SDOH Partner Meeting: SDOH Chronic Disease Accelerator Plan

Tuesday, October 11th, 2022, from 1:30-3:00 PM

Meeting Summary

- More than 100 people representing organizations across the state contributed to the meeting. Staff from MDHHS facilitated the meeting and breakout sessions.
- Participants were provided a SDoH Strategy update, and an overview of what to expect in Phase 2, including a focus on Health Equity and aligning and expanding CHW related efforts, and the development of a SDOH Chronic Disease Accelerator Plan.
- There was a focus on key features of the Accelerator Plan as well as breakout sessions with topics including, effective engagement in your communities & networks, unique opportunities and community assets, and barriers and challenges.
- Feedback from each breakout session was captured and compiled. Input will be synthesized and incorporated into the overarching Strategy.

Discussions

In breakout sessions, participants discussed community engagement success stories, barriers and gaps, and opportunities for improvement. Below are the breakout discussion questions:

1. Success Stories: What strategies has your organization used to gather meaningful, sustained community engagement?
2. Barriers & Gaps: What challenges have you seen to effective community engagement?
3. Guidance for Mini-Grants: What factors should MDHHS consider as we design funding opportunities to support community engagement for SDOH and Chronic Disease?

Summaries from these discussions is below. For questions or comments about the overall Social Determinants of Health Strategy, please contact: MDHHS-SDOHPolicyandPlanning@michigan.gov.

Success Stories: What strategies has your organization used to gather meaningful, sustained community engagement?

Group 3 – Cartyea + Jerin (Facilitator + Note Taker)

- Sustained piece is more difficult
- Regular meetings with CHWs (*mentioned by 2 participants*)
- Health assessments were collecting the right data to find the community members who could contribute (*mentioned by 2 participants*)

- VENUE: Outreach while assisting at local farmers' markets.
    - Helped participant's organization understand its members
    - Know how they access food
    - Great opportunity in certain regions
- Work with partner orgs that already have ongoing engagement at the most local level possible
    - VENUE: Example – Info gathering at schools –> interviewing parents
        - LOCAL PARTNER: **Healthy Livonia Coalition** speaks to schools consistently
- Homeless Vulnerability Level Indicator (HMIS + CC360 integration) HIMS = Homelessness Information Management System
    - Info gathered: Recency and severity of homelessness
    - Contact information of the COC who's helping with person with housing instability
    - Further data linkage to Medical Vulnerability Indicator
        - Creates collaboration mechanism between housing and health case managers

Group 2 – Kehli (Note Taker)

- LOCAL PARTNERS: Community Collaboratives, Human Services Collaboratives—cross-sector multidisciplinary groups
    - Some engage community members actively and collaboratively, while some are more focused on professionals
- We stood up permanent advisory groups—incorporate into all activities—standing stakeholder groups—membership may ebb and flow but have been helpful overall to have ongoing feedback/engagement
- Partnered with **Community Health Assessments:** lots of feedback from lots of different sectors—in person, surveys, social media, etc. Also have a really strong **CHW program** where we collect pathway info—what people need—in that way also, as well as community collaboratives as others mentioned
- With the barrier's Middle eastern population face is the lack of identification. Locally in the Metro Detroit Middle eastern community. We can collaborate with nonprofit organizations, LOCAL PARTNERS: **Municipalities** and **religious initiations** (to name a few) to engage with local populations. Having regular communications with those partnerships.
- We have community workgroups of (LOCAL PARTNER) **migrant service providers** to address the Covid-19 pandemic. Similarly, we have 9 **regional migrant resource councils** composed of hands-on local migrant service providers to elevate the health issues that they encounter and can't resolve. Often this is because a farmworker is undocumented or here on an H-2A visa.
- MPSC has conducted a series of agency assistance (VENUES) fairs and listening sessions in various locations across Michigan. **The Low-Income Energy Policy Board**, an advisory board hosted by the Commission has been intentional about including those with lived experience of energy poverty on the Board.

- *Can people also talk about how they foster engagement—incentives? Other benefits of participating?* Often, those who participate are the most comfortable speaking out. How to recruit others?
    - Patients screened for SDoH—some organizations have resources—collect that data to find out what patients need, then we have a seat at the table to advocate for those with unmet needs
- Our team has found that ensuring our approach/setup of the strategic engagement is authentic and accessible to the community supports active engagement. SUPPORTS: For example, **live CC** during meetings, recording meetings, **reviewing documents for appropriate health literacy levels**, etc.
  LOCAL PARTNER: The **Ottawa County Health Department** did a comprehensive survey of farmworkers health needs. They got more than 300 responses and greatly increased our understanding of farmworkers in general. TOOL: They provided a gift card for completing the long survey, I believe it was $50. They also used **MDHHS migrant program staff** to help get survey responses from their clients.

What special community characteristics, assets, and strengths did your engagement efforts reveal?

How could aspects of the proposed Accelerator Plan build on or expand these successful community interactions?

- Looking at budget levels for CBOs and building capacity to make eligible for …

Group 1 – Darien (Note Taker)

- Resident engagement and resident empowerment is crucial to community initiatives to best understand resident voices/ social needs
- CHW are major mechanisms in partner's work
- Utilizing and improving CHNA efforts to collect meaningful data on residents needs
- Leveraging surveys to gain more in-depth details on residents and community member social needs
- Being proactive and directly reaching out to patients as well as utilizing CHWs are Strategies being used to build connections
- Established a resilience zone for community members in Muskegon heights, specifically impacting African American community
    - Lower life expectancy and other disparities are driven by SDOH factors and disinvestment
- Created a council for community members to have a voice and influence decision-making on their own
    - Started at 2 but now there are 6 **neighborhood associations councils** (LOCAL PARTNER)
- Conducting Livability Lab and using CHNA data (TOOLS) to bring community members together and address SDOH efforts and barriers to move the work forward

- LOCAL PARTNER: **Muskegon Pathways HUB** for care coordination (**Trinity Health Muskegon**): Robust CHW efforts with lots of experience & data help better understand patient social needs
- Conducting common assessments which is a tool developed by the CHIR to help gain understanding of population and can utilize the sample data that comes from the surveys
    - Barrier (funding certain aspects)
- Recruited individuals from neighborhood to do surveys in their own neighborhoods in effort to generate more conversation and gain more information about residents
    - Able to have more meaningful conversation and collect more information on community members needs since the **info is not being filtered through organizations**
- Establishing regional health equity council that creates a space for the community to come together in a more structured and meaningful way
- CHWs are conducting SDOH screenings and receiving referrals to link patients to the appropriate care – almost 50 CHWs
- Incorporating the community and other organizations by creating a joint CHNA (TOOL)
- Involving community residents and doing surveys so the community can directly influence and have a voice
    - Survey channeled through social media, partners at (LOCAL PARTNER) **Greater Health Flint Coalition**, community-based organizations
    - Gathered 100 different surveys and analyzed them to ensure they are collecting information from every zip code in the region and specific SDOH factors
    - **Trusted relationships** are important as they continue to seek funding to support their efforts
- Covers 10 counties in Northwest CHIR – only rural region
- Community engagement strategies:
    - Noticed that (LOCAL PARTNER) **Pathways Community Hub** clients are experiencing homeless after being in addiction treatment
        - Convened with clients, addiction agency, and others in the community to figure out how to address the homelessness barrier
        - One lever that need to be changed: when clients are admitted to addiction treatment, they need to ask who is paying rent and reach out to those who are utilizing housing resources to ensure that housing is secured during the 90-day treatment – convening partners and those with lived experience.
    - Robust CHNA work: Hospitals in northern region contribute to the cost of the assessments and the CHIRS prepare reports that go to IRS
        - Designed (TOOL) CHNA so it can align with needs in other region and can be used across organizations that implement CHNA
    - Conducted Community survey (4 flights of pulse surveys) where different community partners included 1-2 intake questions and was able to collect a variety of valuable data around aging, disabilities, income, etc.

    - Community survey mobilizing for action: utilizing best practices for CHNA from national association from city and council framework
        - Received disability inclusion grant for CHNA (high disability rates)
        - Grant for Equity supplement framework
    - REAL time data collected by CHW, and data is given to a host of community groups (governing body, ccl group, behavioral health group, health equity learning network, etc.)
        - Move from community engagement to community empowerment
            - Example: (LOCAL PARTNER) **Resident facilitated substance use groups** in community

- Utilize quarterly community consultations to help assess community capacity for refugee settlement
    - Must talk about the **complexity of refugees** that the community can **sustainably report**
- Continue to convene agencies and individuals from the community to represent housing, health, education, employment and more

Barriers & Gaps: What challenges have you seen to effective community engagement?

Group 3 – Cartyea + Jerin (Facilitator + Note Taker)

- CC360 + HIMS data not current
- Funding agencies place restriction and parameters that prevent authentic engagement
    - Examples: Demographic, number, and other requirements
- Full continuum of community engagement lacking
    - **Shared decision making** is the more challenging element
    - Intentionality and creativity needed to turn info from community into policy decisions
- Prioritizing the goals within communities where the needs are great

Group 2 – Kehli (Note Taker)

- Health services not being available for the undocumented and H-2A farmworkers.
- A big barrier for citizen migrant farmworkers is that MA is so hard to get in Texas, but especially Florida, that they don't want to close their MA cases there to get medical care here.
- Screening SDoH is needed, also utilizing EMR's to gather HEDIS interventions and make outbound calls to appropriate patients.
- At state level community engagement is a challenge for everyone—have had to develop policies to provide incentives, and develop all the appropriate policies to provide those to participants, and we hope to replicate that across the MDHHS

- LOCAL PARTNER **11 Health Equity Councils** Set-Up with community members on the councils—with attention to power dynamics, etc. We want to keep them going, but will need to secure continued funding to get ongoing input from community members

- Aging population is growing—when we talk about engagement including surveys, education, etc.—so much has transitioned to online—we can't forget about the **digital divide** whether it be due to age, rural areas, technology challenges, etc. We need to remember to not overlook traditional, old-fashioned ways of communicating and connecting

Are there subpopulations you've seen inadequately represented?

What would help community members contribute more consistently?

What would help your organization convert community guidance into practice change?

- Having a requirement (possibly of SDoH?) for state's Medicaid Health plans to engage with vulnerable populations. Then grade them on their outreach initiatives.
- Transportation and childcare are two common barriers
- I am trying to get funding for migrant program staff that I can place with migrant health clinics to help farmworkers get MA and other public assistance as well as help them transition from the care we can provide for their chronic conditions here to health care providers in their home state
- We are nearly done with a brochure in English and Spanish (TOOL) to sum up for farmworkers how they can protect themselves from Covid-19 and to urge those with chronic conditions to seek care, especially Paxlovid
- **Arab American/ Middle eastern and the indigenous population**
- Those engaged in the community mental health system are often experiencing **co-occurring disorders** and are some of the most vulnerable.
- Spanish speaking.
- Undocumented.
- H-2A immigrants
- In my work, there is a struggle for CBOs to locate **ASL interpreters for the deaf community** who can accurately translate medical terms into ASL

Group 1 – Darien (Note Taker)

- Exploring ways to incentivizes residents and CHWs for their work (compensation model)
- Lack of trust with residents/community members makes it challenging to empower residents and build meaningful relationships
- Sustainability/ funding
- How can we involve those who need to be a part of community conversation? - Barriers include transportation, childcare
- Language Barriers
- Importance of continuity

- Regional Health equity council is wanting to recognize the value of community resident and having the residents participate in the council
    - Looking for guidance for possibly designing a compensation model that pays/incentivizes their work
- When talking to resident with lived experience and partners, there is a communication challenge – hired consultant in system change to assist
- SDOHs are easy to discuss but the way they impact health equity can take some time
- Barrier: Got to answer the "so what" to get others engaged

    - **Lack of trust** with the community (underserved) is a barrier, especially when inviting individuals to resident led opportunities/initiatives
        - Cannot use non-profits to understand voice, want to get resident's true voice
    - As funding goes away, must develop a sustainable way of doing work
        - The work takes longer than what's anticipated – end up letting the people down when things finally get to rolling
    - Importance of Continuity: replication of CHIR model in areas that do not have a CHIR – opportunity to learn from each other to best address SDOH?
    - Massachusetts Waiver 11-15 - addresses Medicaid population to help address SDOH
        - Are there any plans for the state to explore additional waivers? (TOOL)
    - There is a need to properly acknowledge the ideas and valuable information that residents share
        - Can be difficult as others monetize the ideas
        - FOLLOW-UP? Has the state looked to partner with CHIRs in other initiatives such as the SDOH Chronic Disease plan?
    - Many of the community members that need to be involved in this conversation are living in poverty with several jobs and may not have the time to devote to meetings.
    - Possibly could remove barriers like **transportation** (making the meetings remote - TOOL), providing **childcare** at meetings, and ensuring the community will get something out of their participation (too many times communities have been used for their ideas **and received nothing in return**)
    - Language can be a challenge, community members who do not speak English are left out of the discussion or require culturally tailored messaging for engagement

    - Let folks know that we are not there to take their ideas but to help empower them and build trusted relationships – how do we sustain these relationships

What factors or opportunities should be considered as we develop funding opportunities to support community engagement?

Group 3 – Cartyea + Jerin (Facilitator + Note Taker)

*What factors should MDHHS consider as we design **funding opportunities** to support community engagement for SDOH and Chronic Disease?*

- Be as open as possible to WHO might receive funding
- Reduce the number of requirements
- Be aware of financing and tax implications
- Recognize community members as experts and relinquish control
    - Set aside some funds for smaller orgs within the community
    - Set goals for environmental changes within the frame of the mini-grant
- Use a validated evaluation tool
    - Example TOOL: SFC Systems of Change
        - Tracks changes in power dynamics, relationships, connections among subjects
- Recognize the importance of getting direct feedback from all stakeholders (including health plan members and providers)
- Frame engagement in a way that creates openness and exploration, outside of areas that might be top of mind to MDHHS. (Humans are by nature intersectional).

Group 2 – Kehli (Note Taker)

- When we talk about unrepresented groups, community development corporations, community-based organizations neighborhood associations, etc.—are often the ones with the level of trust to work effectively with the community—a lot of times funding goes to larger organizations that don't have those relationships, so funding & working with those on the ground local orgs. is important.
- Interpreting and bilingual staff are important to communities who are ESL learners
- Getting working people to participate during work hours is difficult/impossible. Evenings are better, provide a meal or a token payment for their time.
- Do all of us have the same **framework for community engagement?** This is important—the way we used to do it was a very outreach focused effort—walked away from that because was causing harm to communities—in that we needed data and didn't focus on transparent or long-term relationships/reciprocal. We have problems with how our systems run. Having a long-term committee may be very challenging within our systems. Often rely on surveys and focus groups and that's it. Our culture and organizational philosophy on this need to shift

- Build up on **already existing committees/boards**, etc. that are already there instead of creating something new—can help with sustainability of already established groups

- PARTNER: Children Trust Michigan (formerly Children's Trust Fund) represents 100+ programs serving all 83 counties with primary and secondary prevention programs. These are all programs that are connected within their communities

• REDI working on reducing cumbersomeness of the application process to allow for smaller organizations with no grant writer to apply more easily. RFP Announcement language is important—standard boilerplate language can be revised. Less application components, etc.

Group 1 – Darien (Note Taker)

- Balance in funding and continue to utilize efforts that work
- Community benefit spending
- Incentivize CHWs and peer support model through Medicaid Reimbursement
- Balance in continuing efforts that we know work (ex: CHIR model) and new funding
    - Create opportunity for replication and innovation
- For Community Health Centers, we have a patient-leadership mandate in our funding program requirements (51% of Board members must be patients receiving services through the health Center)
- This structure helps ensure that the decision-making table of the FQHC are inclusive of those the health center is intended to serve. It can also provide a leadership development opportunity in the community.
- Could be a consideration for funding: What is the representation in the powerholders of a funded project that will direct the work?
- The state could think through ways in which Michigan can utilize community benefit spending – Michigan is a state that does not use community benefits spending
    - State can leverage this and provide an additional nudge to support partners
- Incentivize Medicaid/Medicare providers to utilize peer support and CHW models
- To incentivize peer support model and CHW, time is billed to Medicaid, however, the current reimbursement is low and not livable
- Look to Medicaid to increase reimbursement rate to support work

Next steps:

- Input from these breakout sessions will be thoroughly reviewed and incorporated into the overall strategy as it is refined.
- Additional engagement opportunities will be available to provide input for the development of the innovative phase 2 Strategy. To stay updated with SDOH Strategy efforts, please subscribe to the SDOH Newsletter.