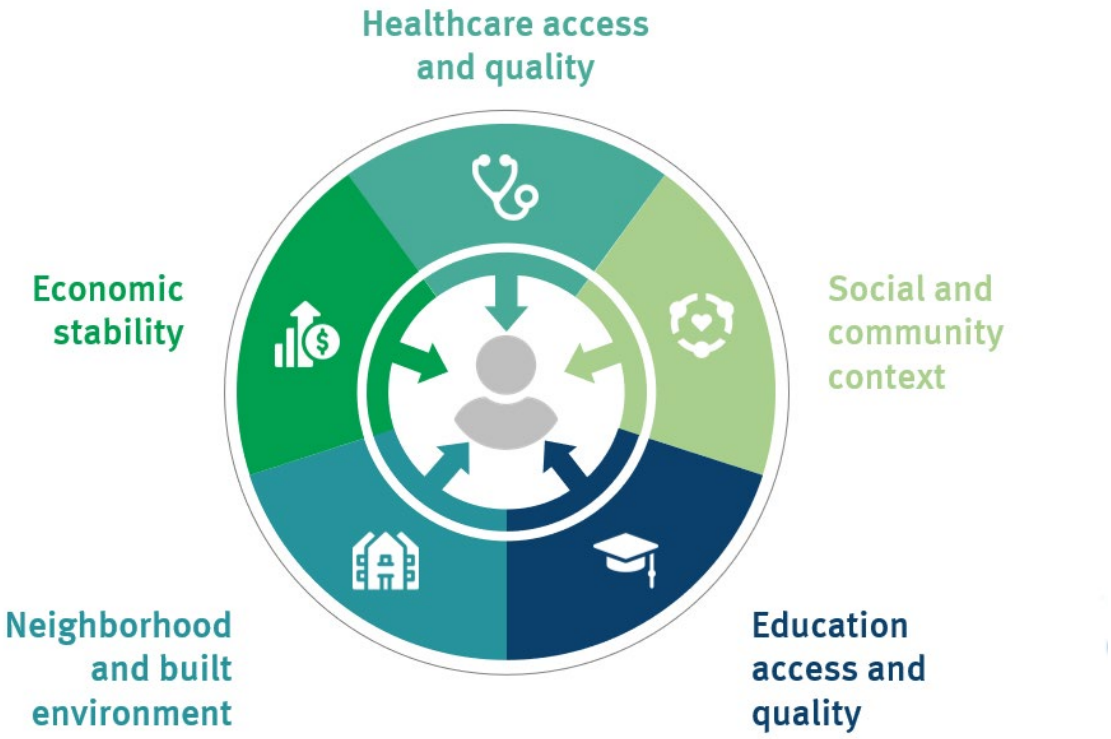


Figure 2. The five domains of the social determinants of health.

HEALTH EQUITY AND ITS DETERMINANTS

> ***"Social determinants of health are life-enhancing resources, such as food supply, housing, economic and social relationships, transportation, education, and health care, whose distribution across populations effectively determines length and quality of life."*** **[15]**

Inequalities in health outcomes in Michigan, and throughout the United States, are significant, persistent, and have been exacerbated by the COVID-19 pandemic. Social and economic conditions, including poverty, income and wealth inequality, racism, and an unsafe environment continue to drive health disparities.

When it comes to health, many people in Michigan face significant barriers. These barriers, including limited access to healthy food, unsafe housing, or lack of transportation, can impact a person's ability to make healthy decisions and affect how healthy we are. In 2020, the United Way's Asset-Limited, Income-Constrained, Employed (ALICE) report found that over 38% of the residents in Michigan – or 1.5 million households – couldn't afford basic needs such as food, housing, and health care **[2]**. Disparities were even more significant for people and families of color.

These differences in health outcomes emerge and persist due to policies, practices, and systems that have disadvantaged people and communities for decades. Long-standing discrimination and the unjust distribution of health promoting factors, including income, healthy housing, and food security perpetuate economic and social inequities.

HEALTH DEPENDS ON OPPORTUNITY

The social determinants of health are so influential to a person's health that the neighborhood you are born into is a predictor of how long you'll live **[3]**. In some Detroit neighborhoods, life expectancy only averages 62 years – a 16-year difference from the Michigan average of 78 years and more than 20 years lower than some neighborhoods less than 10 miles away.

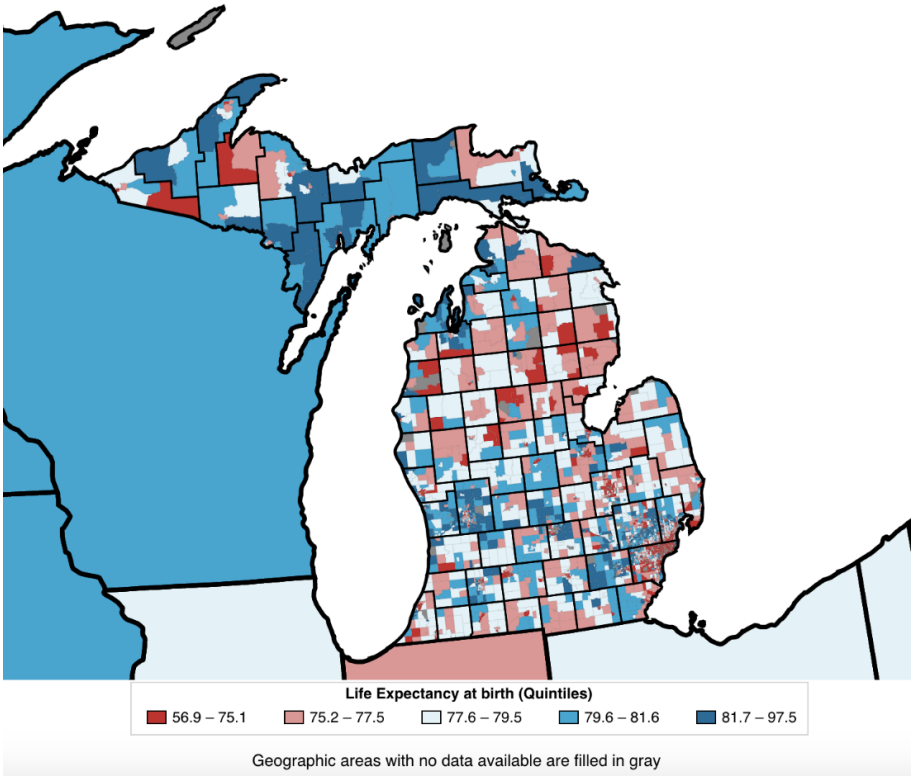


Figure 3. Social determinants of health – which are determined largely by where we live – have such an impact that we see vast differences in life expectancies between census tracts, as seen in this map produced by the CDC.

Vast inequities in health and socioeconomic outcomes continue to exist in all sectors. The MDHHS 2019 Health Equity Report highlights several social determinants of health metrics showing vast disparities by race and ethnicity, including a 91.8% Index of Disparity (ID)[i] in poverty rate. Michigan's Arab American population experienced poverty at 2.9 times the rate of the state average and the African American population experienced poverty at 2.4 times that of the state average.

Unfortunately, though not surprisingly, these inequities in social determinants of health are also reflected in health outcomes, showing significant disparities in morbidity and mortality indicators. For a more complete overview of these indicators, please see Appendix A.

[i] The Overall Population Index of Disparity (ID) is a measure of how much disparity exists in the population. It summarizes how far each group is from the population average. ID=0% indicates no disparity in the population; higher values of ID indicate increasing levels of disparity in the population for that indicator and can be greater than 100%. ID does not reflect health status but reflects how much variation or disparity exists. Data sources: Social Determinants – American Community Survey/U.S. Census Bureau 2017; Health status and behaviors – 2015-2017 Michigan Behavioral Risk Factor Survey (BRFSS) Prevalence Estimates.

ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH TO REDUCE DISPARITIES

In recent years, local communities, social service organizations, health plans, and MDHHS have all been working to address the social determinants of health by adding new services and making it easier for residents to access those services.

In the past five years, new services have been established and existing initiatives have been expanded **[4]**. Across Michigan, communities have been working to connect systems and coordinate discharge policies from hospitals, inpatient centers, and carceral settings to better support people made systematically vulnerable to homelessness or poor health outcomes. Local communities, organizations, and the state are revising policies and procedures to reduce barriers to access and improve service delivery.

Though progress has been made through these efforts, it is often piecemeal, siloed, and variable across communities. Many residents in Michigan still face significant barriers to health, resulting in disparate health outcomes.

To address disjointed efforts and the root causes of health inequity, MDHHS recognizes the need for a stronger, more comprehensive social determinants of health strategy to address health disparities. *Michigan's Roadmap to Healthy Communities* considers strategies from the previous MDHHS SDOH Strategy while also recognizing that there are lessons learned from the COVID-19 pandemic.

Michigan's Path Forward

Michigan's Roadmap to Healthy Communities is an innovative, collaborative strategy to improve health outcomes and advance equity.

MDHHS is a leader in creating opportunities for every Michigan resident to be healthy. Every day, MDHHS staff work to administer practice-tested and evidence-based programs and services that support the health and social well-being of Michigan residents. The 2022-2024 MDHHS Social Determinants of Health Strategy, *Michigan's Roadmap to Healthy Communities*, builds upon existing efforts to address the social determinants of health, while achieving greater collaboration and impact.

Building bridges for collaboration

Michigan's Roadmap to Healthy Communities was developed in collaboration with statewide partners and integrates the input of a diverse group of stakeholders. After MDHHS' Office of Policy and Planning convened initial meetings with leaders involved with the previous Social Determinants of Health Strategy, focus shifted to conducting several brainstorming sessions that included MDHHS leaders and subject matter experts, including representatives from department administrations and program areas, as well as community-based organizations (CBOs). Representatives from other state agencies and administrations including the Michigan Department of Labor and Economic Opportunity (LEO), the Michigan State Housing Development Authority (MSHDA), the Michigan Department of Education (MDE), the Michigan Department of Corrections (MDOC), the Department of Licensing and Regulatory Affairs (LARA), the Michigan Department of Agriculture and Rural Development (MDARD), and the Michigan Department of Environment, Great Lakes, and Energy (EGLE), as well as the Poverty Task Force and the Racial Disparities Task Force, were included in the second round of brainstorming sessions.

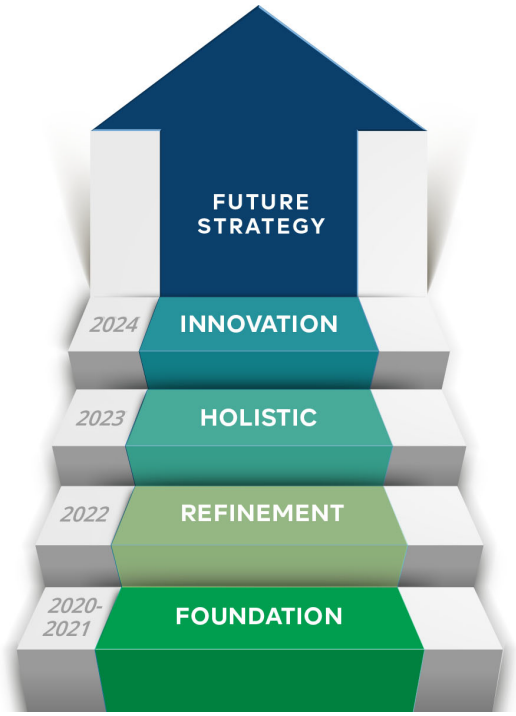
A summary of the brainstorming sessions can be found in Appendix B.

Through this engagement process, the Office of Policy and Planning identified strategic objectives for 2022, in addition to outlining a plan for future engagement to support a more robust Social Determinants of Health Strategy for 2023 and 2024.

FOCUSING OUR APPROACH FOR A GREATER IMPACT

MDHHS program areas address many aspects of the social determinants of health, including housing, food security, and education. However, through a targeted approach, MDHHS can best utilize its resources to have a greater impact. To achieve this, *Michigan's Roadmap to Healthy Communities* provides strategies to facilitate engagement across the department, with other state agencies, and community stakeholder groups. As the strategy is implemented, investment in community partnerships and ongoing outreach and engagement efforts will be essential to its success.

The MDHHS Office of Policy and Planning will support the work being led by the respective program areas and partners by seeking additional resources and exploring opportunities for collaboration. It is in a unique position to build upon existing efforts across the Department and the state to advance health equity and improve the systems that affect health and social outcomes. The Office of Policy and Planning serves as an interagency convener to lead the development of the Social Determinants of Health (SDOH) Strategy by connecting programmatic work and seeking opportunities to refine policies to best support Michigan communities.



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.

Figure 4. Steps to developing the SDOH Strategy.

2022 Strategic Framework

An opportunity for improvement and alignment

To better align our efforts for a greater impact, in 2022, the SDOH Strategy will stratify our efforts based on opportunities for ***improvement*** and ***alignment*** by assessing current State of Michigan administered programs. Assessing the current landscape and aligning efforts is key. MDHHS program areas will examine and identify opportunities for ***improvement***. Once opportunities for improvement are identified, each program area will implement process and qualitative improvements to current initiatives and policies, prioritizing items that are connected to focus areas. Improvements will be assessed and monitored to ensure measurable benefit.

Figure 5. The process of improvement, alignment, and innovation outlined by the SDOH Strategy.

FOCUS AREAS

Three focus areas establish the foundation for the 2022 Overarching Social Determinants of Health Strategy: Health Equity, Housing Stability, and Food Security.

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Figure 6. Focus Areas for the 2022 MDHHS Social Determinants of Health Strategy.

These focus areas were prioritized in the 2020-2021 SDOH Strategy, along with strategies to respond to the pandemic. Through a collaborative process of engagement with social determinants of health stakeholders throughout the Department, state agency partners, and local community partners, it was determined that these focus areas would be most impactful and align with existing State of Michigan-sponsored initiatives and taskforce recommendations. Initiatives connected to these focus areas intersect, especially as an emphasis is placed on health equity and supporting people and communities made vulnerable to adverse health outcomes.

The intersection between focus areas

Many people experiencing housing instability and food insecurity live in underinvested neighborhoods and end up living in areas that lack additional resources, including healthy housing, good schools, quality health care, employment opportunities, and nutritious, affordable food. As the Strategy progresses, connections between the focus areas and additional social determinants of health will be explored to guide future efforts.

2023-2024 Strategic Framework

Making space for innovation

The Policy and Planning Team will continue to identify opportunities to align efforts within MDHHS, as well as with other state agencies and interagency workgroups. It will also continue to work with program areas to survey existing initiatives and policies related to focus areas, connect efforts when appropriate, and mobilize partnerships for a greater impact in communities.

In 2023 and beyond, the SDOH Strategy will maintain ***improvement*** and ***alignment*** efforts, while broadening its approach to include ***innovation***. New, innovative initiatives and cross-cutting policies to address upstream prevention will be explored and ideated. Program areas will assure capacity by identifying the funding and additional resources needed to implement new ideas. Additionally, opportunities within Medicaid will continue to be leveraged to link health care and social needs for our most vulnerable populations. There are many lessons to be learned that can be scaled and adapted from the State Innovation Model (SIM) to support multi-payer delivery and payment reforms that recognize the importance of the social determinants of health. Funding to support regional Social Determinant of Health Equity Regions (SDOH-ER) will allow regions to connect to existing networks of partners, including local public health, Community Action Agencies, Family Resource Centers, and other collaboratives, within their region.

The Policy and Planning Office will also work to align and support **Health in All Policies** efforts across the department by serving as a bridge to remove barriers and leverage opportunities. Through these efforts, MDHHS will develop more robust strategic objectives to leverage the work of other sectors and ensure that a health lens is applied.

Health in All Policies

Health in all Policies (HiAP) is the strategy of evaluating all decisions made and implemented by local, state, and federal government to ensure all policies have neutral or beneficial impacts on the determinants of health. The strategy introduces improved health for all and the closing of health gaps as goals to be shared across all areas of government **[16]**.

Strengthening Partnerships

Building bridges at the community, local, state, and federal level with private and public partners will ensure that Michigan utilizes its resources effectively. Collaboration and communication also support opportunities for innovation and policy development to support healthy, resilient communities.

SUPPORTING COMMUNITIES

Though ensuring people have access to the resources and services they need to become self-sufficient is essential to reduce health disparities, it is also necessary to focus on moving upstream to change community conditions to improve long-term health outcomes through building resiliency and developing policies that support community-driven solutions.

Resident feedback will be incorporated throughout the development and implementation of the strategy to ensure a more equitable, community-based approach. Robust community engagement efforts will ensure that residents have the opportunity to provide meaningful input on policies and programs.

A GREATER IMPACT: ADVANCING EQUITY AND ECONOMIC BENEFIT

As health care costs continue to rise and health disparities persist, it is essential that we focus on upstream prevention to improve the quality of life of Michigan residents and more effectively improve health outcomes.

> ***"These systematic, avoidable disadvantages are interconnected, cumulative, intergenerational, and associated with lower capacity for full participation in society. Great social costs arise from these inequities, including threats to economic development… and the social health of the nation."***
>
> NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS
> HEALTH AND SOCIAL JUSTICE COMMITTEE

There is extensive research that concludes that addressing social determinants of health is important for improving health outcomes and reducing health disparities. In a recent guidance document, CMS states:

> *"Social determinants of health have been shown to impact health care utilization and cost, health disparities, and health outcomes* [5]*. Current research indicates that some social interventions targeted at Medicaid and Children's Health Insurance Program (CHIP) beneficiaries can result in improved health outcomes and significant savings to the health care sector. These investments can also prevent or delay beneficiaries needing nursing facility care by offering services to facilitate community integration and participation and help keep children on normative developmental trajectories in education and social skills."*

Nationwide, studies are showing that programs addressing the social determinants of health are contributing to improved health and reduced health care costs. A recent study from WellCare Health Plans, Inc. and the University of South Florida (USF) College of Public Health found that health care spending is substantially reduced when people are successfully connected to social services that address social barriers, or social determinants of health, including secure housing, healthy food programs, and utility and financial assistance **[6]**.

A Closer Look at the 2022 Strategy

A HOLISTIC APPROACH

The 2022 focus areas, housing stability, food security, and health equity, provide a foundation for process and outcome-based goals and related objectives that drive collective efforts for a greater impact. For each objective, metrics to track improvement, alignment, and innovation are suggested, with the anticipation that they will be refined and expanded by individual programs and initiatives throughout implementation. The MDHHS Office of Policy and Planning worked with partners, stakeholders, and residents to identify specific, targeted strategies and initiatives to improve outcomes for each focus area. Those strategies and initiatives are detailed in Chapters 7-9.

Each focus area is impacted by the others. Addressing housing security can mitigate some of the compounding factors that lead to food security, and vice versa. Health equity provides a foundation for this work, while there is a strong connection between housing stability and food security. At the same time, making measurable advances in mitigating housing and food barriers will have a profound impact on racial and ethnic inequities.

Housing Stability Priorities for 2022

Supporting people made vulnerable to housing instability: Solutions to housing stability will require interventions tailored to people and communities disadvantaged by policies, practices, and systems. People and communities made vulnerable to housing instability include justice system-involved individuals, people who are pregnant and parenting, individuals in need of supportive housing following treatment for substance use disorder (SUD), older adults (seniors, people who are elderly, and aging), youth transitioning out of foster care, low-income households, tribal communities, immigrants, refugees, migrant workers, LGBTQ youth, persons with mental and/or physical disabilities, veterans, racial and ethnic minorities, and other people and communities facing barriers.

Holistic approaches to healthy housing: Supporting healthy and stable housing requires a holistic approach, which includes strategies that incorporate lead mitigation, weatherization, and potable water access, as well as opportunities for alignment with strategies identified within Michigan's Statewide Housing Plan, including the removal of additional hazardous materials (including carbon, radon, asbestos, and mold) and energy efficiency.

Addressing housing access for people experiencing homelessness: Preventing and ending homelessness by expanding eviction diversion programs and increasing and aligning resources to increase access to housing for people experiencing homelessness and people who are precariously housed.

Food Security Priorities for 2022

Supporting people made vulnerable to food insecurity: Solutions to promote food security will require interventions tailored to people and communities disadvantaged by policies, practices, and systems. People and communities made vulnerable to food insecurity include, but are not limited to, people who are pregnant and parenting, older adults (seniors, people who are elderly, or aging), school-aged children, veterans, people experiencing poverty, persons with mental and/or physical disabilities, racial and ethnic minorities, and other people and communities facing barriers. This includes strategies to eliminate barriers to a person's ability to be food secure and supporting community assets that not only improve short-term access to food but strengthen systems for long-term food security.

Streamlining processes to improve access to food benefits: An inward look at MDHHS programs and policies that support food security. Process and quality improvement efforts are needed to best serve Michigan residents. This could include enhancements to MI Bridges as well as other data-sharing and system interoperability solutions.

Alignment on key food security reforms: Community, local, and state partnerships allow us to reach communities and provide enhanced support. Alignment of efforts with existing stakeholders and exploring opportunities to align with additional partners are vital to ensure that programs are connected for a greater impact.

Health Equity Priorities for 2022

Supporting people made vulnerable to adverse health outcomes: Advancing health equity will require interventions tailored to people and communities disadvantaged by policies, practices, and systems. People and communities made vulnerable to specific adverse outcomes, including housing instability and food insecurity, have been identified within their respective focus area. As the capacity of the Strategy expands to include other focus areas, additional programs and policies addressing the social determinants of health will be adapted to mitigate immediate and systemic barriers and ensure that everyone has the opportunity to be as healthy as possible.

Improving MDHHS-driven equity programs and policies: Improving MDHHS programs and policies to better support health equity. These initiatives include implementation of the Equity Impact Assessment in the Policy and Planning Office and launching the Incorporating Equity into the Legislative Bill Analysis Process.

Strengthen community engagement to support community-driven solutions: The Strategy will place an extraordinary emphasis on engaging with community partners to develop policy and funding mechanisms that support community-driven solutions. Michigan regions are diverse and therefore need community-driven strategies and targeted policies to support the needs of each community. Cross-sector collaboration at the state and community level allows us to develop robust and targeted strategies.

Focus Area: Housing Stability

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.

The Housing Stability Focus Area includes three priorities: **supporting populations made vulnerable to housing instability**, **holistic approaches to healthy housing**, and **addressing housing access for people experiencing homelessness**. Within each priority, specific goals and objectives have been outlined to measure progress.

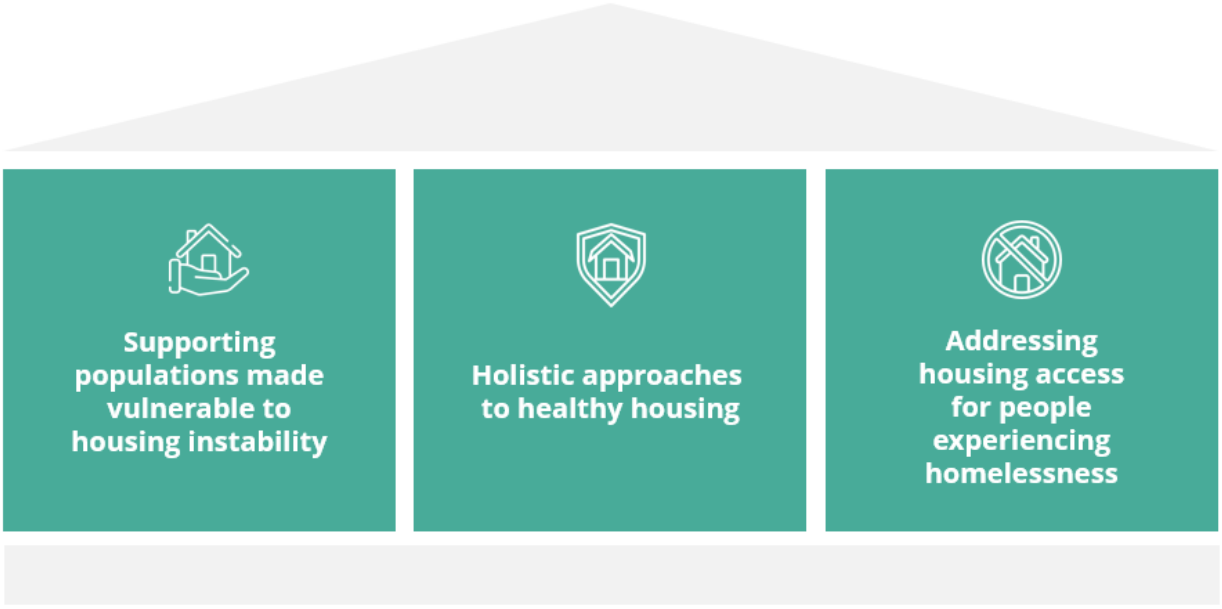

Figure 7. Priorities for the Housing Stability focus area.

Housing Stability Objectives

MDHHS program areas have identified measurable objectives for the Housing Stability focus area that will continue to be refined and expanded throughout implementation of the SDOH Strategy. Current measures for 2022 are process-based as programs focus on the ***improvement*** and ***alignment*** process of the strategy. Looking ahead, the Policy and Planning Team will work to identify opportunities for enhanced ***alignment*** and ***innovation***, seeking out data gaps and providing technical assistance to support the development of outcome-based measures that demonstrate an improvement in health and social outcomes for Michigan residents. MDHHS will facilitate ongoing opportunities for engagement through round tables and community town halls to gather feedback from local communities and ensure the perspective of those with lived experience is incorporated into this process.

Priority: Supporting populations made vulnerable to housing instability

Solutions to housing stability will require interventions tailored to people and communities disadvantaged by policies, practices, and systems. People and communities made vulnerable to housing instability include justice-involved individuals, individuals in need of supportive housing following treatment for substance use disorder (SUD), families, older adults (seniors, people who are elderly, and aging), racial and ethnic minorities, people who are pregnant and parenting, youth transitioning out of foster care, low-income households, tribal communities, immigrants, refugees, migrant workers, LGBTQ youth, persons with mental and/or physical disabilities, veterans, and other people and communities facing barriers.

2022 strategic objectives to support people made vulnerable to housing instability:

Strategy HS-1: Expand access to stable housing for justice-involved individuals.

There is a significant connection between homelessness and the criminal legal system; people currently or previously involved in the justice system are more likely to experience homelessness, and people experiencing homelessness are more likely to interact with the justice system. People who have been incarcerated more than once are 13 times more likely than the general public to experience homelessness, whereas people who have been incarcerated even once are seven times more likely **[7]**.

Strategy HS-1: Expand access to stable housing for justice-involved individuals.

Objective HS-1.1: Increase retention in the Michigan State Housing Development Authority's (MSHDA) housing voucher program by Michigan Department of Corrections (MDOC) returning citizens by 15%, from 63% to 78%, through addressing barriers to success through supportive services.

- **Initiative HS-1.1.1**: Increase the number of housing choice vouchers available to MDOC parolees currently under community supervision who meet the Michigan State Housing Development Authority's (MSHDA) requirements to receive voucher assistance from 150 to 200.
- **Initiative HS-1.1.2:** Survey MDOC housing voucher recipients on barriers to success as a foundation for planning to increase retention in MSDHA housing voucher program by MDOC population.

Strategy HS-2: Expand access to stable housing for individuals in need of supportive housing following treatment for substance use disorder (SUD).

People currently seeking treatment for substance use disorder frequently report housing as their most pressing need. Individuals with SUD may be as much as 10 times more likely to stay in recovery when having access to drug-free recovery housing and day-to-day treatment programs following treatment **[8]**.

Strategy HS-2: Expand access to stable housing for individuals in need of supportive housing following treatment for substance use disorder (SUD).

Objective HS-2.1: Increase the number of **Michigan Association of Recovery Residencies (MARR)** certified beds by 150 from May 2022 to May 2023.

- **Initiative HS-2.1.1:** Support MSHDA's Recovery Housing Program (RHP) by targeting messaging to communities with low access and tracking impact.

Objective HS-2.2: Begin to develop a document that can be used to inform local governments about recovery residences and recovery residence best practices by January 2023.

- **Initiative HS-2.2.1:** Work with stakeholders in Michigan Association of Recovery Residences (MARR) and representatives of local zoning commissions and associations to identify best practices.

The **Michigan Association of Recovery Residencies (MARR)** is the Michigan statewide affiliate of the National Alliance of Recovery Residencies (NARR). Its primary objectives are to certify Michigan recovery residencies to the NARR standards, publish a directory of certified recovery residencies in Michigan, and provide trainings in the NARR standards. "Recovery Residencies" is a broad term describing sober, safe, healthy living environments that help initiate and sustain recovery.

Strategy HS-3: Improve access to healthy, affordable housing for families in need.

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Objective HS-3.1: During FY22 (October 2021 through September 2022), increase the number of leased MSHDA **Family Unification Vouchers** from 40% to 90%.

- **Initiative HS-2.1.1:** Support MSHDA's Recovery Housing Program (RHP) by targeting messaging to communities with low access and tracking impact.

MSHDA™
MICHIGAN STATE HOUSING DEVELOPMENT AUTHORITY

The Michigan State Housing Development Authority (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 **Family Unification Vouchers** are made available to families for whom the lack of adequate housing is a primary factor in the separation, or threat of imminent separation, of children from their families or in the prevention of reunifying children with their families and for youth aging out of foster care. The vouchers enable these families and eligible youth to lease decent, safe, and sanitary housing that is affordable in the private housing market.

Strategy HS-3: Improve access to healthy, affordable housing for families in need.

Objective HS-2.2: Begin to develop a document that can be used to inform local governments about recovery residences and recovery residence best practices by January 2023.

- **Initiative HS-2.2.1:** Work with stakeholders in Michigan Association of Recovery Residences (MARR) and representatives of local zoning commissions and associations to identify best practices.

Objective HS-3.2: During FY22 (October 2021 through September 2022), expand access by increasing the number of counties deploying vouchers from two counties (currently available in Ottawa and Kalamazoo counties) to four counties.

- **Initiative HS-3.2.1:** Support collaboration between the Children's Service Agencies and MSHDA to expand awareness and uptake of vouchers through targeted referrals and broader messaging.

Objective HS-3.3: Reduce arrearages and/or restore water services to approximately 33,000 households by September 30, 2023, to provide immediate relief to low-income households and to mitigate the spread of COVID-19 through implementation of the **Low-Income Household Water Assistance Program (LIHWAP)**.

- **Initiative HS-3.3.1:** Create and implement agreements with 21 Community Action Agencies (CAAs) to provide service in all 83 counties in Michigan.
- **Initiative HS-3.3.2:** Develop and implement a Memorandum of Understanding for use among MDHHS, water providers, and Community Action Agencies.
- **Initiative HS-3.3.3:** Convene a monthly workshop of CAAs to provide ongoing training, technical assistance, and a forum to share challenges, strategies, and best practices.

The **Low-Income Household Water Assistance Program** is a temporary emergency program to improve access to water, for hygiene and consumption, within homes by reducing the burden of water and wastewater bills for low-income homeowners or renters.

Strategy HS-4: Increase access to healthy, affordable housing for older adults (seniors, people who are elderly, and aging).

Strategy HS-4: Increase access to healthy, affordable housing for older adults (seniors, people who are elderly, and aging).

Objective HS-4.1: During FY22 (October 2021 through September 2022), increase participation in MSHDA's **Neighborhood Enhancement Program (NEP)** by statewide Area Agencies on Aging (AAAs) from 12% to 30%.

- **Initiative HS-4.1.1:** Conduct additional outreach and education efforts, in collaboration with the AAAs.
- **Initiative HS-4.1.2:** Work with the AAAs to apply for the NEP on behalf of their service recipients.

The MSHDA **Neighborhood Enhancement Program** provides funding statewide for activities directly tied to stabilization and enhancement of Michigan neighborhoods by nonprofit 501(c)(3) agencies. Improvements can be comprised of both interior and exterior activities of a single-family home or as an enhancement to a public amenity that benefits a neighborhood.

Strategy HS-4: Increase access to healthy, affordable housing for older adults (seniors, people who are elderly, and aging).

Objective HS-4.2: By December 2022, implement improvements to the **MI Bridges** platform, including Project One Day, Project Renew, and the Elderly Simplified Application Project within 100% of MDHHS offices to streamline the processing of assistance applications, improve customer service, and create efficiency gains in MDHHS' largest assistance programs.

- **Initiative HS-4.2.1:** Implement Project One Day to speed up the verification process, with the goal of getting clients approved for all requested programs within one day – a process that could take up to 45 days in the past.
- **Initiative HS-4.2.2:** Implement Project Renew to increase client ease of recertification.
- **Initiative HS-4.2.3:** Implement the Elderly Simplified Application Project to provide streamlined application and recertification for older adults.
- **Initiative HS-4.2.4:** Expand the use of benefits navigators (through phone assistance or providing in-person support) to assist individuals with completing the enrollment process for a range of assistance programs.

MI Bridges is an online site where residents can explore potential eligibility, apply for housing assistance and 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.

Behavioral and Physical Health and Aging Services Administration programming

The Michigan Medicaid program operating through the Behavioral and Physical Health and Aging Services Administration has historically focused on providing health care coverage to the state's most vulnerable populations and ensuring access to a wide array of health care services and supports.

The Behavioral and Physical Health and Aging Services Administration has collaborated with Medicaid providers and payers to address barriers related to housing and improve health outcomes for Medicaid beneficiaries. Examples are included below:

- Michigan's Medicaid Health Plans (MHPs) are subject to contractual requirements related to reducing high-cost utilization and improving quality of care by stabilizing housing, although strategies vary by plan. In previous contract years, MHPs were required to complete Population Health Management templates focused on housing stability. This created momentum for designing targeted approaches for leveraging data and analysis to support inventions. Many MHPs have continued to build on their efforts over the years.
- Medicaid Health Homes, such as the MI Care Team and Opioid Health Home, have focused their efforts on addressing SDOH for individuals with chronic behavioral health and physical health conditions. These programs have begun to codify and assess the needs of the population served by leveraging ICD-10 Z-codes to identify and indicate applicable SDOH needs of those served.
- Under the 1915 (b)(3) Waiver, the Behavioral and Physical Health and Aging Services Administration extends coverage for housing assistance and tenancy supports. This program is primarily administered through the administration and Community Mental Health Service Providers (CMHSPs). Housing assistance is available to individuals with serious mental illness and intellectual and/or developmental disabilities and provides coverage for short-term, interim, or one-time-only expenses (not including room and board costs) for beneficiaries transitioning from restrictive settings and homelessness into more independent, integrated living arrangements while in the process of securing other benefits.

Opportunities to explore to support people made vulnerable to housing instability for the 2023 Social Determinants of Health Strategy

Through a process of ongoing engagement with stakeholders, MDHHS Policy and Planning will identify additional opportunities to support people made vulnerable to housing instability, including racial and ethnic minorities, people who are pregnant and parenting, youth transitioning out of foster care, low-income households, tribal communities, immigrants, refugees, migrant workers, LGBTQ youth, persons with mental and/or physical disabilities, and veterans for inclusion within the 2023 Social Determinants of Health Strategy. These strategies include:

Reduce racial disparities in housing insecurity.

In Michigan, and throughout the United States, most racial and ethnic minority groups experience housing instability and homelessness at higher rates **[9]**. The disproportionality in housing outcomes can be largely attributed to systemic inequity; long-standing racism and discrimination continue to drive disparities. Historical segregation and housing discrimination, including the practice of redlining and more recent redistricting, are root causes of disparate outcomes. Assuring healthy, affordable housing for all is essential to address racial inequity.

- ***Align state efforts though process assessment and improvement.***
- ***Support community-driven solutions through a robust engagement strategy.***
- ***Improve the availability of affordable housing in Michigan.***

Alignment with Michigan's Statewide Housing Plan

MSHDA is currently leading efforts to develop 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 Michigan Statewide Housing Plan to support vulnerable populations, including the promotion of universal and barrier-free housing accessibility and reducing barriers to recovery housing.

A comprehensive list of additional opportunities to explore is included in Appendix C.

Priority: Holistic approaches to healthy housing

Supporting healthy and stable housing requires a holistic approach, which includes strategies that incorporate lead mitigation, weatherization, and potable water access, as well as opportunities for alignment with strategies identified within Michigan's Statewide Housing Plan, including the removal of additional hazardous materials (including carbon, radon, asbestos, and mold) and energy efficiency.

2022 strategic objectives to support healthy housing:

Strategy HS-5: Address the gaps in lead inspection and abatement service availability to increase the volume of lead-safe housing in Michigan and reduce child lead exposure.

Strategy HS-5: Address the gaps in lead inspection and abatement service availability to increase the volume of lead-safe housing in Michigan and reduce child lead exposure.

Objective HS-5.1: Initiate 10 lead abatement projects in FY22 (October 2021 through September 2022), including three rental properties, through implementation of the **MDHHS Lead Poisoning Prevention Fund**.

- **Initiative HS-5.1.1:** Provide $1M in residential financing for the prevention fund.
- **Initiative HS-5.1.2:** Launch a stakeholder engagement plan including local health departments.
- **Initiative HS-5.1.3:** Attend three conferences to discuss the prevention fund to increase awareness.

The **MDHHS Lead Poisoning Prevention Fund** will inject public and private capital into evidence-based prevention programs to effectively eliminate lead hazards in at-risk units. The fund works by creating a loan-loss reserve that de-risks lending for private lenders at below-market rates. This program adds capacity by allowing access to families that may not qualify through Medicaid.

Strategy HS-5: Address the gaps in lead inspection and abatement service availability to increase the volume of lead-safe housing in Michigan and reduce child lead exposure.

Objective HS-5.2: By September 2023, increase the number of referrals to lead abatement services by 25% by expanding the knowledge of available lead services for families, internal partners, and external partners.

- **Initiative HS-5.2.1:** Through strategic partnerships and enhanced communication channels, educate families on the importance of identifying and remediating home lead hazards, as well as supporting family navigation to available lead services.
- **Initiative HS-5.2.2:** Deploy Home Lead Safety e-learning module to MDHHS partners including Children's Protective Services, Foster Care Services, and other home visiting programs.
- **Initiative HS-5.2.3:** Strengthen partnership with local public health to ensure that all households where a child with an elevated blood lead level (EBLL) reside are referred for service.
- **Initiative HS-5.2.4:** Collaborate with the Division of Environmental Health, Community Education and Outreach Section for delivery of clear messaging on available lead services to the highest risk communities, through media campaign messaging, postcards, and door-to-door outreach.

Objective HS-5.3: By September 2023, increase the number of households enrolled in MDHHS-funded lead inspection and abatement services by 25%, to ensure safe and healthy housing for more Michigan children.

- **Initiative HS-5.3.1:** By the end of FY23, hire 22 additional staff to serve in a variety of functions for delivery of lead inspection and abatement services to Michigan families.
- **Initiative HS-5.3.2:** Through data analysis, identify the communities at highest risk and ensure efforts are optimal for availability, access to, and delivery of lead services.
- **Initiative HS-5.3.3:** Collaborate with local public health departments to bolster blood lead testing in communities, to identify children to receive priority services.

Strategy HS-5: Address the gaps in lead inspection and abatement service availability to increase the volume of lead-safe housing in Michigan and reduce child lead exposure.

Objective HS-5.4: Increase the lead abatement firm workforce from 185 to 215 by FY23 to help decrease the number of excess lead abatement projects throughout the state and support future capacity for statewide lead abatement programs.

- **Initiative HS-5.4.1:** Hire a lead abatement workforce development coordinator by FY22, end of QTR 2. Coordinator will be responsible for building relationships across state agencies for innovative workforce solutions, identify barriers and solutions to workforce, and work with contractors on solutions to barriers.
- **Initiative HS-5.4.2:** Utilize the **Lead Abatement Workforce Incentive Program** to encourage current lead abatement vendors to bid on MDHHS funded lead abatement projects. Incentive program provides an additional $1,000 per project, up to five projects to offset abatement costs, such a pollution insurance.
- **Initiative HS-5.4.3:** Build lead abatement firm capacity by utilizing the lead scholarship program to support training costs for lead abatement courses for firms and individuals.
- **Initiative HS-5.4.4:** Align with MSHDA's Contractor Assistance Program to support efforts to expand the workforce.
- **Initiative HS-5.4.5:** Expand awareness and uptake of the **Lead Scholarship Training Program**.
- **Initiative HS-5.4.6:** Establish a new funding opportunity for community partners working to expand the workforce.
- **Initiative HS-5.4.7:** Determine opportunities to align resources across state agencies, including the MDHHS Healthy Homes Program and the Department of Labor and Economic Opportunity (LEO), to support workforce development for lead abatement efforts and to address the workforce shortage.

Through the **Lead Abatement Workforce Incentive Program** that launched in Spring 2021, MDHHS offers a monetary bonus to construction firms completing lead abatement projects under MDHHS funding. MDHHS continues to offer a **Lead Scholarship Training Program**. This program has been offered for nearly 20 years. MDHHS will seek input on opportunities for improvement as part of the broader SDOH Strategy.

Strategy HS-6: Expand weatherization efforts to improve energy efficiency, reduce the cost burden of utilities, and increase the volume of safe, weatherized homes in Michigan.

Strategy HS-6: Expand weatherization efforts to improve energy efficiency, reduce the cost burden of utilities, and increase the volume of safe, weatherized homes in Michigan.

Strategic Objective HS-6.1: From January 2022 to January 2024, increase the number of homes weatherized through the **Weatherization Assistance Program (WAP)** by 60%, from 1,250 units to 2,000 units.

- **Initiative HS-6.1.1:** Expand the number of contractors and crews providing weatherization services.
- **Initiative HS-6.1.2:** Seek additional consistent Low Income Home Energy Assistance Program (LIHEAP) funding from year to year. Most states receive a 15% transfer of LIHEAP to Weatherization annually, Michigan received approximately 3%.
- **Initiative HS-6.1.3:** Seek additional flexible funding, including coordination of utility funds, to increase the program capacity to meet higher production goals and maximum performance now and in the future. The more holistic funding allows us to address more measures on each client's home where we work.
- **Initiative HS-6.1.4:** Pilot a WAP Deferral Reduction Program to increase the number of weatherization households in Michigan.

The U.S. Department of Energy's (DOE) **Weatherization Assistance Program** reduces energy costs for low-income Michigan households, particularly for people who are elderly, persons with disabilities, those with children under age 12, and those with a high energy burden (repeated high utility bills) by increasing and improving the energy efficiency of their homes, while ensuring their health and safety.

Strategy HS-7: Improve potable water access to ensure a healthy home environment for improved hygiene, improved access to clean water, improved sanitation, and reduced lead exposure.

Strategy HS-7: Improve potable water access to ensure a healthy home environment for improved hygiene, improved access to clean water, improved sanitation, and reduced lead exposure.

Strategic Objective HS-7.1: From May 2022 to January 2023, provide premise plumbing repairs to approximately 150 homes in both rural and urban communities.

- **Initiative HS-7.1.1:** Pilot a program to increase the health and safety of low-income households by providing homes with functional equipment and access to clean water, launching in Spring 2022. Based on the Water Repair and Plumbing Program administered in FY20, the current average cost for plumbing repairs is $4,731 per household in urban areas and $5,200 to $13,000 per household in rural areas.

PROMOTING THE CONNECTION BETWEEN STABLE HOUSING AND HEALTH

The MDHHS Policy and Planning Team has developed a robust communications strategy to promote the connection between stable housing and health. Engagement and outreach efforts will include webinars and other virtual events until in-person events can safely resume. A campaign will be developed to support the U.S. Department of Housing and Urban Development's (HUD) National Healthy Homes Month in June.

Opportunities to explore for healthy housing for the 2023 Social Determinants of Health Strategy

Through a process of ongoing engagement with stakeholders, MDHHS Policy and Planning will identify additional opportunities to support healthy homes for the 2023 Social Determinants of Health Strategy. These strategies include:

- ***Promote universal and barrier-free housing accessibility.***
- ***Address household energy needs through the promotion of energy efficient housing and increasing assistance for home energy costs.***
- ***Improve and streamline processes to identify and address home health and safety hazards.***
- ***Connect residents to assistance at every level.***
- ***Build capacity to address the health implications of climate change and advance environmental justice.***

A comprehensive list of additional opportunities to explore is included in Appendix C.

Priority: Addressing housing access for people experiencing homelessness

Preventing and ending homelessness by expanding eviction diversion programs and increasing and aligning resources to increase access to housing for people experiencing homelessness and people who are precariously housed.

2022 strategic objectives to support housing access for people experiencing homelessness:

Strategy HS-8: Build and expand technology solutions that increase care coordination, benefits access, and access to housing resources for people experiencing homelessness.

Strategy HS-8: Build and expand technology solutions that increase care coordination, benefits access, and access to housing resources for people experiencing homelessness.

Strategic Objective HS-8.1: By September 2022, 100% of Medicaid Health Plans and Prepaid Inpatient Health Plans will begin using a Homeless Indicator in **CareConnect360 (CC360)** to identify their homeless beneficiaries.

- **Initiative HS-8.1.1:** Develop and launch a Homeless Indicator in CareConnect 360 to better support care coordination between Medicaid Health Plans (MHPs), Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Agencies (CMHs) and the homeless response system.
- **Initiative HS-8.1.2:** Test the homeless indicator in CC360 to ensure it pulls the most recent information available from the Homeless Management Information System (HMIS). Once rolled out through the CC360 system, MDHHS will gather information from system users on its use, accuracy, and value.
- **Initiative HS-8.1.3:** Collect information from the local homeless response system including the Housing Assessment and Resource Agencies (HARAs) who may be receiving additional outreach from MHPs, PIHPs and CMHs about beneficiaries on those conversations and the value of this new tool as a mechanism for care coordination.

CareConnect360 (CC360) is a statewide Web portal and care management tool developed by the Michigan Department of Health and Human Services (MDHHS) to integrate physical and behavioral health-related information — along with other human services data — to provide a comprehensive view of an individual's care needs.

Strategy HS-9: Develop tools to identify and prioritize people with high medical needs who are experiencing homelessness to more quickly connect them with the most appropriate housing resource.

Housing resources for persons experiencing homelessness continue to be a scarce resource. Since different federal housing programs provide different levels of client engagement, it is important for communities to have an informed method of prioritizing their most vulnerable clients based on their short- and long-term needs.

Strategy HS-9: Develop tools to identify and prioritize people with high medical needs who are experiencing homelessness to more quickly connect them with the most appropriate housing resource.

Strategic Objective HS-9.1: By December 2022, all 20 Continuums of Care (CoCs) will have access to a medical fragility indicator for actively homeless individuals currently enrolled in Medicaid.

- **Initiative HS-9.1.1:** Develop a medical fragility indicator based on a set of health and social needs, as well as homelessness, to inform local prioritization decisions for housing interventions.
- **Initiative HS-9.1.2:** Work with experts to determine how a medical fragility score can be created and how an algorithm can be structured to best weigh the various information gathered to calculate the score.
- **Initiative HS-9.1.3:** Collect and integrate feedback from local homeless response systems on what information they would consider helpful to inform a medical fragility score.
- **Initiative HS-9.1.4:** Determine what technology or process is best suited to share a medical fragility score with local homeless response systems

Strategy HS-10: Leverage long-term resources to sustain local eviction diversion programming and supports.

As individuals and families are engaging with MDHHS for assistance with various state and federal benefit programs, it is important that case workers be aware of and can refer to housing resources when needed.

Strategy HS-10: Leverage long-term resources to sustain local eviction diversion programming and supports.

Strategic Objective HS-10.1: By December 2022, all 83 MDHHS local offices will receive education on housing resources for persons experiencing homelessness and how to access them.

- **Initiative HS-10.1.1:** Work with MSHDA to develop online training modules for MDHHS staff explaining housing resources, the homeless response system, and how to assist their clients with getting connected to emergent and permanent housing.
- **Initiative HS-10.1.2:** Develop a training module on shelter diversion for MDHHS front-line staff to assist them with problem solving conversations with clients who are homeless or precariously housed to help identify possible housing solutions and prevent the need for emergency shelter.
- **Initiative HS-10.1.3:** Match Homeless Management Information System (HMIS) data with BRIDGES data to identify benefits and services that persons experiencing homelessness could be receiving to assist them with housing stabilization.

Alignment with the 2020-2022 State Action Plan developed by Michigan's Campaign to End Homelessness (MCTEH)

MDHHS will work to align with the MCTEH Three-Year Action Plan that includes four primary strategies to end homelessness in Michigan, including:

- Increasing access to affordable and attainable housing for all Michiganders experiencing homelessness.
- Using cross-sector collaboration to impact the other Social Determinants of Health that lead to housing insecurity.
- Enhancing the homeless service delivery system to better serve those in need.
- Increasing prevention and diversion efforts to mitigate the risk of becoming homeless.

Opportunities to explore to address housing access for people experiencing homelessness for the 2023 Social Determinants of Health Strategy

Through a process of ongoing engagement with stakeholders, MDHHS Policy and Planning will identify additional opportunities to support housing access for people experiencing homelessness for the 2023 Social Determinants of Health Strategy. These strategies include:

- ***Increase prevention and rapid re-housing efforts.***
- ***Leverage long-term resources to sustain local eviction diversion programming and supports.***
- ***Build and expand technology solutions that increase care coordination between health care providers and assistance programs.***

A comprehensive list of additional opportunities to explore is included in Appendix C.

Focus Area: Food Security

Food security means that that all people, at all times, have physical, social, and economic access to sufficient, safe, and nutritious food that meets their dietary needs and food preferences for an active and healthy life (1996 World Food Summit). Secure access to quality, nutritious food is essential for health and well-being. Food security leads to other positive outcomes, including poverty reduction and improved health.

FOOD INSECURITY IN MICHIGAN

In 2019, approximately 1.3 million Michiganders faced food insecurity, over 305,000 of which represented children. While finalized statistics for 2020 are yet to be reported, estimates show that food insecurity increased to approximately 1.9 million people in Michigan, including 552,000 children. Black and Hispanic households have consistently faced higher rates of food insecurity than white households. The United States Department of Agriculture's nationwide report for 2020 shows 22% of Black households and 17% of Hispanic households were food insecure. In contrast, just 7% of white households experienced food insecurity. These high food insecurity rates correlate with distinct racial disparities in Michigan.

The Food Security Focus Area includes three priorities for 2022: supporting people made vulnerable to food insecurity, streamlining processes to improve access to food benefits, and alignment on key food security reforms. Within each priority, specific goals and objectives have been outlined to measure progress.

Figure 8. Food Security focus area priorities.

Food Security Objectives

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

For food security objectives to be realized, four dimensions of food security must be fulfilled:

- **AVAILABILITY:** Food must be physically available, which is determined by food production, stock levels, and the supply chain.
- **ACCESS**: People must have economic and physical access to food, which is determined by factors such as income, pricing, and transportation.
- **UTILIZATION**: Sufficient energy and nutrient intake by individuals are determined by factors including food preparation, diversity of the diet, and feeding practices.
- **STABILITY**: A person is still considered food insecure if they do not have adequate access to food on a periodic basis. Crisis situations (including the COVID-19 pandemic and adverse weather events) or economic factors (including unemployment and rising food prices) may have an impact on a person's food security status.

Priority: Supporting populations made vulnerable to food insecurity

Solutions to promote food security will require interventions tailored to people and communities disadvantaged by policies, practices, and systems. People and communities made vulnerable to food insecurity include, but are not limited to, people who are pregnant and parenting, older adults (seniors, people who are elderly, or aging), school-aged children, veterans, people experiencing poverty, persons with mental and/or physical disabilities, racial and ethnic minorities, and other people and communities facing barriers. This includes strategies to eliminate barriers to a person's ability to be food secure and supporting community assets that not only improve short-term access to food but strengthen systems for long-term food security.

2022 strategic objectives to support people made vulnerable to food insecurity:

Strategy FS-1: Strengthen and make it easier for families to connect to the existing food and nutrition safety net, including the* Women, Infants, and Children (WIC) *program and the* Food Assistance Program (FAP)*, also known as the* Supplemental Nutrition Assistance Program (SNAP)*.

Women, Infants, and Children (WIC) is a federally funded special Supplemental Nutrition Program, serving low- and moderate-income pregnant, breastfeeding, and postpartum adults, infants, and children up to age five 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.

The **Food Assistance Program (FAP)**, also known as the **Supplemental Nutrition Assistance Program (SNAP)** provides benefits to buy or grow food for low-income households.

Strategy FS-1: Strengthen and make it easier for families to connect to the existing food and nutrition safety net, including WIC and FAP/SNAP.

- **Initiative FS 1.0.1:** Collect data from focus group interviews conducted by the Michigan Department of Education (MDE) to understand why WIC/SNAP dual-enrollees drop out of the WIC program.
- **Initiative FS-1.0.2:** Identify areas with few to no retailers accepting WIC through the creation of a Food Desert ArcGIS map.
- **Initiative FS-1.0.3:** Develop and implement education programs targeted to retailers and community organizations about WIC benefits.
- **Initiative FS-1.0.4**: Receive vendor feedback on current and future WIC program policies through the **WIC Vendor Advisory Council**.
- **Initiative FS-1.0.5:** Launch a Client Advisory Council (CAC) to inform changes in WIC programming and policies by receiving direct feedback from WIC clients and build a stronger relationship with clients to identify equitable solution-based approaches.

The **WIC Vendor Advisory Council** was established in October 2021, with the following goals:

- Receive vendor feedback on current and future WIC Program policies.
- Gain insight into vendor barriers to improve service to WIC participants.
- Collaborate with vendors to develop:
  - Marketing tools to advance promotion and retention efforts.
  - Training tools to improve program compliance, ensure program integrity, and increase participant access to nutritional foods.
- Address food access and security needs in areas where there are vendor openings and/or low redemption rates.
- Advance Diversity, Equity, and Inclusion (DEI) and Racial Equity efforts to build stronger community partnerships between WIC vendors and participants.

Strategy FS-1: Strengthen and make it easier for families to connect to the existing food and nutrition safety net, including WIC and FAP/SNAP.

Objective FS-1.1: During FY22 (October 2021-September 2022), reduce the "SNAP gap", or the gap between those eligible to enroll in SNAP and those actively enrolled in SNAP, by 20%, from 730,000 to 585,000 individuals.

- **Initiative FS-1.1.1:** Partner with Benefits Data Trust on MI Benefits Center to enroll 4,000 new SNAP clients during 2022.
- **Initiative FS-1.1.2:** Pair SNAP enrollment with Medicaid redetermination process at the conclusion of the Public Health Emergency period.
- **Initiative FS-1.1.3:** Conduct three text outreach campaigns to SNAP gap residents during 2022.

Objective FS-1.2: By December 2024, achieve a 95% SNAP participation rate through outreach, engagement, and collaboration.

- **Initiative FS-1.2.1:** Expand early access to SNAP to improve nutritional outcomes.
- **Initiative FS-1.2.2:** Establish a learning network of SNAP outreach partners to share best practices.

Strategy FS-2: Capture information on areas and conditions of food insecurity statewide to improve awareness and enable strategic decision making.

Strategy FS-2: Capture information on areas and conditions of food insecurity statewide to improve awareness and enable strategic decision making.

- **Initiative FS-2.0.1:** Systematically identify and catalogue areas of food insecurity across Michigan and create a comprehensive Food Insecurity map that captures SNAP enrollment, Michigan Department of Education (MDE) feeding programs, food bank locations, and demographic data from the American Community Survey (ACS).
- **Initiative FS-2.0.2:** Map SNAP retailer locations to identify areas with few to no retailers accepting SNAP.

Strategy FS-3: Increase awareness and utilization of food and nutrition programs for older adults (seniors, people who are elderly, and aging), implemented by the MDHHS Behavioral and Physical Health and Aging Services Administration.

Strategy FS-3: Increase awareness and utilization of food and nutrition programs for older adults (seniors, people who are elderly, and aging).

- **Initiative FS-3.0.1:** Expand access to Senior Project FRESH/Market FRESH to at least one additional underrepresented area.
- **Initiative FS-3.1.2:** Increase awareness and utilization of nutrition programs funded by the Behavioral and Physical Health and Aging Services Administration.
- **Initiative FS-3.1.3:** Continue to offer home-delivered meals through the Program All-inclusive Care for the Elderly (PACE) and the MI-Choice Waiver program.

Senior Project FRESH/Market FRESH provides participants with free nutrition counseling and $20 in coupons that can be exchanged for fresh fruits, vegetables, and other healthy foods sold at local farmers markets and roadside stands.

MDHHS Behavioral and Physical Health and Aging Services Administration programming

The Behavioral and Physical Health and Aging Services Administration administers nutrition programming for older adults through its aging network partners. 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. In addition to nutritious meals, the programs offer opportunities for social interaction and help decrease feelings of isolation. Nutrition programs provides a vital link to other supportive services available in local communities.

The **Program All-inclusive Care for the Elderly (PACE)** is an innovative model of community-based care that enables elderly individuals, who are certified by their state as needing nursing facility care, to live as independently as possible. PACE provides an alternative to traditional nursing facility care by offering pre-paid, capitated, comprehensive health care services.

The **MI-Choice Waiver** is a managed care program that provides home and community-based services for aged and other disabled adults who meet the nursing facility level of care. The program's goal is to provide long-term services and supports

Strategy FS-4: Continue to expand on the innovative and collaborative efforts to provide food benefits that were implemented in response to the COVID-19 pandemic.

Strategy FS-4: Continue to expand on the innovative and collaborative efforts to provide food benefits that were implemented in response to the COVID-19 pandemic.

Successful initiatives to derive best practices from and guide future efforts:

- Partnership with the Food Bank Council of Michigan to provide Quarantine Food Boxes to older adults who were unable to access existing food distribution sites.
- Partnership with the Community Action Agency Network to provide Quarantine and Hygiene Boxes (Q-Boxes) to low-income individuals and families isolating from exposure or recovering from COVID-19.
- Partnership with the Michigan Department of Education to provide supplemental food assistance benefits to students who have temporarily lost access to free or reduced-price school meals due to the pandemic through the Pandemic EBT (P-EBT) Program.

Strategy FS-5: Implement initiatives targeting racial injustice and inequity in food and nutrition.

Strategy FS-5: Implement initiatives targeting racial injustice and inequity in food and nutrition.

- **Initiative FS-5.1.1:** Pilot an equity impact assessment tool to ensure policies, practices, and programs are developed with an equity framework, consider systemic inequities, and examine potential impacts.
- **Initiative FS-5.1.2:** Capture information on areas and conditions of food insecurity statewide to identify disparities and inform future strategies.
- **Initiative FS-5.1.3:** Promote Breastfeeding Advocates of Color, a peer support network of breastfeeding professionals of color, trying to address disparities and improve breastfeeding rates.
- **Initiative FS-15.1.4:** Expand farmers markets into at least one additional underrepresented area in Michigan, such as a low-income area, an area considered a food desert, or a Native American or tribal organization.
- **Initiative FS-5.1.5:** Initiate collaborative discussions with at least two Native American organizations, urban and/or tribal, regarding participation in nutrition programs for older adults.

MDHHS Opportunity Administration programming

The **Food Assistance Program (FAP)/Supplemental Nutrition Assistance Program (SNAP)** provides temporary food assistance for eligible low-income families and individuals.

The **Restaurant Meals Program** provides certain individuals who receive Food Assistance Program (FAP) benefits with the ability to use their Michigan Bridge Card to purchase prepared food from participating restaurants.

Opportunities to explore to support people made vulnerable to food insecurity for the 2023 Social Determinants of Health Strategy

Through a process of ongoing engagement with stakeholders, MDHHS Policy and Planning will identify additional opportunities to support people made vulnerable to food insecurity for the 2023 Social Determinants of Health Strategy. These opportunities include:

- ***Ideate and develop innovative initiatives to improve access to nutritious food.***
- ***Address affordability of food.***
- ***Expanding programs targeting racial injustice and inequity in food and nutrition.***
- ***Mitigate/eliminate immediate barriers to healthy eating.***
- ***Develop innovative ways to go the "last mile" – getting food to people, not people to food.***

A comprehensive list of additional opportunities to explore is included in Appendix D.

Priority: Streamlining processes to improve access to food benefits

This priority includes an inward look at MDHHS programs and policies that support food security. Process and quality improvement efforts are needed to best serve Michigan residents. This could include enhancements to MI Bridges as well as other data-sharing and system interoperability solutions.

2022 strategic objectives to support streamlining processes to improve access to food benefits:

Strategy FS-6: Remove immediate and systemic barriers to access for food and cash assistance programs through process and program improvements.

Strategy FS-6: Remove immediate and systemic barriers to access for food and cash assistance programs through process and program improvements.

- **Initiative FS-6.1.1:** Promote awareness of opportunities for residents to purchase eligible food items online using EBT benefits through SNAP outreach partners.
- **Initiative FS 6.1.2:** Improve services for English Language Learners (ELL) through review of existing language access procedures and policy, and by addressing gaps in services through implementation of new initiatives.
- **Initiative FS-6.1.3:** Promote awareness of the Restaurant Meals Program (RMP). Under this program, some recipients of the Food Assistance Program (FAP) may use their benefits to purchase meals from authorized restaurants in Michigan.
- **Initiative FS-6.1.4:** Review and update processes for information distribution to ensure food assistance programs and residents receive accurate and timely updates.
- **Initiative FS-6.1.5:** Assess the use of work-related sanctions and implement process improvements.

Strategy FS-7: Improve the* MI Bridges *platform to make the application and renewal process easier and more intuitive.

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.

Under **Project One Day**, assistance workers offer to help clients gather needed information, which speeds up the verification process. The goal is to get clients approved for all requested programs within one day – a process that could take up to 30 to 45 days in the past.

Strategy FS-7: Improve the MI Bridges platform to make the application and renewal process easier and more intuitive.

Objective FS-7.1: By December 2022, increase the number of applications being processed using Project One Day methodology to 90%.

- **Initiative FS-7.1.1:** Implement Project One Day and Project Renew within every MDHHS office to streamline the processing of assistance applications, increase client ease of recertification, improve customer service, and create efficiency gains in MDHHS' largest assistance programs.

Objective FS-7.1: By December 2022, increase the FAP/SNAP approval rate by 10% using Project One Day methodology.

Objective FS-7.3: By December 2024, reduce the throttle rate for MI Bridges calls by 20%.

- **Initiative FS-7.3.1:** Implement the Elderly Simplified Application Project to provide streamlined application and recertification for older adults.
- **Initiative FS-7.3.2:** Expand the use of benefits navigators (through phone assistance or providing in-person support) to assist individuals with completing the enrollment process for a range of assistance programs.

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

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

Objective FS-8.1: By October 2023, increase by 5% the number of Medicaid recipients who are cross-enrolled in the Food Assistance Program (FAP) and the Women, Infants, and Children (WIC) program.

- **Initiative FS 9.1a.** Expand pilot project of 2021 texting campaign to all WIC offices.

Objective FS-8.2: By December 2024, increase the number of children ages 5 and under who are cross-enrolled in Medicaid, the Women, Infants, and Children (WIC) Program, the Food Assistance Program (FAP), and State Emergency Relief (SER) program by 5%.

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

Objective FS-8.3: By December 2022, increase the number of referrals sent by community partners on behalf of clients from 0 to 50 through implementation of the MI Bridges Closed-Loop Referral Pilot Program**.**

- **Initiative FS-8.3.1:** Create the ability for pilot groups of MI Bridges Community Partners to send referrals to other Community Partners on behalf of clients.

Objective FS-8.4: By the end of December 2022, attain 60% of referrals that are successfully connected with services.

MI Bridges Closed-Loop Referral Pilot Program: In 2022, the No Kids Hungry Project will enhance the community partner navigator and referral functionality to improve residents' ability to access services and community partners' ability to coordinate services. The project will be a pilot with the Food Bank Council of Michigan and several food banks across the state. Current navigator and referral partner functionality in MI Bridges requires clients to initiate all interactions (connecting with navigators, searching for resources, and sending referrals). This project will test out the ability for community partners to do these things on behalf of a client. This project will increase access to critical services for residents and improve the ability of our community partners to serve residents in coordination with the department. The following changes will be made to MI Bridges for the pilot:

- Navigators and referral partners will have the ability to send referrals to additional community partners on behalf of clients.
- Clients will also be given the ability to request help using MI Bridges from Navigation partners before creating an account.
- Reporting features will include information on the outcomes of referrals.

PROMOTING THE CONNECTION BETWEEN FOOD SECURITY AND HEALTH

The MDHHS Policy and Planning Team has developed a robust communications strategy to promote the connection between food security and health. Engagement and outreach efforts will include webinars and other virtual events until in-person events can safely resume. A campaign will be developed to support the American Academy of Nutrition and Dietetics National Nutrition Month in March.

Opportunities to explore to support streamlining processes to improve access to food benefits for the 2023 Social Determinants of Health Strategy

Through a process of ongoing engagement with stakeholders, MDHHS Policy and Planning will identify additional opportunities to support streamlining processes for the 2023 Social Determinants of Health Strategy. These opportunities include:

- ***Improve support and funding for community-based initiatives working to address food insecurity in their communities.***
- ***Connect residents to assistance at every level by integrating services from existing programs and creating strong partnerships.***
- ***Connect farms and farmers markets to residents via online ordering platforms.***

A comprehensive list of additional opportunities to explore is included in Appendix D.

Priority: Alignment on key food security reforms

Community, local, and state partnerships allow us to reach communities and provide enhanced support. Alignment of efforts with existing stakeholders and exploring opportunities to align with additional partners are vital to ensure that programs are connected for a greater impact.

Strategy FS-9: Identify additional opportunities to align with recommendations from the Michigan Food Policy Council *and the* Michigan Poverty Task Force *to support people made vulnerable to food insecurity.*

The **Food Security Council (FSC)** was created by Governor Whitmer's Executive Order No. 2020-167 as an advisory body in the Department of Health and Human Services to adequately inform the state's response to food insecurity. It is charged with coordinating across state government and with industry and community stakeholders to ensure a broad range of input from relevant entities, reporting on best practices to ensure safe and effective food distribution to Michiganders in need.

Efforts are ongoing to finalize recommendations from the Food Security Council. As recommendations are released, MDHHS Policy and Planning will review them to identify opportunities for alignment.

The **Michigan Poverty Task Force** was created by Governor Whitmer's Executive Order No. 2019-19 as an advisory body in the Department of Labor and Economic Opportunity (LEO). It is charged with making recommendations to the governor on how to best coordinate and activate efforts within state government to lift Michigan families out of poverty and help them on a path to opportunity.

Michigan Poverty Taskforce recommendation directly related to food security:

End Asset Tests for Food Assistance

Michigan is one of only 16 states that has an asset test to obtain food assistance. While state officials took a step in the right direction by raising the asset test for food assistance from $5,000 to $15,000, the PTF strongly recommends that Michigan not use an asset test for food assistance at all. Asset tests can discourage low-income families from saving money, which leaves them vulnerable to food insecurity when emergencies arise. Conversely, if a family has a short-term financial win, they can find themselves disqualified from receiving needed food assistance. Since food assistance dollars are provided by the federal government, the state can save money by reducing the administrative costs of assessing families' eligibility.

Strategy FS-10: Leverage public-private partnerships and local coalitions to address systemic food access issues.

Strategy FS-10: Leverage public-private partnerships and local coalitions to address systemic food access issues.

- **Initiative FS-10.0.1:** Partner with the Food Bank Council of Michigan (FBCM) to provide funding for a pilot program that offers home delivery of charitable fresh and shelf-stable foods through the DoorDash courier service.
- **Initiative FS-10.0.2:** Partner with community-based organizations, including the Detroit Food Policy Council, to work with local stores to stock WIC-approved items.

Opportunities to explore to align on key food security reforms for the 2023 Social Determinants of Health Strategy

Through a process of ongoing engagement with stakeholders, MDHHS Policy and Planning will identify additional opportunities to support alignment on key food security reforms for the 2023 Social Determinants of Health Strategy. These opportunities include:

- ***Reform policies and programs to expand opportunities to access healthy food online and through locally based retailers.***

A comprehensive list of additional opportunities to explore is included in Appendix D.

Focus Area: Health Equity

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

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MEASURING HEALTH EQUITY

For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants. Though many objectives laid forth in this plan will measure average impact on the health of Michigan residents as a whole population, additional measurements are needed to show the impact on equity. A commitment to health equity requires accountability and evaluation of both the outcomes among populations that have been disadvantaged and the disparities between disadvantaged and advantaged groups.

This commitment to reducing disparities is also codified in federal and state law. Michigan Medicaid is required to monitor the quality and appropriateness of the health care services delivered by the participating Medicaid Health Plans (MHPs) to the 2.2 million beneficiaries in their care. **[10]** Disparities identification and reduction have been priorities for Michigan Medicaid for several years and they produce an annual report on their efforts. Both federal and state laws address the need to reduce racial/ethnic disparities in health care and outcomes. Federal regulations require that MHPs provide services "in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds." **[11]** The Affordable Care Act (ACA) includes language that prohibits discrimination under any health program or activity that is receiving federal financial assistance. **[12]** The ACA also includes improved federal data collection efforts by ensuring that federal health care programs collect and report data on race, ethnicity, sex, primary language, and disability status. **[13]**

On a state level, Michigan Public Act 653 of 2006 directs MDHHS to develop strategies to reduce racial and ethnic disparities, including the compilation of racial and ethnic specific data including, but not limited to, morbidity and mortality.

MDHHS provides an annual report to the Legislature on the department's efforts to address racial and ethnic health disparities, as required by Public Act 653. This legislation was passed by Michigan's 93rd Legislature in 2006 and became effective in January 2007.

Public Act (PA) 653 focuses on five racial, ethnic and tribal populations in Michigan: African American, Hispanic/Latinx, Native American, Asian American/Pacific Islander, and Arab/Chaldean American. In accordance with this law, MDHHS has the responsibility to establish a departmental structure to address racial and ethnic minority health disparities, monitor minority health, promote workforce diversity, and develop policy and actions to advance health equity as specified in the provisions of the act.

Measuring disparities in health, as well as disparities in opportunities for optimal health (including social determinants of health measures) is necessary to document progress and guide future efforts needed to advance health equity. Although MDHHS has tracked and reported on many health equity related measures, ensuring transparency and better access to relevant data is necessary to inform decision making. The specific metrics utilized to evaluate outcomes and the impact on equity for this strategy are currently being developed as part of a comprehensive data strategy.

Health Equity Goals and Objectives

The Health Equity focus area is the foundation for this work and is integrated throughout the strategy and its implementation. The strategy will take 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 overarching strategy outlines actions in 2022 to **support populations made vulnerable to adverse health outcomes**, **improve MDHHS-driven equity programs and policies**, and **strengthen community engagement to support community-driven solutions**. Current measures for 2022 are limited in scope, with a focus on improving internal programs and policies and seeking out opportunities for alignment. Looking ahead, stakeholders will develop and implement strategies to address systemic barriers to health equity.

Priority: Supporting populations made vulnerable to adverse health outcomes

In 2022, MDHHS will focus efforts on supporting populations made vulnerable to adverse health outcomes by tailoring interventions to people and communities that have been historically disadvantaged by policies, practices, and systems. This includes enhanced efforts to identify populations made vulnerable to adverse health outcomes.

2022 strategic objectives to support populations made vulnerable to adverse health outcomes:

Strategy HE-1: Increase access to health and social programs and services through immediate barrier mitigation.

Strategy HE-1: Increase access to health and social programs and services through immediate barrier mitigation.

- **Initiative HE-1.0.1:** Build on efforts working toward Integrated Service Delivery through transformative changes to **MI Bridges** and the assistance application to reduce the time necessary to apply for assistance and align with a new renewal form.
- **Initiative HE-1.0.2:** Improve services for English Language Learners (ELL) through review of existing language access procedure and policy and by addressing gaps in services through implementation of new initiatives.
- **Initiative HE-1.0.3:** Enhance systems and data sources that describe where gaps in cross-enrollment exist.
- **Initiative HE-1.0.4:** Evaluate programs to ensure and culturally competent services.
- **Initiative HE-1.0.5:** Evaluate opportunities for improved, human-centered design, including MDHHS office lobby configuration.
- **Initiative HE-1.0.6:** Collaborate with social determinants of health partners to mitigate immediate barriers associated with the coronavirus pandemic.

Opportunities to explore to support vulnerable populations for the 2023 Social Determinants of Health Strategy

Through a process of ongoing engagement with stakeholders, MDHHS Policy and Planning will continue to identify additional opportunities to support people made vulnerable to adverse health outcomes for the 2023 Social Determinants of Health Strategy. These strategies include:

- ***Mitigate and eliminate immediate and systemic barriers to health, including poverty and lack of access to basic needs, to ensure everyone has a fair opportunity to be as healthy as possible.***
- ***Increase opportunity and economic mobility for populations that have been historically disadvantaged by programs, policies, and systems.***
- ***Expand efforts to develop a comprehensive resource database to inventory existing initiatives and address gaps.***
- ***Enhance care coordination and connection to services.***

A comprehensive list of additional opportunities to explore is included in Appendix E.

Priority: Improve MDHHS-Driven Equity Programs and Policies

Efforts to advance health equity within the department are led by the Office of Equity and Minority Health (OEMH), within the Office of Race, Equity, Diversity, and Inclusion (REDI), and enhanced by recommendations from statewide task forces, including the Department of Labor and Economic Opportunity's (LEO) Poverty Task Force and the Coronavirus Racial Disparities Task Force. The Policy and Planning Office seeks to integrate existing efforts to advance health equity within the Social Determinants of Health Strategy, align efforts with statewide agencies, and integrate equity recommendations into all MDHHS programs and policies.

Strategy HE-2: Align efforts with statewide agencies and health equity partners to coordinate efforts and collate resources.

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- **Initiative HE-2.0.1:** Support priorities of the Office of Equity and Minority Health, including:
    - Support and initiate programs, policies, and applied research to address social determinants of health that contribute to health inequities for racial and ethnic minority populations in Michigan;
    - Collaborate in the development of Michigan Department of Health and Human Services prevention, health service delivery, and research strategies to improve health outcomes for racial and ethnic minority populations in Michigan; and,
    - Facilitate implementation of culturally and linguistically appropriate health services throughout the Michigan Department of Health and Human Services.

Strategy HE-2: Align efforts with statewide agencies and health equity partners to coordinate efforts and collate resources.

- **Initiative HE-2.2:** Engage in efforts related to the implementation of Michigan's Prosperity Roadmap, which outlines a comprehensive plan to leverage the state's nearly $6 billion in federal American Rescue Plan Act (ARPA) funding. The Plan, From Rescue to Prosperity: A Roadmap to Michigan's Future, focuses the state's ARPA resources in a coordinated matter across five key areas: infrastructure, fiscal health, thriving communities, a strong economy, and public health and safety.
    - Through a **Health in All Policies** approach, the Policy and Planning Office will coordinate efforts across the Department to provide a health lens to cross-sector initiatives by participating in interagency workgroups and building strategic relationships with state and local partners.
- **Initiative HE-2.3:** Provide support for the Michigan Department of Labor and Economic Opportunity (LEO) to implement the following initiatives:
    - Continue to implement process improvements to reduce sanctions in the Family Independence Program (FIP).
    - Conduct research on the state's use of federal Temporary Assistance for Needy Families (TANF) funding and evaluate barriers to state assistance programs.
    - Develop a coordinated plan to address the digital divide, which acts as a barrier for families accessing available economic, educational, health, housing, and safety services.
- **Initiative HE-2.4:** Support efforts to improve care delivery systems and eliminate disparities.
    - Members of the MDHHS Policy and Planning Team will serve on the Michigan Health & Hospital Association (MHA) Keystone Center health equity task force.
    - Members of the MDHHS Policy and Planning Team will serve on the Statewide Deferral Reduction Workgroup.

Strategy HE-3: Integrate recommendations from statewide Task Forces and entities supporting the advancement of health equity.

The **Michigan Coronavirus Racial Disparities Task Force** was created per Executive Order No. 2020-55 and will act in an advisory capacity to the Governor. It studies the causes of racial disparities and recommends actions to address historical and systemic inequities.

Recommendations from the Coronavirus Racial Disparities Task Force include:

- **Increase culturally competent data collection.** Incorporating a thoughtful and consistent emphasis on cultural competence when performing all essential public health functions, including data collection, creates a necessary foundation for efforts to reduce health disparities and enables professional to adapt programs to benefit individuals and groups from varying cultural backgrounds. Furthermore, improving cultural competence among public health practitioners could help reduce health disparities and improve the quality of care and health for everyone.
- **Fully leverage Health Information Technology and data to reduce racial health disparities.** Current gaps in Health Information Technology (HIT) and technology barriers have led to challenges in patient care. For example, different health care providers use different platforms that make it difficult to consolidate data to best serve patients. The Task Force identified ongoing issues with interoperability between systems, which prevents adequate and effective sharing of patient data. Improving access to data would better allow providers and policy makers to identify and address disparities. However, the lack of consistent data reinforces racial disparities. Therefore, the PCC Workgroup recommends the development of a central repository of data to share Electronic Health Records and other social service organizations.

The **Michigan Poverty Task Force** outlined 35 recommendations, including recommendations for economic policy, benefits policy, criminal justice policy, health, safety, and housing policy, and education policy. Their recommendations have incorporated into the 2022 strategy and will be further reviewed to identify opportunities for alignment in 2023 and beyond.

To review the full list of policy recommendations, please visit: www.Michigan.gov/LEO
Direct link: PTF recommendations

Strategy HE-4: Implement an* Equity Impact Assessment *that will guide the decision-making process for evaluating the potential impacts of existing and future policies and programs.

Strategy HE-4: Implement an Equity Impact Assessment that will guide the decision-making process for evaluating the potential impacts of existing and future policies and programs.

- **Objective HE-4.0.1:** Implement the **Equity Impact Assessment** in the Policy and Planning Office to refine policy and programs and identify and implement opportunities for improvement.

The **Equity Impact Assessment** is a decision-making model that MDHHS has begun to introduce to provide a concrete, organized, and more objective way of assessing processes, budget allocations, policies and programs through an equity lens. Inequities in programs and outcomes are sometimes unintentional and embedded into government systems and may be amplified by implicit bias or the blind spots of leaders. The Equity Impact Assessment will guide MDHHS leaders to think through the full implications these programs have on minority populations. This informed perspective helps reduce disparities, inequities, and unintended discrimination in policy development and program deployment.

Priority: Strengthen community engagement to support community-driven solutions

The strategy emphasizes engaging with residents, especially those with lived experience, to develop policies and funding that supports community-driven solutions. Michigan regions are diverse and therefore need community-driven strategies and targeted policies to support the needs of each community. Cross-sector collaboration at the state and community level allows us to develop robust and targeted strategies.

Strategy HE-5: Engage benefits recipients and community members to obtain experiential knowledge to improve opportunities and services provided.

Strategy HE-5: Engage benefits recipients and community members to obtain experiential knowledge to improve opportunities and services provided.

- **Initiative HE-5.0.1:** Develop and distribute surveys following benefits enrollment and program participation with strategic questions aimed at identifying needs and assessing services.
- **Initiative HE-5.0.2:** Ensure comprehensive input by engaging with residents who could or do not qualify for services, not just those who are actively enrolled.
- **Initiative HE-5.0.3:** Offer various opportunities to provide feedback, including the use of different platforms (e.g., email, text, mail surveys), wide ranging meeting times, and designing language-accessible surveys and questionnaires.
- **Initiative HE-5.0.4:** Develop incentives for engagement to compensate participation from community members.
- **Initiative HE-5.0.5:** Facilitate connections with community organizations that are implementing initiatives on a local level to ensure the needs of each community are met.
- **Initiative HE-5.0.6:** Facilitate connections between program areas to identify outreach opportunities and coordinate efforts between programs with overlapping services.

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

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

• **Initiative HE-6.0.1:** Through the SDOH Accelerator Grant Proposal (RFP), MDHHS will support local health departments, Family Resource Centers, Regional Perinatal Quality Collaboratives, and other local organizations by:
  ○ Providing resources, including technical assistance and funding, to support strategic planning processes for regional collaboration, capacity building, and systems change work at a local level.
  ○ Facilitating collaborative efforts to reduce the disparate impact of the social determinants of health.
  ○ Providing technical assistance to local partners to support community-driven health equity efforts.

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

Opportunities to explore to strengthen community engagement to support community-driven solutions for the 2023 Social Determinants of Health Strategy

Through a process of ongoing engagement with stakeholders, MDHHS Policy and Planning will identify additional opportunities to strengthen community engagement for the 2023 Social Determinants of Health Strategy. These strategies include:

- ***Enhance partnerships with interagency departments and community stakeholders to create policies, systems, and environments to advance health equity and improve population health.***

A comprehensive list of additional opportunities to explore is included in Appendix E.

EXPANSION OF THE HEALTH EQUITY FOCUS AREA

Looking ahead to 2023 and beyond, the Health Equity focus area will expand its priorities to include utilizing data and analytics to **understand and account for progress in addressing health disparities**, **increase health equity policy development**, and more explicitly **address the impact of structural racism, marginalization, and discrimination** that are driving forces of the social determinants of health and health inequities.

Priority: Address the impact of structural racism, marginalization, and discrimination that are driving forces of the social determinants of health and health inequities.

Discrimination is, "a socially structured action that is unfair or unjustified and harms individuals and groups. It can be attributed to social interactions that occur to protect more powerful and privileged groups at the detriment of other groups." **[14]**

Discrimination, including racism, whether implicit or overt, is a driver of health disparities that have resulted in longstanding health inequities. To advance health equity, the policies, practices, and systems that perpetuate discriminatory programs and implicit bias in service delivery must be identified, addressed, and dismantled.

Achieving health equity is rooted in principles of racial equity

MDHHS has chosen to have an intentional, but not exclusive, focus on race as a way to address systemic racism and other forms of oppression and exclusion. A racial equity approach allows the department to design policies, practices, and strategies that result in fair and equitable opportunities for everyone. Using this approach compels the Department to:

1. Understand the historic and current drivers of health and social inequalities, including racism, sexism, heterosexism, ableism, and ageism;
2. Identify how MDHHS contributes to, and can deconstruct these inequalities;
3. Work in partnership with the communities we serve to achieve equity;
4. Use statistical data to assess and monitor the impact of diversity, equity and inclusion initiatives on the workforce;
5. Monitor the effectiveness of our efforts; and
6. Ensure sustainability.

MDHHS DIVERSITY, EQUITY, AND INCLUSION PLAN

Strategy: Support implementation of the* Minority Health Law (PA 653)*, aimed at addressing racial and ethnic health disparities in Michigan to improve health equity.

Public Act 653 requires MDHHS to:

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

Strategy: Increase opportunities for MDHHS staff to translate knowledge into action to address health equity.

MDHHS Diversity, Equity, and Inclusion (DEI) efforts are led by the Office of Race Equity, Diversity, and Inclusion (REDI). Workforce development is underway to strengthen staff knowledge and skills regarding health equity.

Strategy: Increase the ability of MDHHS staff to translate knowledge into action to address health equity.

- **Initiative:** Provide ongoing educational and training opportunities for Department staff to incorporate a health equity framework into programs and services.
- **Initiative:** Continuously explore funding for health equity training and technical assistance opportunities.
- **Initiative:** Offer Implicit Bias and Anti-Racism training for MDHHS staff.

Meaningful collaboration to advance equity and bolster impact

The Health Equity focus area reaches across the department and highlights the intersectionality of the strategy with the broader work of the MDHHS Office of Equity and Minority Health (OEMH). The Policy and Planning Office is also supporting the development of the MSHDA Statewide Housing Plan and the Poverty Task Force Annual Report, which will focus on social determinants of health. Additionally, recommendations from the Coronavirus Racial Disparities Task Force will be integrated into the broader strategy to help address health disparities.

Work is ongoing to inventory additional health equity efforts and develop objectives.

Data Strategy

Maximizing data to support SDOH and health equity efforts

Housing stability, food security, and other social factors greatly affect the health and wellness of residents, particularly for those who experience racial disparities or other social vulnerabilities. MDHHS will work with many partners, including the Health Information Technology (HIT) Commission to develop and implement an updated health IT strategy to address how to coordinate care beyond clinical spaces and integrate health-related social care data. This innovative approach, of leveraging health IT to address both clinical outcomes and social determinants of health is outlined in the *Bridge to Better Health Report* released by the HIT Commission and MDHHS in February 2022. This report, along with collaboration with many other pioneers and leaders in this space, will be leveraged to help support the work of the SDOH Strategy.

Strategy DS-1: Analyze quality and complete integrated data sets to measure the effects of policies and programs that address inequities.

Strategy DS-1: Analyze quality and complete integrated data sets to measure the effects of policies and programs that address inequities.

- **Initiative 1.0.1:** Through the Race & Ethnicity in **Master Person Index (MPI)**, funded by the Michigan Health Endowment Fund, MDHHS strives to standardize and better aggregate how State agencies collect and report race, ethnicity, gender, gender identity, and sexual orientation data.

The **Master Person Index (MPI)** uses a probabilistic algorithm to link and match data across the disparate MDHHS systems, creating a holistic view of an individual across the MDHHS Enterprise while also enforcing rigorous data privacy and security standards. The initiative seeks to design, develop and implement the addition of Race and Ethnicity values in the MDHHS Master Person Index (MPI).

Strategy DS-2: Develop an interoperable infrastructure between health care and social care organizations through the establishment of a Closed-Loop Referral System.

As part of the of the 2022-2024 strategy, *Michigan's Roadmap to Healthy Communities*, closed-loop referral policy and statewide recommendations will be developed through engagement across MDHHS and with statewide stakeholders. Effective closed-loop referral policy would support the efforts of the health equity, food security, and housing stability focus areas.

A **Closed-Loop Referral System** is one that successfully secures the right resources for residents at the right time based on screening and assessment questions. The system shares pertinent information to support holistic approaches to improving health outcomes to stakeholders such as clinical providers, community-based organizations (CBOs), or State safety net agencies. The "closed-loop referral" is a tech-enabled workflow that provides a real-time view of the status of a resident's care coordination, assigns tasks to the care team in pursuit of meeting health-related social care needs, and reporting on outcomes of referrals and services provided (or not provided) by coordinating agencies. Closed-loop referrals can help ensure that the social determinants of health (SDOH) are addressed before a resident leaves a clinical or community-based provider, via integrated assessments that trigger next steps based on results of a screening.

2022 Milestones

1. Survey Michigan's nine Managed Care Organizations (i.e., Medicaid Health Plans) to track their current screening system platform as well as barriers and opportunities for closed loop referrals based on current system.
2. Implement the **No Kids Hungry MI Bridges Closed Loop Referral Pilot**; evaluate barriers, opportunities, and recommendations for expansion beyond food security.
3. Host brainstorming sessions with MDHHS, state agency and local partners (Community Health Innovation Regions (CHIRs), Michigan Coronavirus Racial Disparities Taskforce (RDTF), Poverty Task Force, etc.) to garner input regarding policy needed and best practices to support closed loop referrals; a summary of MHPs survey and CHIRs evaluation will be shared as well as progress on **MI Bridges Pilot**.
4. The MDHHS Policy and Planning Office will perform an environmental scan and literature review of current national standards practices and best practices.
5. MDHHS will improve engagement with CBOs to develop policy and funding that will increase IT capability and uptake among social service partners.

2023 Milestones

1. Implement the RDTF Primary Care Connections (PCC) workgroup recommendation to fully leverage health information technology:
    - Enhance and support regional Community Information Exchange (CIE) efforts, leveraging the statewide Health Data Utility infrastructure;
    - Ensure that closed-loop screening, assessments, and referrals are optimized for use within and between regional Community Information Exchanges (CIE) initiatives; and,
2. Provide funding to support community-based organizations onboarding to state Health Data Utility infrastructure for coordinated connectivity and evaluation and determine a strategy to show the value of capturing social data, how it will be protected, and other concerns.
3. Assess electronic health records (EHR) needs for local health departments (LHD), Federally Qualified Health Centers (FQHC), and Federal Records Centers (FRC) to support the needed infrastructure for closed-loop referrals.
4. Integrate lessons learned from the **No Kids Hungry Closed Loop Referral Pilot in MI Bridges** and develop MDHHS standards/best practices.

No Kids Hungry Closed Loop Referral Project in MI Bridges

The No Kids Hungry Closed-Loop Referral Project in MI Bridges seeks to increase access to critical services for residents and improve the ability of community partners to serve residents in coordination with the Department. As a result, we expect to see an increase in number of referrals sent by community partners on behalf of clients and an increase in the number of requests for assistance with MI Bridges submitted by users before creating accounts. Furthermore, we expect to see an increase in attachment to services among clients based on the tracking, support, and follow up provided by community partners. Ultimately, a greater attachment to food support services will lower the incidence of food insecurity in the state.

Strategy DS-3: Implement a robust social determinants of health data strategy.

Strategy DS-3: Implement a robust social determinants of health data strategy.

Improve data quality

- In alignment with the State Health IT strategy, implement cross-sector conformance initiatives to improve source data shared through CIE and account for the effects of incomplete, biased, or inaccurate demographic data.
- Enhancing conformance and data quality will improve stakeholder ability to evaluate program design and implementation.
- Improving alignment between clinical and social care providers by engaging cross-functional public entities, such as the Michigan Coronavirus Racial Disparities Taskforce, to better understand where gaps and barriers exist in data sets that describe quality of life for communities of color.
- Support the development of statewide Health Data Utility to facilitate the regional sharing of health, social care, and demographic data.
- Continue to partner and align with advisory entities, like the Michigan Health IT Commission, the Michigan Food Bank Council, the Michigan Health and Hospital Association, to continually improve upon coordination and data sharing solutions that support health equity efforts and metrics development to measure progress.

Produce complete data sets

- Collect and report data on age, gender, geography, race/ethnicity, socioeconomic status, disability, sexual orientation, and other health disparities, as data become available.
- Support statewide efforts to develop regional-based data collection and resource allocation to identify where disparities and service scarcities most affect vulnerable communities.
- Integrate information on residents we serve into more complete records that account for longitudinal outcomes, especially to enable identification of disparities.
- Leverage cross-enrollment data for localized utilization and needs evaluation to guide population health activities, including the design and implementation of evidence-based interventions.

Strategy DS-3: Implement a robust social determinants of health data strategy.

Measure the effects of policies and programs

- Produce public data sets and dashboards for partners and residents to analyze and track progress in statewide efforts to address disparities and inequities.
- Develop quality improvement metrics for public programs that address racial health disparities, access to support services, and closed loop referral.
- Developing strategies to improve how the State of Michigan leverages evidence on program performance and disparities.
- Equipping the MDHHS workforce with the ability to access, comprehend, and leverage data on the residents we serve to identify, intervene, and reduce disparities.

Strategy DS-4: Develop capacity for regional collaboratives and academic institutions to evaluate community intervention strategies to end health disparities.

Strategy DS-4: Develop capacity for regional collaboratives and academic institutions to evaluate community intervention strategies to end health disparities.

- **Initiative DS-4.0.1:** Create scalable statewide infrastructure through Health Data Utility to connect regional collaboratives with the State and other partners to better coordinate, evaluate utilization, and identify service scarcities.
- **Initiative DS-4.0.2:** Health equity data gaps will be identified and mitigated when feasible by MDHHS.
- **Initiative DS-4.0.3:** Identify and work with regional collaboratives (e.g., Community Health Innovation Regions, organizations that facilitate community-clinical linkages) and academic institutions to determine and disseminate replicable and evidence-based practices to end health disparities.
- **Initiative DS-4.0.4:** Create and disseminate evaluations and/or reports of regional collaborative program intervention strategies addressing health disparities.

Next Steps for Michigan

Moving toward a more holistic approach to improve health outcomes and advance equity

The 2022-2024 MDHHS SDOH Strategy, *Michigan's Roadmap to Healthy Communities*, is an iterative strategy. It will continue to improve through robust engagement, data analysis, and environmental scans of national best practices. The strategy establishes focus areas and a framework for future efforts while detailing goals, objectives, and policies, and implementing actions that move Michigan towards a more holistic approach to improving health outcomes and advancing health equity.

MDHHS will also continue to review data, and identify opportunities to improve data, to ensure that the strategy is informed by current and emerging trends. As emerging opportunities arise, like the Build Back Better Act, MDHHS will explore opportunities to ensure that a health lens is applied as we all work together to support Michigan communities. An environmental scan of national best practices is underway, as MDHHS plans to move more upstream towards establishing economic mobility and environmental health as focus areas for 2023-2024. Supporting regional collaboration, as well as continued diverse stakeholder engagement, are key approaches to ensure that the strategy evolves with the everchanging landscape in Michigan.

SUPPORT REGIONAL COLLABORATION

Collaboration at the local level can be supported through state policy and funding mechanisms. Community led solutions that include cross-sector collaboration build community capacity to drive improvements and create innovative solutions to support community residents. Through the SDOH Accelerator Grant Proposal (RFP), MDHHS will support regional collaboration through local health departments, **Family Resource Centers**, **Regional Perinatal Quality Collaboratives**, and other local organizations. The Accelerator Grant will provide funding to deepen efforts to address social determinants of health in communities. The focus of this work is twofold – to change community conditions so they better support health and well-being to assist individuals with health-related social needs. The evaluation of this project in conjunction with the evaluation of the Community Health Innovation Regions (CHIRs) will help Michigan develop a roadmap for supporting regional collaboration to address social determinants of health throughout Michigan.

RFP Release Date: March 2022

Grant Activities: June 2022- September 2023

Regional collaboration

Family Resource Centers (FRC) are community-based or school-based, flexible, family-focused, and culturally sensitive hubs of support and resources that provide programs and targeted services based on the needs and interests of families.

The **Regional Perinatal Quality Collaboratives (RPQC)** are key drivers of the Mother Infant Health and Equity Improvement Plan (MIHEIP). There are nine RPQCs, representing every Prosperity Region in Michigan. Each RPQC convenes regular meetings with diverse stakeholders and partners to address their respective region's largest concerns with individualized attention.

RPQCs are charged with improving birth outcomes for moms, babies and families through data-driven quality improvement projects that are tailored to the strengths and challenges of each region. The RPQCs utilize both community and clinical approaches by bringing together health care professionals, community partners, families, faith-based organizations, Great Start Collaboratives, home visiting agencies, and others in a unified, collaborative effort.

ESTABLISHING VEHICLES TO INFORM AND DRIVE THE STRATEGY

As the Poverty Task Force, COVID-19 Racial Disparities Task Force, State Housing Plan Interagency Workgroup, and many others acknowledge the need to address social determinants of health, it is the ideal time to establish an Interagency SDOH Workgroup and, eventually, a statewide Coalition that will include representation across Michigan from community, as well as private and public, stakeholders.

Action teams and workgroups, comprised of state and local partners, will continue to meet to determine opportunities for alignment, improvement, and innovation.

Additionally, there will be a reconvening of the MDHHS Health Information Exchange Workgroup who will work collaboration with the HIT Commission, MDHHS leadership and stakeholders to continue to expand our health information exchange capabilities and develop best practices for data governance.

Establish Interagency SDOH Workgroup by April 2022

Establish Statewide SDOH Advisory Coalition by October 2022

IMPLEMENTATION OF THE STRATEGY

An implementation guide with recommendations and toolkits will be developed and shared to continue alignment across sectors and support continued collaboration.

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Appendix A: Morbidity and Mortality Indicators with a High Index of Disparity by Race and Ethnic Background in Michigan

Table 2: Morbidity Prevalence with a High Index of Disparity by Race and Ethnic Background in Michigan[1]

Morbidity Indicators	African American, NH	Hispanic/ Latinx[a]	A/PI[b], NH	Native American	Arab	White, NH	Total	Index of Disparity[c] (ID)
COPD prevalence % (ever told)	10.1%	5.2%	7.6%	16.3%	3.3%	7.2%	7.6%	48.2%
Any cardiovascular disease prevalence % (ever told)	10.2%	10.3%	3.6%	14.1%	9.0%	8.2%	8.5%	29.0%
Asthma prevalence % (ever told)	19.9%	12.9%	7.3%	24.3%	12.5%	16.2%	16.3%	28.5%
Diabetes prevalence % (ever told)	13.2%	14.2%	12.9%	9.2%	12.1%	8.8%	9.6%	26.4%
Cancer prevalence % (ever told)	6.6%	4.7%	10.7%	11.5%	9.1%	11.6%	10.7%	25.0%
Obese prevalence % (ever told)	40.7%	41.8%	13.7%	36.6%	27.2%	31.0%	32.1%	24.5%

1: Numbers in red are the highest for indicator and numbers in blue are the second highest.
NH = Non-Hispanic, A/PI = Asian/Pacific Islander
a: Population defined as "Hispanic" in data sources for "Health status and behaviors" and "Morbidity and mortality"
b: Population defined as "Asian" in data sources for "Health status and behaviors" and "Morbidity and mortality"
c: The Overall Population Index of Disparity (ID) is a measure of how much disparity exists in the population. It summarizes how far each group is from the population average. ID=0% indicates no disparity in the population; higher values of ID indicate increasing levels of disparity in the population for that indicator and can be greater than 100%. ID does not reflect health status but reflects how much variation or disparity exists.
Data sources: Morbidity – 2015-2017 Michigan Behavioral Risk Factor Survey (BRFSS) Prevalence Estimates.

Table 3: Mortality Rates with a High Index of Disparity by Race and Ethnic Background in Michigan[1]

Mortality Indicators	African American, NH	Hispanic/ Latinx[a]	A/PI[b], NH	Native American	Arab	White, NH	Total	Index of Disparity[c] (ID)
Kidney disease mortality per 100,000	28.3	21.1	***	***	27.7	13.1	15.0	56.4%
Diabetes mortality per 100,000	35.3	26.8	7.8	33.3	37.0	20.2	21.9	46.0%
Chronic lower respiratory disease mortality per 100,000	31.6	17.6	***	65.0	28.8	46.5	44.2	35.2%
Heart disease mortality per 100,000	272.4	120.8	71.2	172.6	267.3	187.2	194.9	32.3%
Accidents mortality per 100,000	64.3	44.8	15.8	73.4	38.6	51.2	52.1	29.3%
Stroke mortality per 100,000	51.8	31.3	26.3	30.0	62.2	38.6	39.9	28.3%
Suicides mortality per 100,000	9.7	12.1	6.5	***	12.8	16.4	15.0	27.1%

1: Numbers in red are the highest for indicator and numbers in blue are the second highest.
*** = Data Not Available
NH = Non-Hispanic, A/PI = Asian/Pacific Islander
a: Population defined as "Hispanic" in data sources for "Health status and behaviors" and "Morbidity and mortality"
b: Population defined as "Asian" in data sources for "Health status and behaviors" and "Morbidity and mortality"
c: The Overall Population Index of Disparity (ID) is a measure of how much disparity exists in the population. It summarizes how far each group is from the population average. ID=0% indicates no disparity in the population; higher values of ID indicate increasing levels of disparity in the population for that indicator and can be greater than 100%. ID does not reflect health status but reflects how much variation or disparity exists.
Data sources: Mortality –2018 Michigan Resident Death Files/Division for Vital Records & Health Statistics. Starting in 1999 disease mortalities are defined with the following ICD-10 codes: Accidents Mortality codes V01-X59,Y85-Y86, AIDS Mortality codes B20-B24, All Cause Mortality all ICD codes, Alzheimer's Mortality codes G30-G30.9, Cancer Mortality Per codes C00-C97, CLRD Mortality codes J40-J47, Diabetes Mortality codes E10-E14, Heart Disease Mortality codes I00-I09.I11.I13.I20-I51, Homicide Mortality codes U01-U02.X85-Y09.Y87.1, Kidney Disease Mortality codes N00-N07.N17-N19.N25-N27, Liver Disease Mortality codes K70.K73-K74, Pneumonia and flu Mortality ICD-10 codes J09-J18, Septicemia Mortality codes A40-A41.9, Stroke Mortality codes I60-I69, Suicides Mortality codes U03.X60-X84.Y87.0.

Appendix B: Brainstorming Session Summaries

Housing Stability Brainstorming Session Summary

Tuesday, December 14, 2021 from 10-11:30am

Meeting Summary

- More than 120 people representing organizations that lead and support housing stability efforts contributed to the meeting. Staff from MDHHS facilitated the meeting and breakout sessions.
- Participants were provided an overview of the overarching strategy and the priorities of its Housing Stability Focus Area. These priorities include supporting vulnerable populations, holistic approaches to healthy housing, and addressing homelessness housing access.
- Participants were asked to join a breakout session most relevant to their work to discuss opportunities for improvement and alignment, as well as innovative ideas for each priority.
- Feedback from each breakout session was captured and compiled. Input will be synthesized and incorporated into the overarching strategy.

Discussions

In breakout sessions, participants learned more about specific programs related to each of the housing stability priorities. While considering the identified priority, participants were asked:

1. What are the gaps in current service?
2. Where are there areas for alignment (internal or across agencies)?
3. How can we better improve opportunities to meet people where they are?

Summaries from these discussions is below.

Breakout 1 – Holistic approaches to healthy housing: Weatherization and LIHWAP

A brief overview of the MDHHS Weatherization Assistance Program and Low-Income Household Water Assistance Program (LIHWAP) were provided.

- Challenges identified include workforce shortages and program deferrals.

Gaps in current services:

- Ensuring both homeowners and renters have access to programs, as well as residents in multifamily housing.
- Assistance for deliverable fuel; rural communities are left behind.
- Addressing housing affordability.
- Addressing indoor air quality as a measure of a healthy home.

    - Includes the health risks of gas and propane stoves.
    - Compartmentalizing multifamily housing units to prevent the spread of COVID (or other health hazards).
- Wells, septic, and ground tanks are often left out of water quality programs.
- Addressing water affordability:
    - Includes reducing water use by installing low-flow fixtures, repairing leaks, and emphasizing outdoor water conservation efforts (also reduces stress on the storm system).
- Rate design reform: opportunity to fix charges based on property value, rather than flat rate.
- More data is needed to identify the impact of weatherization efforts and home improvements, including the reduction of medical intervention, cost savings (should be reinvested in these programs).

Areas for alignment:

- Connecting weatherization programs to job training and placement programs to help address both employment barriers and staffing limitations.
- Broadening home assessments and utilizing them as a tool to better direct and align residents with services they need.
- Identifying and implementing best practices to simplify work.
- Connection to economic development.
- Working with local and county Treasury offices to assist homeowners that are unable to pay their property taxes because of excessively high utility costs.
- Alignment with LARA Michigan Public Service Commission (MPSC).

Opportunities to better meet people where they are:

- Outreach to manufactured home residents.

Additional comments:

- Addressing diminishing return from certain weatherization measures (Ex. installing a 30-year furnace in a manufactured home that may only have five years of use left); more beneficial to replace the home by bundling funding sources.
- Paperwork and the bidding process for DHHS projects can be a barrier for contractors.

Further reading / relevant links:

- Michigan Upper Peninsula Housing Baseline Study
- Addressing links between poverty, housing, water access and affordability in Detroit
- Growing water affordability crisis touches all Michiganders, urban and rural
- Book: Scarcity: The New Science of Having Less and How It Defines Our Lives

Breakout 2 – Supporting vulnerable populations: Pregnant and parenting women, families, youth, and older adults (seniors, the elderly and aging)

Gaps in current services:

- Need more HUD-subsidized housing for migrant workers.
- Housing is only being built in the most 'desirable' areas, not where housing is needed
- Work force shortages to repair deteriorated homes.
- Need for housing for low-income older adults that offers wrap-around health services.
- Need for retrofitting homes (gap in direct grant financial assistance) to accommodate older adults aging in place.
- Need more housing resources in the 211 system.
- Access to reliable internet service/internet devices.
- Need for standardized application/intake processes that is easy to complete.

Areas for alignment:

- Alignment with zoning boards; share best practices and ensure equity.
- Better alignment with landlords to ensure residents are provided with safe, healthy housing.
- Identify a representative from MSHDA to sit on council that oversees farmworker housing and other migrant service agencies.
- Partnership with Housing North; offer tools for implementing affordable year-round and rental housing (such as zoning ordinances, etc.).

Opportunities to meet people where they are:

- Intentional outreach for populations with low literacy levels.
- Provide support for people that lack understanding/comfort with tech.
- Ensure kind, inclusive communication from program representatives.

Additional comments:

- Children's Trust Fund will be implementing a pilot program in 2022 to support Family Resource Centers (FRC) to help remove barriers in access to resources.
- Opportunity for DHHS to host a learning collaborative.

Further reading / relevant links:

- National Well Home Network Support and Services at Home (SASH) Program

Breakout 3 – Supporting vulnerable populations: Justice-involved and returning citizens and recovery housing/SUD-supportive housing

Gaps in services:

- Support for justice-involved (JI) families and residents engaged in eviction court.
- Lack of data collection; need more inclusive, accurate demographic data and IEP, educational needs/assets.
- Access to internet service/devices to access digital resources.
- Lack of recovery housing.
- Need for holistic housing to meet basic needs and provide economic/social support.
- Need for ongoing case management for JI/returning citizens, recovering population, and chronically homeless.
- Need for childcare and job training services.
- Need for financial support to ensure individuals do not lose housing voucher while in long-term treatment (inability to pay).
- Need for centralized, accessible, localized (organized by region/county/prosperity region/PIHP) resource database.
- Address zoning barriers.
- Need for more flexible funding; federal funding cannot be used to buy houses (just repair) and Medicaid cannot be used for recovery housing.

Opportunities for alignment:

- Data utilization to collaborate across siloes.
- Working with faith-based networks.
- Advocacy to HUD to include more supportive services in tenancy support.
- Coordinate Housing Choice Voucher (federal) and Housing Assessment and Resource Agency (HARA) (state) programs to provide services after housing is secured.
- Support for Rapid Rehousing Programs.
- Coordination with Offender Success Agencies (MDOC).
- Collaboration with reentry professionals (parole and probation officers); key advocates to train in accessing services, facilitating referrals, and aligning state resources.

Opportunities to meet people where they are:

- Provide opportunities to hear from those served; provide incentives for participation.

Further reading / relevant links:

- Calvin Prison Initiative

Breakout 4 – Addressing homelessness housing access

- Notes from this breakout are still being compiled; an update will be provided soon.

Food Security Brainstorming Session Summary

Thursday, January 13, 2022, from 2-3:30pm

Meeting Summary

- More than 40 people representing organizations that lead and support food security efforts contributed to the meeting. Staff from MDHHS facilitated the meeting and breakout sessions.
- Participants were provided an overview of the overarching strategy and the priorities of its Food Security Focus Area. These priorities include supporting people made vulnerable to food insecurity, streamlining processes to improve access to food benefits, and aligning on key food security reforms.
- Participants were asked to join a breakout session most relevant to their work to discuss opportunities for improvement and alignment, as well as innovative ideas for each priority. These breakout sessions correlated with food security priorities and included: logistics and planning, healthy food initiatives and partnerships, and improving state and local government alliances.
- Feedback from each breakout session was captured and compiled. Input will be synthesized and incorporated into the overarching strategy.

Discussions

In breakout sessions, participants learned more about specific programs related to each of the Food Security priorities. While considering the identified priority, participants were asked:

4. What are the gaps in current service?
5. Where are there areas for alignment (internal or across agencies)?
6. How can we better improve opportunities to meet people where they are?

Summaries from these discussions is below.

Breakout 1 – Logistics and Planning

Description: Many of our communities have a need for healthy food options, safe and clean shopping environments, and easily accessible options for access, but do not have a viable plan to meet these needs. In this work group, we will discuss ideas to assist in the planning and logistics of bringing healthy food, safe and clean consumer sites, and needed items into our underserved communities.

A brief overview of existing food security initiatives to support people made vulnerable to food insecurity was provided.

- Challenges identified include going 'the last mile' to get food to people (instead of getting people to food) and a lack of support for community-based organizations working to address food insecurity.

Gaps in current services:

- Connecting farmers markets and farms to customers in SNAP-eligible communities via online ordering platforms. Suggested opportunities to support this include:
  - Adopting a centralized SNAP processing model for local produce like this model in MA. Something like this would drastically reduce the labor burden SNAP poses to small farms.
  - Work with Food and Nutritional Services (FNS) to streamline the SNAP authorization process for farms/local food business.
  - Applying this bulk processing to SNAP online retailer authorization for farms/markets. This process is even more burdensome than the normal authorization process.
  - Collaborate with legislators to continue to support state funding for free wireless SNAP processing equipment for farms/farmers markets.
- Authorizing farmers markets and farmers to provide produce for the Women, Infants, and Children (WIC) Program.
  - Establish a partial authorization process for a retailer to become WIC-authorized that's only selling a portion of the WIC package.
  - Federal funds for innovations in WIC technology – state can apply through FNS
- Providing support and resources to ensure that food pantries and food rescue organizations are able to stay operational through crises (Ex. power outages, flooding, the COVID-19 pandemic).
- Low SNAP enrollment

Areas for alignment:

- Streamlining processes for information distribution; ensuring organizations and residents receive accurate and timely updates.
- Facilitating the formation of regional coalitions to increase purchasing power.
- Expand partnerships with large food retailers (Ex. Meijer) to ensure good food isn't going to waste.

Opportunities to better meet people where they are:

- Getting food to people who need it – going the 'last mile'. Suggested opportunities to support this include:
  - DoorDash partnership with Feeding America; the Food Bank Council currently has a grant from DoorDash.
  - Providing support to community-based organizations that are already solving this issue.
  - Providing additional support for communities facing barriers, including seniors and people living in rural areas.

- Reforming cottage food laws to expand opportunities for small-scale food entrepreneurs to feed their communities and have successful businesses (including allowing online sales).
- Addressing all types of food insecurity: people who have been experiencing food insecurity, but are well-connected to resources (ensure they continue to receive support), people who are newly food insecure (Ex. people who work in the hospitality industry that lost income due to the pandemic), and people made more vulnerable to food insecurity because of the pandemic.

Further reading / relevant links:

- Food Security organizations and initiatives: Fresh Food Box, Taste the Local Difference, Forgotten Harvest, Partridge Creek Farm
- Cottage food laws: Government Too Often Gets in the Way of Home Cooking Sales, Study Finds, California Microenterprise Home Kitchen Operation

Breakout 2 – Healthy food initiatives and partnerships

Description: This work group will explore community partnerships that bring healthy food options to communities in need. We will identify options that work, how those options can be applied on a larger scale, and the partnerships that we need to facilitate to bring these initiatives into more underserved communities.

Gaps in current services:

- Cataloguing and promoting available resources so residents know what programs and services are available, improving education and outreach efforts.
- Also need to catalogue state resources for grocers, farmers, community-based organizations to find support.
- Supplemental food benefits during the pandemic were piecemeal; took additional time and effort to get what was needed.
- Continuing the increase in supplemental benefits implemented during the pandemic; they allowed people to choose for themselves what they want.
- Lack of data on utilization of programs and identifying barriers.
- Providing access to food that people actually want; mental and physical health are impacted by giving people 'leftovers'.
- Delivery costs are not included for SNAP; need to build infrastructure for a regional delivery system.
- Many people are food insecure but do not qualify for benefits.
- Addressing stigma in getting help.
- Funding and support for community-based organizations.
- Flexible funding for a food security plan.
- Reliable vehicles to deliver food and provide transportation for people that need rides to access food.

Areas for alignment:

- Example of successful alignment: Partnership between the Community Health Innovation Regions (CHIRs) and the United Way to connect residents to resources.

Opportunities to meet people where they are:

- Improving public transportation.
- Co-location of services – having Community Health Workers at food pantries to talk about what resources they need and provide information about how to apply for a Bridge card or get utilities assistance.
- Food delivery programs with mobile markets; need real investment to be sustainable.
- Community-based organizations that do not receive funding from the state/federal government have more flexibility.
- Investing in people, facilitating connections, providing resources.

Further reading / relevant links:

- Flint programs: Rides to Wellness and Ride to Groceries
- Dungytreei Heritage Foundation

Breakout 3 – Improving state and local government alliances

Description: This work group will explore community partnerships that bring healthy food options to communities in need. We will identify options that work, how those options can be applied on a larger scale, and the partnerships that we need to facilitate to bring these initiatives into more underserved communities.

Gaps in services:

- Providing food to people living in rural communities.
    - Opportunity: combining service offerings in common spaces to increase access.
- Transportation systems are not adequate, and many people lack access to a personal vehicle.
- Growing population of older adults; need to increase capacity of programs supporting seniors, people who are aging and elderly.
    - Opportunity: cross-enrollment in Senior Project Fresh and other assistance programs when qualifying for SNAP.
- Discharge policies for recovery programs, hospitals, etc. to ensure care coordination and service connections.
    - Opportunity: eligibility specialists embedded into clinical services; use public and private funding.
- Acknowledge and address racial and community disparities.

Opportunities for alignment:

- Sharing data to identify disparities, predict measure of demand.
- Aligning Area Agencies on Aging (AAAs), Aging Council to address needs in aging population.

- Grantmaking with co-designed/cross-sector approach (including those making macro investments and those implementing in the planning phase).
    - Learning from Office of Children's Services on their implementation of co-design.
- Connections between mental health and food insecurity.

Opportunities to meet people where they are:

- Be respectful and provide a dignified safety net that accounts for disparities and community needs.
- Including assistance beneficiaries in feedback loops and planning:
    - Engaging people with lived experience in these phases.
    - Engaging with people who could, cannot, or would qualify for services; not just those who are actively enrolled.
        - Learning more about stigma and aversions.
- Respecting and inquiring about identity/cultural/religious/community preferences to better connect and serve residents:
    - Training or peer support resources.
    - Acknowledging what we don't know.
    - Sincerity; ask and listen.

Appendix C: Opportunities to Explore to Support Housing Stability Efforts in 2023 and Beyond

Priority: Supporting populations made vulnerable to housing instability	
Strategies	**Opportunities to Explore**
Reduce racial disparities in housing insecurity	Alignment with Michigan's Statewide Housing Plan to improve equity and racial justice.
Align state efforts though process assessment and improvement	Collaborate with MSHDA to develop training resources for MDHHS field office staff to enhance familiarity with subsidized housing programs and how they are accessed.
	Review housing application data for the State Emergency Relief (SER) Program and propose specific policy changes to reduce denials.
	Determine the impact of Project One Day on SER housing benefits to shorten the approval time.
	Strengthen connections between MSHDA and MDHHS Aging Services to address Michigan's high rate of housing instability among older adults.
	Collaborate with MSHDA and Housing Assessment and Resource Agencies (HARAs) to develop specific policy recommendations to protect families with housing choice vouchers from discrimination.
	Collaborate with housing stability partners to adjust the max rent allowance to be based on zip code (instead of an entire metropolitan area) to improve housing affordability.
	Create a resource database to inventory existing programs and address gaps.
	Identify additional opportunities to align with Michigan's Statewide Housing Plan to support people and communities made vulnerable to housing instability.
Support community-driven solutions through a robust engagement strategy	Facilitate connections with community organizations that are implementing initiatives on a local level to ensure the needs of each community are met.

	Collaborate with local zoning stakeholders to alleviate barriers to recovery housing.
	Engage Michigan foundations that are addressing key issues related to housing stability.
	Support local initiatives and healthcare providers that refer individuals to housing resources and additional resources in their communities. • Improve justice system, hospital, and inpatient program discharge policies to ensure people are not being discharged into homelessness or housing instability.
Improve the availability of affordable housing in Michigan	Internal and external stakeholders will be engaged to discuss strategies that support affordability during 2022.
Priority: Holistic approaches to healthy housing	
Strategies	Opportunities to Explore
Promote universal and barrier-free housing accessibility	Improve awareness of The MI Choice and MI Health Link Home and Community Based Services (HCBS) waivers to provide environmental accessibility adaptation services or home modifications to eligible enrollees to safely support continued care within the beneficiary's home and community.
	Identify additional opportunities to align with Michigan's Statewide Housing Plan to promote universal and barrier-free housing.
Address household energy needs through the promotion of energy efficient housing and increasing assistance for home energy costs	Facilitate connections with the energy efficiency sector to address longstanding health inequities through the expansion of energy efficiency programming.
	Leverage available resources and utilize a wide range of funding sources to respond to household energy needs, expand cash assistance, and increase access to healthy and stable housing.

Improve and streamline processes to identify and address home health and safety hazards	Developing a universal home assessment screening tool to streamline the process of identifying health and safety hazards.
Connecting residents to assistance at every level	Integrate services from existing programs and create strong partnerships.
Build capacity to address the health implications of climate change and advance environmental justice	
Priority: Addressing housing access for people experiencing homelessness	
Strategies	Opportunities to Explore
Increase prevention and rapid re-housing efforts	Promote and expand use of the MSHDA Emergency Solutions Grant (ESG) Program.
	Support the Emergency Housing Voucher (EHV) Program: MSHDA has partnered with the Continuum of Cares and Local Planning Bodies in the delivery of EHVs and to identify and mitigate barriers that individuals/families may encounter in renting a housing unit.
	Collaborate with MSHDA to promote and expand the 811 Project Rental Assistance (PRA) Program to expand the number of supportive housing units available in order to promote the integration of low-income people with disabilities into the community who might otherwise be institutionalized or become homeless.
	Capture the full count of school children experiencing homelessness to expand access to funding provided by the McKinney-Vento Homeless Assistance Act for the Michigan Department of Education (MDE).
	Advocate for the continuation and/or enactment of moratoriums on sweeps of encampments.

Leverage long-term resources to sustain local eviction diversion programming and supports	Support continued partnership and collaboration with MDHHS field offices, Housing Assessment and Resource Agencies (HARA) and courts.
Build and expand technology solutions that increase care coordination between healthcare providers and assistance programs	

Appendix D: Opportunities to Explore to Support Food Security Efforts in 2023 and Beyond

Priority: Supporting populations made vulnerable to food insecurity	
Strategies	**Opportunities to Explore**
Ideate and develop innovative initiatives to improve access to safe, nutritious food.	Create a resource database to inventory existing programs and identify gaps.
	Support local coalitions to increase the number of WIC-approved retail stores that sell a variety of high quality and affordable food and beverages.
	Make remote services, offered in response to the COVID-19 pandemic, permanent.
	Expand the availability of free meals to all students.
	Engage Michigan foundations that are addressing key issues related to food security.
	Support local initiatives and healthcare providers that refer individuals to food resources and additional social determinants of health resources in their communities.
Address affordability of food.	Expand initiatives that provide vouchers or coupons for fresh, healthy food items.
Expanding programs targeting racial injustice and inequity in food and nutrition.	Establish community-based food initiatives to support building functional hoop houses to provide a year-round fresh food supply.
	Examine program contracts to ensure culturally competent offerings.
	Expand culturally appropriate meals for children.
	Improve nutrition assistance for Tribal communities.

Mitigate/eliminate immediate barriers to healthy eating.	Providing 'cooking kits' to families with essential tools to prepare and cook food.
	Work with the MDHHS Oral Health Unit to address oral health issues that may cause dietary restrictions.
Develop innovative ways to go the "last mile" – getting food to people, not people to food.	Build infrastructure for regional food delivery systems and address the lack of funding available to cover food delivery costs.
	Expand support to community-based organizations that are already solving this issue.
	Provide additional support for communities facing barriers, including seniors and people living in rural areas.
	Provide reliable transportation for people that need rides to access food.
Priority: Streamlining processes to improve access to food benefits	
Improve support and funding for community-based initiatives working to address food insecurity in their communities.	Improve support and resources to ensure that food pantries and food rescue organizations are able to stay operational through crises (Ex. power outages, flooding, etc.)
	Facilitate the formation of regional food coalitions to increase purchasing power and align efforts.
	Expand grant-making with a co-designed/cross-sector approach.
Connect residents to assistance at every level by integrating services from existing programs and creating strong partnerships.	Expand partnerships with large food retailers to ensure good food is not wasted.
	Combine service offerings in common spaces to increase access to multiple benefits programs and resources.

	Increase the capacity of programs supporting older adults; this could include cross-enrollment in supplemental assistance programs (Ex. Senior Project FRESH) when qualifying for SNAP.
	Leverage available resources and utilize a wide range of funding sources to respond to nutritional needs, expand cash assistance, and increase access to healthy food.
Connecting farms and farmers markets to residents via online ordering platforms.	Adopt a centralized SNAP processing model for local produce to reduce the labor burden SNAP poses to small farms.
	Work with Food and Nutritional Services (FNS) to streamline the SNAP authorization process for farms and local food businesses.
	Expand state funding for free wireless SNAP processing equipment for farms and farmers markets.
	Authorize farms and farmers markets to provide produce for the Women, Infants, and Children (WIC) program. This could include establishing a partial authorization process for a retailer to become WIC-authorized that's only providing a portion of the WIC package.
	Make connections with local co-ops to connect SNAP-eligible communities in Michigan to farmers offering fresh produce through online stores.
Priority: Alignment on key food security reforms	
Reform policies and programs to expand opportunities to access healthy food online and through locally based retailers.	Reform cottage food laws to expand opportunities for small-scale food entrepreneurs to feed their communities and have successful businesses (including allowing online sales).

	Allow WIC participants to shop and purchase groceries online.

Appendix E: Opportunities to Explore to Support Health Equity Efforts in 2023 and Beyond

Priority: Supporting populations made vulnerable to adverse health outcomes	
Strategies	**Opportunities to Explore**
Mitigate and eliminate immediate and systemic barriers to health, including poverty and lack of access to basic needs, to ensure everyone has a fair opportunity to be as healthy as possible.	Flexible community institutions: Given the lack of services and infrastructure in many disadvantaged communities, existing community institutions must often fill a variety of roles and have the ability to address a wide range of SDOH needs.
	Invest in infrastructure: Expand broadband, public transportation, etc.
	Advance anti-poverty programs and policies.
	Support the expansion of eligibility for childcare services, in partnership with the Michigan Poverty Taskforce.
	Expand the MI Tri-Share Childcare program: Through Tri-Share, the cost of childcare is shared equally by an eligible employee, their employer and the State of Michigan, with coordination being provided regionally by a facilitator hub.
	Provide support to the Michigan Department of Corrections (MDOC) to expand apprenticeship opportunities for incarcerated individuals.
	Leverage technology as a bridge to opportunity.

Increase opportunity and economic mobility for populations that have been historically disadvantaged by programs, policies, and systems.	Support and Incubate Children's Savings Accounts: Children's Savings Accounts offer a highly effective asset-building strategy to improve financial literacy, boost educational achievement for low-income children and build wealth in low-income families.
Expand efforts to develop a comprehensive resource database to inventory existing initiatives and address gaps.	Partner with the Department of Labor and Regulatory Affairs (LARA) and 211 to create a baseline/matrix of existing programs & services to align 211 and MI Bridges.
Enhance care coordination and connection to services.	Improve discharge policies for recovery programs, hospitals, etc. to ensure care coordination.
	Embed eligibility specialists into clinical services.
Priority: strengthen community resiliency, engagement, and empowerment	
Enhance partnerships with interagency departments and community stakeholders to create policies, systems, and environments to advance health equity and improve population health.	Inventory effective health equity-focused work at federal, state, and local levels.
	Seek grant funded opportunities that address the enhancement of health equity.
	Create opportunities for collaboration and share knowledge in support of developing 2023 strategic objectives and goals.
	Address emerging community health needs, including public health emergencies like the COVID-19 pandemic, by supporting adaptable, innovative, outcome-focused, sustainable programs.
	Increase linkages of people to resources that improve population health through the development and support of community-based partnerships.

	Support community organizations that address social determinants of health and improve health-related infrastructure.
	Improve health outcomes by supporting integration and coordination of health services, primary care providers, and the public health sector.
	Expand outreach and communication and develop stakeholder partnerships that lead to sustainable initiatives that eliminate health disparities.
Build a strong, diverse workforce to support health equity.	

Appendix F: Acronyms and Initialisms

BHHDA – Behavioral Health and Developmental Disabilities Administration

CMHSP – Community Mental Health Service Providers

EHV – Emergency Housing Voucher Program

ESG – Emergency Solutions Grant Program

HARA – Housing Assessment and Resource Agency

HUD – U.S. Department of Housing and Urban Development

LARA – Michigan Department of Licensing and Regulatory Affairs

MDE – Michigan Department of Education

MDHHS – Michigan Department of Health and Human Services

MDOC – Michigan Department of Corrections

MHP – Medicaid Health Plan

MSHDA – Michigan State Housing Development Authority

OEMH – MDHHS Office of Equity and Minority Health

PRA – 811 Project Rental Assistance Program

SDOH – Social Determinants of Health