MDHHS | Social Determinants of Health

Michigan Department of Health & Human Services

Social Determinants of Health (SDOH) Accelerator Plan to Prevent Chronic Disease

Plan Overview – October 2023

Dear Partners,

I am thrilled to inform you that your collective expertise and diverse perspectives were instrumental to the development of the Social Determinants of Health (SDOH) Accelerator Plan to Prevent Chronic Disease. Your invaluable contributions have been essential in shaping this plan into a powerful instrument for community well-being.

Your ability to highlight the unique challenges and opportunities faced by different communities has helped us refine our approach towards addressing SDOH, with a focus on community needs.

In an ever-evolving landscape, the importance of having an adaptable plan cannot be overstated. We have taken your feedback to heart and have committed ourselves to developing a plan that not only reflects your recommendations but is also responsive to the distinct characteristics of the populations we aim to serve.

As we proceed to the implementation phase of the SDOH Accelerator Plan, we want you to know that your insights and recommendations are not only acknowledged but will be actively integrated into the plan. Your involvement and support are integral to the success of this endeavor. We believe that the work we are doing together will positively impact public health, prevent chronic diseases, and enhance the well-being of communities across Michigan.

This letter is not only a token of our gratitude but also a commitment to continue our collaboration in the future. We are eager to work closely with you to transform our shared vision into tangible outcomes. Together, we can make real and lasting change in the communities we serve.

Ninah Sasy

Director, Policy and Planning

Michigan Department of Health and Human Services (MDHHS)

To better support existing efforts, align work across the state of Michigan, and improve health and equity, the Michigan Department of Health and Human Services (MDHHS) recently released the statewide SDOH Strategy, *Michigan's Roadmap to Healthy Communities*. The SDOH Accelerator Plan to Prevent Chronic Disease is a component of the existing SDOH Strategy, as one of four structural interventions outlined in Phase II:

Figure 1. Phases of the SDOH Strategy

WHAT IS THE

SDOH Accelerator Plan?

The SDOH Accelerator Plan is a comprehensive plan designed to address the social and environmental factors that contribute to the development and progression of chronic disease. The plan involves a multi-sectoral approach that includes health care, public health, community organizations, governmental agencies, and – most importantly – individuals impacted by chronic disease.

Accelerator Plan Goals

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

Why is the Accelerator Plan needed?

Chronic diseases account for seven of the 10 leading causes of death in Michigan and are responsible for a great deal of morbidity and disability[1].

More than 60% of Michigan's adult population suffers from a chronic disabling condition, such as arthritis, heart disease, hypertension, or diabetes. In addition, more than 95% of Michigan adults report behaviors that can lead to many chronic diseases, such as smoking, unhealthy diet, lack of physical activity, and alcohol use.

Chronic disease presents significant challenges to public health, health care systems, and the overall well-being of the population. A few of the most prevalent chronic diseases in Michigan include obesity, diabetes, cardiovascular disease, cancer, respiratory diseases, and mental and behavioral health conditions.

In 2021, heart disease was the leading cause of death in Michigan.

Michigan, like many states, faces persistent health disparities related to chronic disease outcomes. Many of these disparities are exacerbated by SDOH factors, including limited access to health care, healthy foods, and opportunities for physical activity.

[1] MDHHS Division of Chronic Disease and Injury Control, 2021

Accelerator Plan Overview

KEY SDOH FACTORS: Targeted strategies have been identified to support the **built environment**, including **housing stability** and **food and nutrition security**.

TARGET POPULATION: All Michiganders with representation from nine of the 10 Prosperity Regions. Please see *AP Listening Session Summaries* for detailed information.

CLOSING THE DISPARTIY GAP

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

Who is most impacted?

Population: Racial and ethnic minorities

The MDHHS 2021 Health Equity Report highlights several SDOH metrics showing vast disparities by race and ethnicity. These disparities are reflected in health outcomes, showing disparate outcomes in morbidity and mortality indicators.

Within the African American community, some of the largest disparities exist around economic factors and chronic health disease:

- As of 2020, **35%** of African Americans in the state were in poverty (at 100% of the federal poverty level or below), compared to **17%** of the state's overall population.
- **15.5%** of African Americans in the state have diabetes, compared to **11.7%** of the state's overall population.
- **42.5%** of African Americans in the state have obesity, compared to **34.7%** of the state's overall population.

Population: Racial and ethnic minorities

Significant economic and chronic disease disparities also exist within the Native American community:

- As of 2020, **30.6%** of Native Americans in the state are in poverty, compared to **17%** of the state's population in poverty.
- **22.3%** of Native Americans have cardiovascular disease prevalence, compared to **9.7%** of the state's population.
- **19.3%** of the community has diabetes, compared to **11.7%** of the state's overall population.

While disparities within additional minority communities are less significant, there are still areas of concern. The population of Michigan is very diverse, with multiple nationalities represented in each community. Limitations in being able to disaggregate populations into more respective nationalities and cultural identities can often mask disparities. To address these limitations, multiple data sources will continue to be collected and analyzed to understand and account for progress in reducing disparities.

Population: Counties with High Social Vulnerability Index (SVI) Scores

Communities have social and demographic factors, including socioeconomic status (income, employment, education), minority status (racial minority, limited English proficiency), household composition (age, disability, single parent), and housing and transportation (housing type, crowding, access to a vehicle), that make them more vulnerable to poor health outcomes. These upstream factors are often drivers of inequities in the burden of chronic disease. Counties in the state with greater social vulnerability often report higher chronic disease incidence and mortality. As of 2020, the counties in Michigan with greater social vulnerability were[2]:

I. Wayne County, Michigan 2020 Overall SVI Score: **1.000**

II. Clare County, Michigan 2020 Overall SVI Score: **0.9878**

III. Chippewa County, Michigan 2020 Overall SVI Score: **0.9756**

These counties also have a higher burden of chronic disease outcomes, including a higher geographic burden of diagnosed diabetes and high rates of obesity[3]. Additionally, all three counties have age-adjusted mortality rates for heart disease that are above the national rate, with Wayne and Clare Counties having some of the highest rates in the state.

[2] CDC Social Vulnerability Index, 2020 (Link)

[3] America's Health Rankings, 2021 (Link)

Partnerships and Engagement

The Accelerator Plan was developed with input from a diverse group of partners across Michigan. Robust engagement efforts included community engagement through Regional Listening Sessions, the Accelerator Plan (AP) Leadership Team, and state government partner convenings and interviews:

Figure 2. Accelerator Plan Engagement Components

The **AP Leadership Team** was convened to advise on the development of the SDOH Accelerator Plan. The Leadership Team utilized a community-based participatory approach by ensuring shared decision-making and building on identified existing resources. Members of the Leadership Team included representatives from different sectors with the expertise and authority to accomplish the development of the implementation ready SDOH Accelerator Plan in the selected SDOH priority areas:

- **Dena Austin**, Blue Cross Complete, Region 10 (*see Appendix B for a map of Prosperity Regions*).
- **Rod Auton**, Battle Creek Community Foundation and the Albion Healthcare Alliance, Region 8.
- **Akia Burnett**, MDHHS Division of Chronic Disease and Injury Control (DCDIC) , Heart Disease and Stroke Prevention Unit, Region 10.
- **Sabrina Ford**, Michigan State University, College of Human Medicine, Region 7.
- **Amanda Gallaher**, MDHHS DCDIC, Tobacco Section, Region 7.
- **Juliana Harper**, Easterseals MORC, Inc., Region 10.
- **Sarah Hong**, Jewish Family Services Region 8.
- **Kay Judge**, Meridian, Region 10.
- **Jessie Korte**, Honest Medical Group, Region 10.
- **Candice Lee**, MDHHS, Region 7.
- **Mark Lee**, Better World Builders, Region 8.
- **Lauren Neely**, MDHHS Diabetes and Kidney Unit, Region 9.
- **Harry Petaway**, Equity Communities of Practice, Region 8.
- **Adam Russell**, National Kidney Foundation of Michigan, Region 4.
- **Jane Sundmacher**, Northern Michigan Community Health Innovation Region (CHIR), Region 2.
- **Faiyaz Syed**, Michigan Primary Care Association (MPCA), Region 7.
- **Sarah Westerman**, Aetna/CVA, Region 10.
- **Denise White Perkins**, Henry Ford Health, Region 10.
- **Emily Williams**, United Healthcare Community Plan of Michigan, Region 10.
- **Rachel Williams**, Gleaners Community Food Bank, Region 10.

Regional Listening Sessions served as a unique form of community engagement, providing an opportunity for community members to voice specific thoughts and feelings regarding social drivers of health and their impact in communities.

Ten different local host organizations coordinated a total of 17 regional listening sessions between June 28 and September 7, 2023, as shown in Figure 3, below.

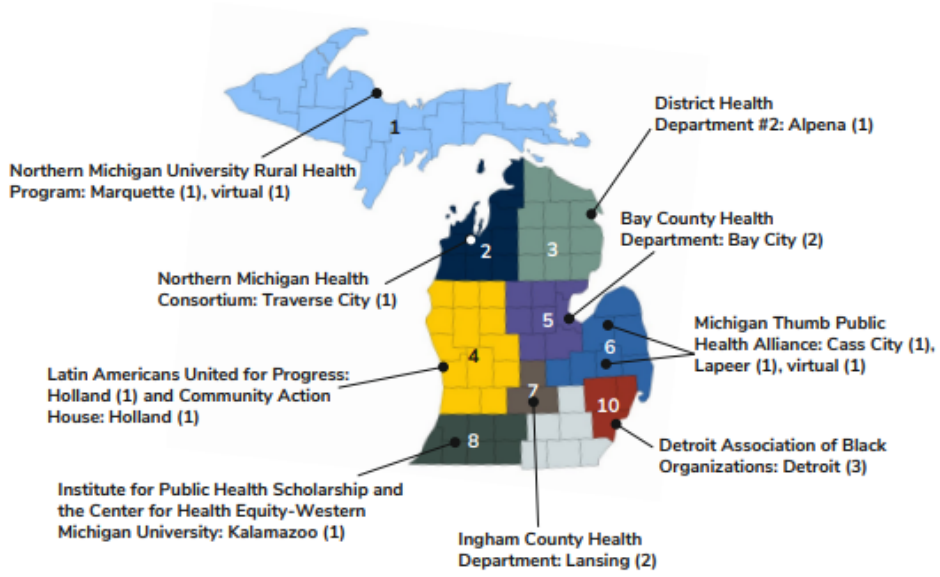

Figure 3. Number of Listening Sessions by Host Organization and Prosperity Region

The feedback gathered from these sessions provided critical insight into perceived barriers to health within communities and across the state of Michigan, which informed the development of the plan and will ensure community-driven interventions. The sessions were hosted from June through September 2023. The University of Michigan was hired to facilitate group discussion. A detailed overview of the regional listening sessions is available.

State Government Partner Convenings and Interviews took place in July through September 2023. MDHHS contracted with Public Sector Consultants (PSC) to conduct a **survey of program areas and subsequent interviews**. The purpose of the survey was to identify programs that included efforts to address social determinants of health. Once program areas were identified, group discussions were facilitated to build on the information gathered from the survey, including learning more about programs already engaged in addressing SDOH to identify promising practices and barriers faced in doing this work. PSC then conducted one-on-one interviews with program staff who participated in the group discussions. Interviewees were asked to provide more details about their programs' activities, partnerships, community engagement strategies, and potential future initiatives related to SDOH.

To ensure a broad range of state agency partners were engaged in this work, the Policy and Planning team hosted two group meetings to bring together representatives from State of Michigan Departments, including the Michigan Department of Transportation (MDOT), the Michigan Public Service Commission (MPSC), the Michigan State Housing Development Authority (MSHDA), the Michigan Department of Agriculture and Rural Development (MDARD), the Michigan Department of Environment, Great Lakes, and Energy (EGLE), and several program areas within MDHHS including the Race Equity, Diversity, and Inclusion (REDI) Office and Tribal Government Services Office. During these meetings, opportunities for alignment were discussed, in addition to identifying challenges and barriers of this work.

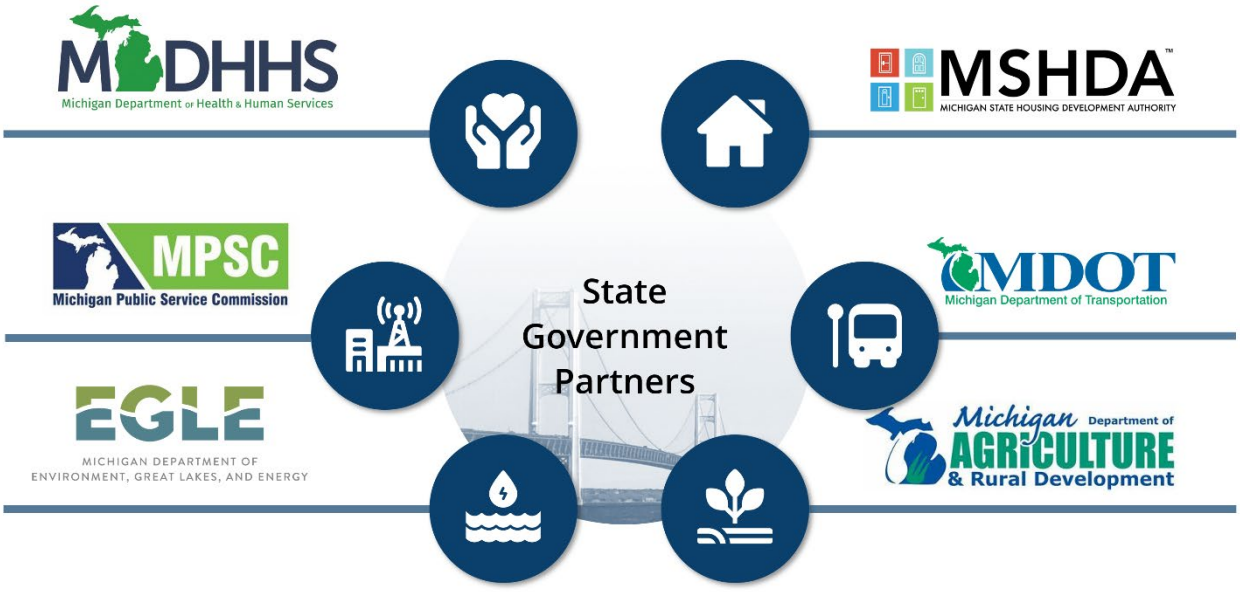

Figure 4. State Government Partners Contributing to the Development of the Accelerator Plan

Key Findings

Community-led interventions are vital in Michigan due to the state's rich diversity, as they recognize that various communities have unique SDOH needs. Embracing community leadership ensures tailored, culturally sensitive, and effective approaches to addressing these diverse SDOH, ultimately fostering healthier and more equitable outcomes for all residents.

The SDOH team partnered with local host organizations in nine different Michigan Prosperity Regions to ensure the SDOH Accelerator Plan was informed by the lived experiences of community members. Sessions sought input from people with unmet social needs, people with chronic disease experience, and social service providers. Each local host organization coordinated between one and three listening sessions for community members in their region. Host organizations recruited participants through their existing networks, by partnering with other organizations in their region, and through social media.

The listening sessions were designed to allow participants to share their experiences with food access, including food retail sites, the emergency food system, and food assistance programs; the built environment, including walkability, transportation, recreation opportunities, and housing; access to medical care; and environmental quality.

The University of Michigan Program Evaluation Group (PEG) team provided facilitation, audio-recording, and notetaking for each listening session. PEG team members also administered a brief survey at the beginning of each session to capture participant demographics and experiences with social determinants of health.

Through the Regional Listening Sessions, common themes were identified and documented through the regional listening sessions, outlined on the next page.

Food Security

- Grocery stores are hard to reach.
- Emergency food options are limited.
- Food assistance is hard to navigate, and criteria are unreasonable.
- Communities want food education.

Transportation

- Public transportation is limited or non-existent in most communities.
- Taxis and ride share services are cost prohibitive and are not available in all areas.

Health Care

- There are not enough medical providers or mental health resources.
- People want relationships with their health care providers.
- Navigating the health care sector is challenging.
- Some communities want health education.

Housing

- There is not enough affordable housing.
- Utility costs are high and building maintenance is poor in some communities.
- Multiple communities have seen an increase in people who are unhoused.

Built Environment

- Infrastructure does not promote walkability.
- Recreation opportunities are limited.

Economic Opportunities

- A shortage of job opportunities is leading to population decline in some areas.
- The lack of child care facilities makes it difficult for parents to work.

Environmental Quality

- Poor air quality and unsafe drinking water are the top environmental concerns in communities.

Identifying promising practices and opportunities for alignment with state agency partners is critical to the success of the Accelerator Plan. Public Sector Consultants was hired to conduct a survey, focus groups, and interviews to identify programs' activities, partnerships, community engagement strategies, and potential future initiatives that could be leveraged to drive meaningful collaboration for a greater impact to better support people with chronic conditions.

Through the **State Government Partner Convenings and Interviews**, a common thread across these programs was the importance of robust partnerships, whether with health care providers or community organizations. These collaborations were seen as vital to overcoming challenges and reaching underserved populations effectively.

These programs are actively engaging communities and expanding their reach. Though interviewees shared a high level of satisfaction with their programs, they described challenges as well, including funding limitations and siloed communication across different administrations, bureaus, and sections within MDHHS. However, they were able to identify the potential for increased collaboration and communication with a wide variety of programs both inside and outside of MDHHS.

There was consensus among the interviewees that implementing proactive preventive strategies to address SDOH faces significant challenges rooted in two main factors—funding constraints tied to grants supporting their programs and insufficient communication and coordination across various programs within MDHHS.

Interviewees stated that funding for their programs often comes with specific stipulations that limit programmatic flexibility and the potential to expand their efforts. In addition to funding-related constraints, a lack of effective communication and collaboration across different MDHHS programs was highlighted as a major challenge. Interviewees said many programs are operating in isolation, with limited sharing of information, resources, or best practices. This fragmentation can hinder the development of holistic strategies to address SDOH and can result in missed opportunities for collaborative efforts.

Interviewees' collective commitment to addressing SDOH and managing chronic conditions reflects a promising path forward for the MDHHS Office Of Policy and Planning in the development of an SDOH Accelerator Plan. By implementing solutions to enhance communication and collaboration, MDHHS can pave the way for more effective, integrated, and impactful approaches to addressing SDOH and chronic conditions in the state.

Recommendations

In our collective pursuit of a healthier and more equitable future, we recognize that sustainable change begins at the grassroots level. Local communities are the heart and soul of our society, and it is within these communities that the most profound impact on issues such as food security, housing stability, and the built environment can be achieved.

Local communities possess a deep understanding of their unique challenges and assets. They have the capacity to devise tailored solutions that address the specific needs of their residents. By empowering these communities with the resources and support they require, we can catalyze transformative change from the ground up.

In tandem with these locally led interventions, we also recognize the importance of state-level recommendations. These recommendations, including the implementation of Community Information Exchange (CIE), Community Health Worker (CHW) sustainability, and health equity partnerships, play a crucial role in creating a supportive ecosystem for sustainable solutions.

State-Level Strategies and Recommendations

CIE fosters collaboration, sharing vital data, and knowledge among local stakeholders. This exchange enables communities to make informed decisions and identify best practices to address issues related to food and nutrition security, housing stability, and the built environment.

CHW sustainability ensures that individuals who provide vital health and social services at the local level are supported, well-trained, and adequately compensated. This not only strengthens the community's capacity to address health disparities but also enhances the overall quality of life for its residents.

Health equity partnerships reinforce the importance of collaboration between local entities, state agencies, and organizations that share a commitment to achieving equity in health outcomes. These partnerships leverage resources, expertise, and influence to implement policies and initiatives that mitigate the risk factors associated with chronic diseases.

> By uniting locally led interventions with state-level recommendations, we can create a dynamic and adaptive system that empowers communities to sustainably tackle the pressing issues of food security, housing stability, and the built environment. Together, we are better equipped to break the cycle of chronic diseases and foster a brighter, healthier, and more equitable future for all.

Based on the specific focus on determinants that impact chronic disease risk factors and health outcomes, the SDOH priority areas that have been selected are **built environment** and **food and nutrition security**.

Built Environment

The built environment includes all the man-made structures and features where we live, work, learn, and play. Creating well-designed spaces can help individuals engage with their community, access everyday destinations, and prevent and manage chronic conditions, ultimately improving health outcomes and reducing health disparities. Strategies and activities that support a healthy built environment and active communities include:

- Increase connectivity and accessibility to everyday destinations.
- Increase active transportation and walkability.
- Create or enhance existing infrastructure to increase the number of communities that have access to safe and accessible parks and green spaces.
- Increase access to fresh and affordable food.
- Create work environments that promote employee well-being and ADA compliant infrastructure.

This work includes, but is not limited to funding for trails, sidewalks, wayfinding signage, cross walks, accessibility improvements, and lighting. Many of these approaches reduce greenhouse gas emissions at the community level and provide opportunities to increase community resiliency to climate change impacts.

Michigan will continue to assess current state efforts related to housing security and built environment including our smoke-free policy, Low Income Home Energy Assistance Program (LIHEAP), Weatherization Assistance (Wx) Program, and Michigan's Statewide Comprehensive Outdoor Recreation Plan (SCORP); SCORP is a five-year strategic plan that shapes investment by the State of Michigan and local communities in priority outdoor recreation infrastructure and programming. A policy review provided insight into areas of alignment, barriers, and opportunities to better support the prevention of chronic disease, especially in our most vulnerable communities.

Domain: Food Security

Evidence-based practices aimed at improving food and nutrition security will center around enhancing physical and economic access to sufficient, safe, and nutritious food to meet dietary needs and food preferences for an active and healthy life. This includes activities that increase access to MDHHS programs and services that support food and nutrition security by:

- Expanding the use of benefits navigators and Community Health Workers (through phone assistance or providing in-person support) in the identified communities of interest to assist individuals with completing the enrollment process for a range of assistance programs.
- Streamlining the processing of assistance applications, improving customer service, and creating efficiency gains by implementing improvements to the MI Bridges platform, including Project One Day, Project Renew, and the Elderly Simplified Application Project.
- Increasing awareness of available programs and services through direct outreach and community engagement.
- Providing financial support and technical assistance for the implementation of new programs to improve food and nutrition security, including produce prescription programs and medically tailored meal programs.

Domain: Housing Stability and Built Environment

Interventions aimed at improving the built environment will center around enhancing access to sufficient, safe, and healthy housing, active transportation, and physical resources that support health. This includes a built environment that minimizes exposure to environmental hazards, promotes physical activity, and enhances protective factors that prevent chronic disease. This includes activities that increase access to MDHHS programs and services that support a healthy built environment, including:

- Establishing and expanding on partnerships that facilitate holistic approaches to healthy housing, which includes lead mitigation, weatherization, removal of additional hazardous materials, and energy efficiency.
- Expanding eviction diversion programs and increasing access to housing for people experiencing homelessness and people who are precariously housed.

Solutions to reducing the burden of chronic disease must also consider additional SDOH that intersect with the built environment, as well as risk multipliers like climate change. Healthy building standards are often “green” building standards that benefit the climate, such as energy efficiency measures sourcing sustainable materials, and resiliency measures to address flood and heat risks onsite. Taking a holistic approach considers the broader environment that further enables or constrains health and a person’s ability to make healthy choices. This shifts the lens from individual responsibility to the myriad institutions, structures, and inequalities that health behaviors are grounded in.

Closing the Disparity Gap

Prioritizing the needs of populations disproportionately impacted by poor economic, social, and health outcomes to give everyone the opportunity to live a healthy life.

The **SDOH Accelerator Plan to Prevent Chronic Disease** aims to reduce disparities in health outcomes related to chronic disease.

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

The **Rural Health Equity Plan** considers the unique challenges faced by rural communities to find ways to make things better for people living in rural areas.

Community-led Strategies and Interventions

For specific recommendations regarding community-led food and nutrition security and built environemnt interventions that can be implemented based on the key findings of the Regional Listening Sessions, review the list in Appendix A. Implementation of these interventions may occur through SDOH Hubs, established through Phase III of the SDOH Strategy.

SDOH Hubs are a primary mechanism to support implementation of the recommendations identified in each community. SDOH Hubs establish a dynamic and inclusive framework where health care intersects with social support to advance health equity. Each Hub is structured with a lead organization and a diverse network of partners. Hubs are designed to expand or build foundational capacities. They also reflect the unique needs and strengths of the communities served.

Implementation

Accelerator Plan implementation will be integrated into SDOH Hubs to create comprehensive and lasting solutions to tackle health inequities, fostering healthier and more equitable communities across the state. SDOH Hubs will provide the infrastructure necessary to support implementation by investing funding and resources into:

CHW TRAINING, HIRING, AND INTEGRATION

Strengthening CHW capacity to address SDOH and prevent chronic disease.

CIE PLANNING AND IMPLEMENTATION

Bridging clinical and social care data to provide holistic case management.

IMPLEMENTATION OF COMMUNITY LED INTERVENTIONS

Supporting interventions that reflect the needs of each community.

Measurement and Evaluation

Measuring the effectiveness of the Accelerator Plan is a multifaceted process that involves both quantitative and qualitative indicators. Health outcomes and progress in closing disparity gaps are crucial metrics. Short- and intermediate-term changes in chronic disease incidence and prevalence rates, as well as relevant clinical indicators (e.g., A1C levels, blood pressure, etc.) will be monitored within the context of targeted interventions. Qualitative data, collected through engagement with the affected communities, will also provide valuable insight to monitor the impact of the Accelerator Plan and identify barriers, successes, and opportunities that arise.

While the Accelerator Plan will start to be implemented in tandem with the release of Phase III of the SDOH Strategy in January 2024, it does not have a desinated end date, as it is intented to be an interative framework for ongoing efforts. However, to ensure its relevance and promote accountability, annual check points have been established to update strategies and make improvements. Following these designated annual check points, a progress report will be developed to share relevant updates, data, and impact.

A Community-led Interventions

Food and Nutrition Security Recommendations

1. **Community Transportation Solutions**
   - Advocate for improved public transportation options, such as buses or community shuttles, that connect underserved neighborhoods with larger supermarkets.
   - Collaborate with transportation authorities to create designated routes to these supermarkets, ensuring that they are accessible to all residents.
2. **Mobile Markets**
   - Establish mobile farmers' markets or grocery store vans that visit underserved areas on a regular schedule, providing fresh and healthy food options.
   - Subsidize or support these mobile markets to keep prices affordable for low-income individuals.
3. **Local Food Co-Ops**
   - Encourage the formation of community-based food cooperatives that source fresh and healthy produce from local farmers and distribute it at affordable prices.
   - Provide resources and assistance to set up and run these co-ops effectively.
4. **Community Gardens**
   - Support the development of community gardens in underserved areas, where residents can grow their own produce, fostering self-sufficiency and access to fresh food.
   - Provide education and resources for gardening to community members.
5. **Healthy Food Financing Initiatives**
   - Advocate for and support state or local policies that provide financial incentives and low-interest loans to businesses that want to establish grocery stores in food deserts.
   - Encourage the adoption of zoning laws that make it easier to open supermarkets in underserved neighborhoods.
6. **Nutrition Education and Cooking Classes**
   - Offer nutrition education programs and cooking classes in the community to help individuals with dietary restrictions or health conditions make the most of the available resources.
   - Teach budget-friendly meal planning and preparation.

Food and Nutrition Security Recommendations

7. **Local Partnerships**
    - Collaborate with local food banks, nonprofits, and health organizations to provide food assistance and guidance to individuals facing dietary restrictions or health conditions.
    - Develop programs that offer tailored support for these specific needs.
8. **Data Collection and Analysis**
    - Collect and analyze data on food access and the specific needs of residents with dietary restrictions and health conditions. This information can help tailor solutions to the community's unique challenges.
9. **Food Assistance Multi-Language Support**
    - Offer application forms, informational materials, and support in multiple languages to accommodate diverse communities.
    - Ensure that non-English-speaking or Limited English Proficient (LEP) individuals can access and understand the available assistance.
10. **Follow-Up and Support**
    - Establish a system for follow-up assistance, ensuring that applicants receive support throughout the application process and beyond.
    - Provide resources for recipients to understand program rules and reporting requirements.
11. **Feedback Mechanisms**
    - Establish a feedback mechanism that allows applications to provide input on their experience with the application process.
    - Use this feedback to make continuous improvements to food assistance programs.

Built Environment/Transportation/Mobility Recommendations

Supporting ride-sharing services can improve transportation accessibility, especially in areas with limited public transit options. Recommendations to promote and support ride-sharing initiatives include:

Ride-Sharing Recommendations

1. **Partnerships with Ride-Sharing Companies**
   - Collaborate with ride-sharing companies, such as Uber and Lyft, to establish partnerships that extend their services into underserved or low-income neighborhoods.
   - Negotiate fare discounts, flat rates, or special programs for residents in these areas.
2. **Subsidies for Low-Income Riders**
   - Provide subsidies or vouchers for low-income individuals and families to use ride-sharing services, ensuring affordability. These subsidies can be administered through government agencies or nonprofit organizations.
3. **Integration with Public Transit**
   - Promote integration between ride-sharing and public transit systems by creating designated pick-up and drop-off points at transit hubs.
   - Offer incentives for riders who use both services for their commute.
4. **Accessibility for People with Disabilities**
   - Ensure that ride-sharing services offer accessible vehicles and options for people with disabilities.
   - Collaborate with organizations advocating for disability rights to develop and implement inclusive policies.
5. **Older Adults and Medical Transportation**
   - Partner with ride-sharing companies to provide older adults and individuals with medical appointments access to reliable transportation. Subsidize these rides to make them more affordable for these populations.
6. **Community Ride-Share Incentives**
   - Support and fund local, community-based ride-sharing initiatives that are tailored to meet the specific needs of underserved areas.
   - These initiatives may include ride-sharing cooperatives or volunteer driver programs.

Housing Stability Recommendations

Addressing housing stability challenges will require a sustained and collaborative effort from government agencies, nonprofit organizations, the private sector, and the community at large. Communities can work toward providing affordable housing, reducing utility costs, and addressing homelessness in a comprehensive and compassionate manner.

1. **Affordable Housing Initiatives**
    - **Subsidized Housing Programs:** Expand government-subsidized housing programs to increase the availability of affordable housing for low-income individuals and families.
    - **Affordable Housing Tax Credits:** Provide tax incentives for developers and investors to build affordable housing units.
    - **Inclusionary Zoning:** Implement inclusionary zoning policies that require developers to include a percentage of affordable units in new housing projects.
2. **Energy Efficiency and Utility Cost Reduction**
    - **Weatherization Programs:** Offer financial assistance and programs to help low-income homeowners upgrade their homes for energy efficiency, reducing utility costs.
    - **Energy-Efficient Renovations:** Incentivize property owners to make energy-efficient renovations to older homes, potentially through grants or tax credits.
    - **Education and Outreach:** Provide resources and education to residents on energy-saving practices and home improvements that can lower utility bills.
3. **Support for Residents Experiencing Homelessness**
    - **Housing First Approach:** Prioritize a "Housing First" strategy, where people experiencing homelessness are provided with stable housing as a first step, and then offered support services to address underlying issues like addiction or mental health.
    - **Rapid Re-Housing Programs:** Create rapid re-housing programs that provide temporary financial assistance and case management to quickly transition individuals and families from homelessness to stable housing.
    - **Housing Outreach Teams:** Establish specialized outreach teams to engage with people experiencing homelessness, assess their needs, and connect them with appropriate services.

Housing Stability Recommendations

4. **Community-Based Solutions**
    - **Affordable Tiny Homes:** Explore the feasibility of tiny home communities as a cost-effective and scalable solution for transitional and affordable housing.
    - **Community Land Trusts:** Support community land trusts that can acquire and maintain land for affordable housing developments.
    - **Shared Housing Initiatives:** Encourage programs that match older adults or people with extra space in their homes with individuals in need of affordable housing.
5. **Preventing Homelessness**
    - **Rent Assistance Programs:** Develop rent assistance programs that help individuals and families facing eviction due to economic hardship.
    - **Legal Aid Services:** Provide legal aid services for tenants facing eviction to protest their rights and prevent homelessness.
6. **Mental Health and Addiction Services**
    - **Expanded Services:** Increase funding for mental health and addiction services to address the underlying issues that can lead to homelessness.
    - **Crisis Intervention Teams:** Train law enforcement officers to respond to mental health crises and divert individuals away from the criminal justice system and into appropriate care.

Environmental Quality Recommendations

Addressing poor air quality and unsafe drinking water, which are critical environmental concerns, involves a combination of regulatory measures, community engagement, and public awareness. Here are the recommendations to tackle these issues:

Air Quality Recommendations

1. **Public Transporation and Active Transport**
   - Invest in efficient and widespread public transportation systems to reduce the number of vehicles on the road.
   - Promote active transportation options, such as walking and cycling, by creating pedestrian-friendly infrastructure.
2. **Green Urban Planning**
   - Encourage the development of green spaces, parks, and tree planting in urban areas to improve air quality and provide green lungs for cities.
   - Implement green building standards to reduce emissions from construction and energy use.
3. **Public Awareness and Education**
   - Educate the public about the health risks of poor air quality and how to protect themselves, especially vulnerable populations.
   - Promote the use of air quality monitoring apps and services for real-time information.

Water Quality Recommendations

1. **Water Quality Monitoring**
   - Implement a comprehensive and regular water quality monitoring system to detect and address contamination promptly.
   - Make the results of water quality tests easily accessible to the public.
2. **Infrastructure Investment**
   - Invest in upgrading and maintaining water infrastructure, including pipes, treatment plants, and distribution systems.
   - Prioritize funding for underserved and vulnerable communities with the greatest need.

Water Quality Recommendations

3. **Source Water Protection**
   - Establish source water protection programs to safeguard water sources from pollution and ensure a clean and sustainable supply.
   - Regulate activities near water sources, such as agriculture and industrial operations.
4. **Lead Service Line Replacement**
   - Identify and replace lead service lines to prevent lead contamination in drinking water.
   - Provide financial assistance to low-income households for lead pipe replacement.
5. **Community Engagement**
   - Engage communities in the monitoring and protection of their water sources.
   - Encourage community-based initiatives for water conservation and source protection.
6. **Emergency Response Plans**
   - Develop and regularly update emergency response plans for dealing with water contamination incidents.
   - Ensure prompt communication and coordination with affected communities.
7. **Water Quality Education**
   - Educate the public about the importance of water quality and steps to maintain safe drinking water at home.
   - Promote water conservation and responsible chemical disposal.
8. **Regulatory Enforcement**
   - Strengthen regulations governing drinking water quality and impose penalties for non-compliance by water utilities and other responsible entities.

Social Determinants of Health (SDOH) Accelerator Plan to Prevent Chronic Disease

MDHHS | Social Determinants of Health

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