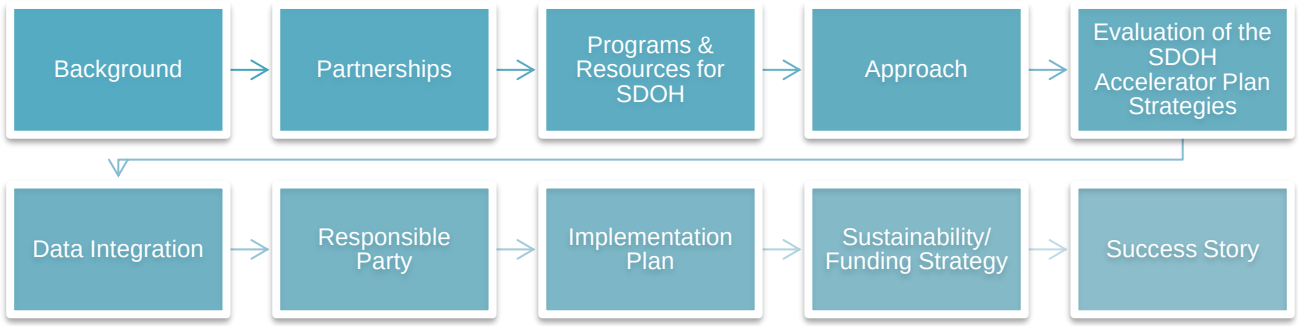
SDOH Accelerator Plan Template

Name: North Central Community Health Innovation Region **Date:** 12/27/23

The recipient is required to include the following components in the SDOH Accelerator Plan.



BACKGROUND

Community Background

☐		Describe and define the tribe, community, or catchment area that the SDOH Accelerator Plan will address. Include any relevant background or historical information that contributes to current health and social community context. The catchment area for the SDOH Accelerator Plan includes the 10-counties of the North Central Community Health Innovation Region (NCCHIR). The 10 counties in the project's catchment area, are designated as "rural health areas" by the U.S. Health Resources and Services Administration[1]: Arenac, Clare, Gladwin, Isabella, Lake, Mason, Mecosta, Newaygo, Oceana, Osceola. Due to the rural nature of the NCCHIR, communities are often under-resourced across the drivers of health (housing, transportation, access to care, education, economic security, etc.). Rural populations experience higher rates of chronic disease, disability, and poverty. The residents in our counties are older in age and have lower life expectancy. Residents in these rural counties are less likely to receive recommended preventative services due to healthcare barriers and inadequate transportation. The total population among the NCCHIR counties is 320,472. NCCHIR counties are predominantly comprised of a Non-Hispanic White population; however, eight counties (Arenac, Clare, Gladwin, Lake, Mason, Mecosta, Newaygo, Oceana, and Osceola) have a higher than Michigan (0.7%) American Indian and Alaska Native population, three (Arenac, Isabella, and Osceola) are higher than Michigan (Less than 0.05%) for Native Hawaiian and other Pacific Islander and two (Newago and Oceana) are higher than Michigan (5.7%) for Hispanic or Latino[2].

Community Health Issues

☐		Identify primary health issues in the community and describe how the recipient used data to determine primary health issues in the community including information about the Community Health Needs Assessment (CHA) if relevant. In the 2021 MiThrive Community Health Assessment (CHA), transportation, chronic disease, economic security, and access to health services were identified as prioritized strategic issues in need of improvement within the NCCHIR 10-county region[11]. In the NCCHIR, 45.2% of providers said transportation resources or services for patients are missing in the community they serve. Transportation is a critical factor that influences people's health and the health of a community. Barriers to transportation options may result in missed or delayed health care visits, increased health expenditures and overall poorer health outcomes. Unreliable transportation and lack of transportation was identified through healthcare provider surveys and surveys of community members.

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Community systems assessments conducted with community collaborative groups identified transportation barriers as impacting the health of their community with a need for increased transportation options at a reasonable cost and easily accessible.

Additionally, 53.8% of providers identified access to quality healthcare services as a top factor for a thriving community and 35.6% of the providers stated that primary care services for patients are missing in the community, they serve [11]. Improving the healthcare system emerged as a theme in the pulse survey mini client interviews when patients were asked to list ways to ensure good health and wellbeing over time. Healthcare and insurance emerged as themes in the pulse survey series when patients were asked to identify what separated individuals with good health versus individuals with poor health. When asking residents to identify top factors for a thriving community, 42.6% said access to quality healthcare services.

Another priority area for this region is economic security. Economic security emerged as a top theme in five of six data collection activities within the 2021 MiThrive CHA. Providing opportunities for the community such as housing, childcare, employment, and schooling is necessary for economic security. Poverty emerged as a theme in the pulse survey series when asking patients to think what separated individuals with good health versus poor health. Furthermore, a lack of job availability and low wages emerged as a theme in the pulse survey for clients who rated the following statement poorly; “There is economic opportunity in the community.”

Several factors, including poverty, lack of access to transportation, and lack of housing may weaken a community’s ability to prevent human suffering and financial loss in a disaster. These factors are known as social vulnerability[3]. The NCCHIR target counties have moderate to high or high areas of social vulnerability. NCCHIR counties have significantly high scores, especially Lake, for the theme of poor socioeconomic status. Oceana County has the highest vulnerability score for theme 3, minority status and language, followed by Isabella County and Newaygo County, respectively.

Figure 1. Social Vulnerability Index by NCCHIR Counties

County	SVI Score	SVI Category	Theme 1: Socioeconomic Status	Theme 2: Household Composition & Disability	Theme 3: Minority Status & Language	Theme 4: Housing Type & Transportation
Arenac	0.5054	Moderate to High	0.7717	0.6396	0.1503	0.2709
Clare	0.772	High	0.8869	0.7345	0.2614	0.674
Gladwin	0.5398	Moderate to High	0.7057	0.6565	0.15	0.4788
Isabella	0.6016	Moderate to High	0.7188	0.0525	0.4712	0.9086
Lake	0.7818	High	0.9395	0.5317	0.2967	0.6877
Mason	0.3376	Low to Moderate	0.392	0.6625	0.2426	0.327
Mecosta	0.5975	Moderate to High	0.7156	0.1878	0.1573	0.9258
Newaygo	0.6318	Moderate to High	0.6723	0.7456	0.4132	0.4963
Oceana	0.858	High	0.7436	0.8914	0.7348	0.7281
Osceola	0.7401	Moderate to High	0.7411	0.9016	0.155	0.7724

The alarming demographic, economic/social, physical environment, and health behavior factors discussed above are associated with a high chronic disease burden. Chronic disease was identified as a priority in the NCCHIR counties in the 2021 CHA. In NCCHIR counties, 34.6% of providers identified disease and illness prevention as a top factor for a thriving community. Disease and illness prevention ranked #4 out of 15 factors. According to the MiThrive CHA (updated using the 2022-2018 Michigan BRFSS), seven counties have percentages of adults who were ever told they have diabetes that are greater than the State (10.8%) in 2021[5,6]. Five counties have a greater cancer age-adjusted incidence rate than the State (428.6), and five counties have Major Cardiovascular Disease age-adjusted mortality rates higher than the state overall (266.3 per 100,000)[7,8]. Seven of the ten counties have higher percentages of adults with obesity than the State in 2021 (34.4%) and five counties have higher percentages of adults reporting overweight than the State in 2021 (34.2%)[5,6]. According to the Robert Wood Johnson 2023 County Health Rankings, five counties have a higher rate than the state (7,900) of potential years of life lost per 100,000[9]. Eight counties rank within the lower 50% of Michigan counties for clinical care, seven counties for health behaviors, seven counties for health outcomes, eight counties for health-related quality of life, and seven counties rank in the lower 50% for health factors [9].

Figure 2. MiThrive Community Health Assessment Chronic Disease Indicators by NCCHIR Counties

BACKGROUND

County	Adult: Ever told Diabetes (%)	All Cancer (Age-adjusted) Incidence Rate per 100,000	Major Cardiovascular Disease (Age-adjusted Mortality per 100,000)	Adults: Obese	Adult: Overweight
Arenac	*	**419.1**	**289.4**	**40.5**	**36.1**
Clare	**19.4**	**470.1**	**355.0**	**48.2**	**28.0**
Gladwin	**18.3**	**470.5**	**307.1**	**43.6**	**31.0**
Isabella	**12.2**	**399.4**	**294.6**	**38.3**	**29.5**
Lake	*	**476.1**	**243.9**	**32.4**	**36.2**
Mason	**15.1**	**414.1**	**241.5**	**37.1**	**38.2**
Mecosta	**9.2**	**440.7**	**295.7**	**28.4**	**46.0**
Newaygo	**11.8**	**440.3**	**247.2**	**43.3**	**32.4**
Oceana	**14.6**	**312.4**	**241.6**	**35.9**	**39.2**
Osceola	**12.9**	**397.8**	**239.9**	**33.8**	**32.4**

Residents in the NCCHIR experience multiple risk factors for health disparities at rates greater than the State as a whole, as reported by Sparkmaps Community Commons[4]. Overall, the population is more isolated (average 57.4 people per square mile versus State at 176.0); older (20.0% of residents are age 65+ versus State at 17.2%); less educated (17.6% age 25+ has earned a Bachelor's degree versus State at 29.1%); poorer (17.7% have income at or below 100% of Federal Poverty Level versus State at 13.7%) and has a greater percentage of disabilities compared to the state (28.5% versus State at 14.2%). A considerable proportion of residents have inadequate access to healthy food (18.8% live in a Food Desert Census Tract), few options for transportation to resources (9.2% of occupied households with no motor vehicle versus State 7.9%); and limited access to safe, affordable housing (21.4% of occupied housing units are in substandard condition and 40.7% spend over 30% of income on shelter costs). In addition, adults in the region engage in health risk behaviors at greater rates than the State as whole. Overall, more adult residents drink alcohol excessively (20.6% versus State at 20.5%); smoke cigarettes (21.5% versus State at 18.6%); eat adequate amounts of fruits and vegetables (30% versus State at 22%); and engage in no leisure time activity (21.8% versus State at 21.7%).

Selected Population(s)

Describe the population(s) selected and the process by which this population was identified. Include description of data used to identify selected population(s) (e.g., demographic, geographic, political boundaries, size of population).

The catchment area for the SDOH Accelerator Plan includes the 10-counties of the North Central Community Health Innovation Region (NCCHIR). The 10 counties in the project's catchment area, are designated as "rural health areas" by the U.S. Health Resources and Services Administration1: Arenac, Clare, Gladwin, Isabella, Lake, Mason, Mecosta, Newaygo, Oceana, Osceola. The selected population will be individuals who are experiencing financial struggles; either below the Federal Poverty Level or ALICE threshold and/or individuals who have one or more disabilities. These individuals often experience barriers to social connectedness and access care within the community.

Recognizing a 10-county region is a large catchment area, the Leadership Team took into consideration sub-populations to target focus group engagement. This included collecting focus group data from individuals within Clare, Isabella, Lake, Mecosta, and Oceana counties that align with the selected population for the grant. Even further breaking down these groups, the Leadership Team took special considerations to include individuals aged 60 and older and families with children under the age of five.

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Out of the ten counties, Lake and Clare have the highest percentage of residents in poverty, have the most residents below the ALICE threshold, and most residents under the age of 65 with at least 1 disability [2,10]. Lake County has a population estimate of 12,308 residents, 16% are under the age of 18 and 31% are over the age of 65. In Lake County, 9% of the population is without health insurance, 22% of the population under 65 have a disability, 57% of households are below the ALICE threshold, and 19% of the population is in poverty[2,10]. Clare County has a population estimate of 31,065 residents, 20% are under the age of 18 and 25% are over the age of 65. In Clare County, 9% of the population is without health insurance, 19% of the population under 65 have a disability, 53% of households are below the ALICE threshold, and 19% of the population is in poverty [2,10]. Additionally, Oceana County and Isabella County have the highest percentage of residents without insurance. In Isabella County 10% of the population is without health insurance and in Oceana County 11% do not have insurance, compared to the state which has 6% uninsured. Isabella County has a population estimate of 64,813 residents, 18% are under the age of 18 and 14% are over the age of 65. Oceana County has a population estimate of 26,815 residents, 22% are under the age of 18 and 22% are over the age of 65. All ten counties have at least 3 out of 4 indicators (% of Individuals in Poverty, % of ALICE Households, % 65 and under with a Disability, % of Uninsured Individuals) higher than the state of Michigan [2,10].

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Figure 3. Percent of residents in each county that fall below the ALICE threshold, under 65 years of age with a disability, without health insurance, and below the Federal Poverty Level

	Arenac	Clare	Gladwin	Isabella	Lake	Mason	Mecosta	Newaygo	Oceana	Osceola
% of households below the ALICE threshold	47%	53%	44%	49%	57%	40%	48%	39%	44%	43%
% of individuals 65 and under with a Disability	14.60%	18.60%	15.00%	11.10%	22.00%	11.50%	13.00%	14.50%	11.70%	14.10%
% of individuals without Health insurance	8.30%	9.20%	8.40%	9.70%	8.60%	7.70%	8.30%	7.70%	10.60%	9.00%
% of individuals below the Federal Poverty Level	14.90%	18.90%	15.90%	18.10%	18.70%	13.80%	17.60%	14.50%	14.40%	12.90%

PARTNERSHIPS

Leadership Team

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Describe the Leadership Team, including the organizational affiliation of each team member, the community and/or population that each member represents, and the role they will serve in developing and reviewing the SDOH Accelerator Plan.

Each member and organization committed representation on the Leadership Team and engagement in the co-creation of the SDOH Accelerator Plan. The Leadership Team consists of the following community partners across the 10-county NCCHIR region.

- **Chiara Cameron-Wood, Executive Director, 2-1-1 of Northeast Michigan:** Provides a free-to-use, confidential service that connects individuals with local community-based organizations across the State of Michigan – regional call center serving Arenac, Clare, Gladwin, and Isabella counties.
- **Anna Reetz, Health Promotion Supervisor, Central Michigan District Health Department:** Local health department serving individuals in Arenac, Clare, Gladwin, Isabella, and Osceola counties.
- **Jenifer Murray, Director, Community Connections:** A free program helping adults, children, and families navigate the community system with Community Health Workers across the 10 NCCHIR counties.
- **Kara Laferty, Chief Quality and Compliance Officer, Community Mental Health for Central Michigan:** Mental health agency serving individuals in Clare, Gladwin, Isabella, Mecosta, and Osceola counties.
- **Scott Lombard, Community Health Manager, Corewell Health:** Health system serving individuals in Lake, Mason, Mecosta, Newaygo, Oceana, and Osceola counties.
- **Terri Robbins, Community Education and Outreach, Disability Network of Mid-Michigan:** Provides assistance to people with disabilities, their families, and the community in Arenac, Clare, Gladwin and Isabella.
- **Brad Hastings, Advocacy & Certified ADA Coordinator, Disability Network of West Michigan:** Provides independent living resources for people with disabilities in Oceana, Newaygo, Lake, and Mason Counties.
- **Sarah Oleniczak, Deputy Health Officer, District Health Department #10:** Local health department serving individuals in Lake, Mason, Mecosta, Newaygo, and Oceana counties.
- **Jacob Walker, Community Affairs, DTE Energy:** Energy utility company serving individuals across the State of Michigan.
- **Julie Tatko, President and CEO, Family Healthcare:** Federally qualified health center providing services for individuals in Lake, Mecosta, and Newaygo counties.
- **Lily Boutwell, SNAP-Ed Coordinator, Gratiot Isabella RESD:** Regional education service district serving individuals in Isabella County.
- **Mary Lynn Clark, Vice President of Health Services, McLaren Health:** Medicaid health plan provider serving individuals across the State of Michigan.
- **Sarah Kile, Director of Community and Partner Engagement, Michigan 2-1-1:** Provides a free-to-use, confidential service that connects individuals with local community-based organizations across the State of Michigan.

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- **Ashley Brenner, Community Health Supervisor, MyMichigan Health:** Health system serving individuals in Arenac, Clare, Gladwin, Isabella, and Osceola counties.
- **Nicole Whitman, Director of Health Home Coordination, West Michigan Community Mental Health:** Mental health agency serving individuals in Mason, Lake, and Oceana counties.

Multisectoral Partners

Describe multisectoral partner roles, responsibilities, and goals.

The Leadership Team is a sub-committee to the NCCHIR Steering Committee. The NCCHIR Steering Committee is comprised of executive-level leaders representing cross-sector organizations and entities with a shared vision of healthy people in equitable communities. The role of the Leadership Team was to co-create the SDOH Accelerator Plan with the ultimate aim of improving chronic disease outcomes among persons experiencing health disparities and inequities. This included attending monthly virtual meetings, engaging in asynchronous engagement formats, supporting action items, and participating in accelerator plan development workshops. These workshops included analyzing data, identifying themes, prioritizing needs, and researching evidence-based strategies to address priorities. Additionally, Leadership Team members served as trusted messengers with individuals of the project's priority population to promote project engagement opportunities including the resident survey, focus groups, and strategy questionnaire.

The Leadership Team remained open to new partners and community members throughout the duration of the grant and asynchronous engagement options were made available for participation. The role of the NCCHIR backbone staff (also referred to as project staff) was to support the tactical and logistical elements of the Leadership Team. This included coordinating and facilitating meetings, sending meeting notes, supporting action items, and communicating project updates. The Steering Committee stayed informed on the project development and provided additional insight as requested.

Identify potential missing partners that may contribute to improving SDOH.

Potential partners that may have contributed to improving the SDOH Accelerator Plan include representatives of local Tribal Nations, specifically the Little River Band of Ottawa Indians and Saginaw Chippewa Indian Tribe, and community partners supporting individuals experiencing housing insecurity. Additionally, transportation authorities were identified as a missing partner. Given transportation emerged as a prioritized strategy, the Leadership Team and project staff identified engagement methods outside of the monthly Leadership Team meetings to connect with transportation partners via a transportation environmental scan. This involved email, phone calls, and virtual meetings with transportation partners.

Describe method used to engage diverse and inclusive new and existing partners in program planning and implementation efforts.

Due to the development and successes of the NCCHIR network over the past three years, many community partners completed letters of support during the grant application phase. Organizationally, the Leadership Team was a sub-committee of the NCCHIR Steering Committee which allowed for frequent project updates to the Steering Committee with opportunities for Steering Committee members not on the Leadership Team to provide feedback, ask questions, and offer as needed support. Community partner stipends were written into the grant application to support time for partners to engage in the yearlong project. While stipends for the entire Leadership Team were secured, only one organization required the funding for participation. The Leadership Team voted to allocate the remaining funds to bolster community engagement efforts to support the development of the SDOH Accelerator Plan. Promotion for joining the Leadership Team was also incorporated into the NCCHIR quarterly newsletters which included project updates, ad hoc engagement opportunities, and contact information to join the Leadership Team. The Leadership Team was open to all individuals, partners, and organizations/agencies with an interest in contributing to the SDOH Accelerator Plan. Recognizing everyone's capacity fluctuates, synchronous (monthly virtual meetings) and asynchronous (emails, SharePoint folder, surveys, and Mural Board) engagement options were offered. Additional, engagement methods, outside of the meetings, were conducted by project staff with transportation authorities and partners. A transportation environmental scan was conducted to connect with transportation authorities to incorporate feedback into the planning process and inform implementation.

Describe new partner linkages and how duplication of services across partners was minimized or avoided.

Many of the community partners engaged in the Leadership Team are a part of the NCCHIR Network which includes the Steering Committee, MiThrive Workgroup (Community Health Assessment & Improvement Planning), and the Community Clinical Linkages (Community Health Workers) Workgroup. New community partner linkages as a result of this grant include strengthened relationships with two area Disability Networks: Disability Network West Michigan and Disability Network of Mid-Michigan. These partners played a critical role in the development of the SDOH Accelerator Plan as representatives of the project's priority population.

Within the NCCHIR, alignment, coordination, and strategic coherence of efforts across the region are essential. The Leadership Team took an asset-based approach to developing the SDOH Accelerator Plan by conducting an inventory of programs, services, and initiatives that aligned with the two priority domain areas of community clinical linkages and social connectedness as a method for minimizing and avoiding duplication of efforts. This approach resulted in an SDOH Accelerator Plan that builds off existing services, programs, and complements existing regional plans such as the NCCHIR Community Health Improvement Plan.

Shared Mission and Goal Statement

PARTNERSHIPS

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The Leadership Team will articulate a shared mission statement that represents the purpose of the SDOH Accelerator Plan, with mutually agreed upon goals.

NCCHIR Vision: Healthy People in Equitable Communities.

Leadership Team Mission: Through development of an implementation ready SDOH Accelerator plan the NCCHIR Leadership Team will address issues of access to and utilization of chronic disease prevention and management services and increase social connectedness to improve chronic disease outcomes among individuals with disabilities and/or struggling financially.

Leadership Team Goals:

- Increase social connectedness among priority population.
- Address access and utilization issues of chronic disease prevention and management services to reduce chronic disease rates among priority population.

PROGRAMS AND RESOURCES FOR SDOH

Existing Resources and Programs

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Describe the existing resources and programs available for the selected population(s). If multisectoral intake and referral systems exist, include a description of how the various programs currently work together.

A landscape analysis was conducted to identify existing resources and programs available for the priority population (individuals with disabilities and/or struggling financially) within the NCCHIR 10-county region. The landscape analysis focused on resources, services, programs, and initiatives related to chronic disease, community-clinical linkages, and social connectedness. A shareable Excel document was developed to inventory this information with the following categories: entity, service/program/resource, catchment area, priority population, and additional notes. This file was made available via the Leadership Team SharePoint site and shareable beyond the Leadership Team via Box access link. Additionally, high-level summary data was incorporated into the Leadership Team's priority area profiles that were utilized during the accelerator plan workshops.

The landscape analysis yielded a comprehensive inventory, unveiling two predominant themes. First, a noticeable disparity emerged in the distribution of resources across counties, highlighting unequal resource availability. Second, there was not a common awareness of these resources across the Leadership Team. Summary information illuminating the unequal distribution of resources across the 10-county region are as follows:

- Newaygo and Oceana counties have the most Community Clinical Linkages resources identified with a total of fourteen respectively, while Arenac County has the lowest number of Community Clinical Linkages resources with a total of two identified.
- Lake County had the most social connectedness resources identified with a total of thirteen; while Osceola County had the lowest number of social connectedness resources with a total of zero identified.
- Oceana County was identified to have the highest number of chronic disease programs and services with a total of thirteen; while Arenac County has the lowest number of chronic disease programs and services with one identified.

See attachment: NCCHIR SDOH Accelerator Plan Inventory

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SDOH Priority Areas

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Describe the selected SDOH priority areas (a minimum of two (2)) and provide justification for selecting the priority areas.

The prioritization of community-clinical linkages and social connectedness as priority areas for the SDOH Accelerator Plan was informed by the extensive data analysis conducted during the 2021 MiThrive CHA across 31 counties in Northern Michigan. This comprehensive assessment revealed a web of interconnected challenges affecting various demographic groups disproportionately within the region. Identified through surveys and collaborative discussions, a multitude of issues surfaced, including affordable housing shortages, substance use disorders, limited access to mental health services, transportation barriers, economic instability, lack of community support, disparities in broadband access, food insecurity, and obesity, among others.

Given the widespread impact of these factors on health and well-being, stakeholders and residents prioritized four strategic concerns: mental health, economic security, chronic disease, and access to healthcare. It was evident that addressing these concerns required a holistic approach focusing on community-clinical linkages and fostering social connectedness. By concentrating efforts on these priority areas, the NCCHIR SDOH Accelerator Plan aims to mitigate health disparities and improve chronic disease outcomes. Recognizing that health outcomes are influenced beyond medical settings, this initiative seeks to mobilize stakeholders, align initiatives, and forge partnerships beyond traditional healthcare realms. This approach underscores

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the vital connection between resilient communities and healthier individuals, drawing in diverse partners to collectively fortify the target populations in the NCCHIR.

The following shared definitions were used during the development of the SDOH Accelerator Plan:

Community Clinical Linkages: Connections made between health care, public health, and community organizations to improve population health. These connections can reduce health disparities by bridging the gap between clinical care, community or self-care, and the public health infrastructure (CDC). Access to healthcare refers to the ability of individuals to obtain necessary medical services and treatment without financial, geographic, or systemic barriers, ensuring that everyone has the opportunity to maintain and improve their health. Access to healthcare is vital because it not only preserves and enhances individual health but also promotes social equity and well-being by making sure that all members of a society can receive essential medical services and treatments when needed. When looking specifically at rural communities, access to healthcare ensures that residents in these areas can receive timely and quality medical services, reducing health disparities and improving overall well-being despite the challenges of geographic isolation and limited healthcare infrastructure.

Social Connectedness: Social connectedness refers to the degree to which individuals or groups in society feel connected to and engaged with each other. It encompasses the sense of belonging, the quality of relationships, and the extent of social interactions within a community or society. Social Connectedness has various benefits for individuals and society as a whole. It can lead to increased happiness, improved mental and physical health, reduced stress, and a greater sense of purpose and well-being. Conversely, low social connectedness can lead to feelings of isolation, loneliness, and alienation, which can have negative consequences for individuals' mental and physical health (CDC).

Outcomes

Describe the short-, intermediate, and long-term outcomes that will result from the planned SDOH strategies and activities.

The Leadership Team defined outcomes as follows:

- Short-Term Outcomes – Immediate effects: weeks-months; This could look like changes in knowledge, skills, awareness, attitudes, or beliefs.
- Intermediate Outcomes – Intended effects that occur over the mid-term: months-years; This could look like a change in policies or behaviors, practices, and actions.
- Long-Term Outcomes – Long-term effects: years-decades; This could look like changes in culture, systems, and health outcomes.

Reduce stigma associated with disability, mental illness, and substance use.

- Short-Term: Increased awareness, knowledge, and skills to reduce to stigma.
- Intermediate: 1) Improved healthcare experiences. 2) Improved community experience.
- Long-Term: 1) A more inclusive and empathetic community. 2) Decreased social isolation.

Improve the accessibility of events, programs, services, and community spaces.

- Short-Term: Increased knowledge on best practices to support accessibility of events, programs, services, and community spaces.
- Intermediate: Increased participation in community events, programs, services, and community spaces.
- Long-Term: Increased social connectedness among residents in our communities.

☐ **Establish shared understanding and promote effective communication for social determinants of health across sectors.**

- Short-Term: Improved understanding of the importance of social determinants of health.
- Intermediate: 1) Established shared language for social determinants of health across sectors. 2) Increased motivational interviewing capacity across partners. 3) Increased capacity to address social determinants of health needs across sectors.
- Long-Term: Improved culture of recognizing the relationship between social determinants of health and improved health outcomes across sectors.

Increase Community Health Worker capacity to address chronic disease.

- Short-Term: 1) Increased awareness of chronic disease services and programs. 2) Improved ability to refer clients to chronic disease programs and services.
- Intermediate: 1) Increased number of individuals being referred to chronic disease programs and services. 2) Increased number of individuals participating in chronic disease programs and services. 3) Increased number of chronic disease prevention and management programs.
- Long-Term: 1) Improved health outcomes for referred individuals. 2) Lower healthcare costs on the healthcare system. 3) Reduced chronic disease disparities among priority population.

Make social connectedness a community norm.

- Short-Term: 1) Increased knowledge and awareness of community events. 2) Increased awareness about the importance of social connectedness within the community.
- Intermediate: 1) Increased participation among community members at community events. 2) Integration of connectedness principles into existing services and programs.

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- Long-Term: 1) Improved social connectedness among community. 2) Sustainable and holistic support structures within the community, where connectedness is a core value embedded in all services and programs, resulting in a stronger, more resilient community.

Facilitate community-led interventions addressing barriers to care.

- Short-Term: 1) Improved relationships with community members, grassroots organizations, and community power building entities. 2) Improved awareness of opportunities to address barriers to care.
- Intermediate: 1) Improved community buy-in. 2) Increased funding to support place-based initiatives that address barriers to care. 3) Improved recognition of social determinants of health needs.
- Long-Term: Improved access to care.

Increase awareness and coordination of social determinants of health resources.

- Short-Term: Increased awareness of Community Health Workers, navigators, resource navigation platforms, and resources supporting access to social determinants of health resources.
- Intermediate: 1) Improvements in referral numbers (CHW's & 211). 2) Increased number of community partners updating their 211 information.
- Long-Term: 1) Improved self-sufficiency. 2) Improved health outcomes for referred individuals.

Enhance accessible and efficient transportation services.

- Short-Term: 1) Increased awareness of transportation resources. 2) Strengthened partnership between transportation authorities and community partners.
- Intermediate: 1) Identified assets and gaps in the transportation system. 2) Regional coordinated transportation service model developed. 3) Increased access to transportation services.
- Long-Term: 1) Increased opportunities for social connections. 2. Increased access to healthcare services.

Activities

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Describe the process for identifying and tailoring approaches to the selected tribe, community, or catchment area.

Planning activities included identifying a resident voice and engagement approach, completing a SWOT (strengths, weaknesses, opportunities, and threats) analysis, completing an existing services and resources landscape analysis, collecting secondary data, and engaging in four accelerator plan workshops. The accelerator plan workshops were designed using a combination of the Mobilizing Action Through Planning and Partnerships Framework and the ABLe Change Action Learning Cycle. A Mural Board (virtual whiteboard) was used for all workshops to record progress and allow for asynchronous engagement outsides of the monthly meetings. Additionally, a transportation environmental scan was conducted to build relationships with transportation authorities and partners and tailor activities within the transportation strategy. The culmination of these planning activities enabled the Leadership Team to develop strategies, activities, and outcomes (short, intermediate, and long-term) for the domain areas of social connectedness and community clinical linkages.

The Leadership Team made a commitment to prioritize resident voice and engagement in the development of the SDOH Accelerator Plan. Early in the project, the team reviewed the community engagement continuum and assessed realistic benchmarks for the committee to achieve. The community engagement continuum benchmarks selected were to inform, consult, and involve individuals a part of the project's priority population. The aim of these engagement methods was to ensure accuracy, support transparency, listen deeply when seeking information from and working with community, model to others by acknowledging and applying shared learnings, and prioritize deeper understanding and authentic community involvement.

Outputs of this commitment included conducting a resident voice survey, focus groups, and a post-focus group strategy questionnaire with residents. The goal of the survey and focus groups were to gather information from the priority population related to access to healthcare, social connectedness, and accessing community resources. Individuals were compensated $25 for completing the survey and $100, $15 gas card, and provided food for engaging in the focus group. Data and information collected from the survey and focus groups informed the development and prioritization of the accelerator plan strategies. Once the strategies were prioritized by the Leadership Team, a post-focus group strategy questionnaire was developed to close the engagement loop. The purpose of this questionnaire was to value residents as experts, socialize the prioritized strategies with residents, identify any course correction opportunities and incorporate additional feedback into the activity development phase. The following questions were posed to residents:

1. Do these strategies address the barriers you are experiencing related to access to services and/or social connectedness?
2. What is your favorite strategy and why?
3. What is your least favorite strategy and why?
4. Do you have any alternative ideas or solutions to propose that are not listed above?
5. Select one strategy from above and give us some tips for incorporating the strategy into your community.
6. What other ways do you think we should include residents in this process? (example; invite to workgroup, project-specific mailings, project-specific townhalls, collaborate on finding grants, etc.)
7. Do you have any concerns or reservations that haven't been addressed?

Individuals were able to provide feedback asynchronously via email or by engaging in a phone call with project staff. Individuals were compensated $25 for completing the questionnaire. As a result, residents shared that they felt heard in the planning

process, were thankful for a safe space to express concerns and voice ideas and felt increased buy-in in the project. Largely, the participants expressed that they were grateful for the chance to voice ideas, and even connect with others experiencing the same types of challenges/barriers. The post focus group strategy questionnaire gave a chance for the participants to see that they were heard, and to have a voice in the process, leading to more "buy-in" and brainstorming of ideas. This process gave the Leadership Team direction to further refine and redirect efforts, further solidifying future buy-in with the community, as well as acts as a check and balance to make sure the Leadership Team were getting the most accurate picture of the barriers experienced. In addition to engaging community for the development of the accelerator plan, the Leadership Team's diverse membership served as a critical element for consistently weaving in important contextual information pertinent to the priority population.

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Describe the activities required to improve SDOH for the selected population(s).

The following activities are organized by strategy and aligned by domain area.

Community Clinical Linkages:

- Establish shared understanding and promote effective communication for social determinants of health across sectors.
  - Identify who is implementing social determinants of health screenings (outside of the health sector) and if none in use promote the Community Connections tool.
  - Develop business sector relationships.
  - Develop relationships with disability networks for social determinants of health screening and referral.
  - Support more partners receiving motivational interviewing & Community Health Worker training.
  - Secure additional Community Health Workers to respond to increased need.
  - Respond to SDOH needs identified via Community Health Workers.
- Increase awareness and coordination of social determinants of health resources.
  - Environmental scan of existing care coordination groups and care coordinators in the region.
  - Develop a clinical linkages collaborative meeting in each county.
  - Establish and/or improve interagency referrals.
  - Identify reasons why partners are not using 211 and collaboratively problem solve these barriers.
  - Advocate for 211 to support warm hand offs.
  - Improve partnerships with businesses to support employees accessing community services.
- Increase Community Health Worker capacity to address chronic disease.
  - Utilize Community Health Workers to connect residents with chronic disease resources.
  - Implement chronic disease health education modules.
  - Track chronic disease learning modules that Community Health Workers implement.
  - Align chronic disease pathways with available health education modules in the community.
  - Conduct Community Health Worker training on chronic disease resources within the NCCHIR.
  - Increase promotion of chronic disease services and programs.
  - Secure additional Community Health Workers to respond to increased need.
- Facilitate community-led interventions addressing barriers to care.
  - Build relationships with trusted partners in the community already connecting with residents.
  - Identify resources already available to build off of for mini-grants.
  - Secure funding to support resident led interventions.

Social Connectedness:

- Improve the accessibility of events, programs, services, and community spaces.
  - Conduct accessibility reviews of existing community spaces.
  - Promote Disability Network trainings on accessible events.
  - Educate the community on how to host a barrier free event.
  - Advocate for businesses to adhere to ADA guidelines.
- Make social connectedness a community norm.
  - Root cause analysis (via listening sessions with residents) to identify barriers to engagement in events, services, and programs.
  - Identify outreach best practices across partners.
  - Encourage cross-sector community event sharing.
  - Support central locations to promote social events going on in the community.
  - Implement community-wide campaign on the benefits of social connectedness.
  - Embed connectedness practices into existing services and programs.

Hybrid Community Clinical Linkages & Social Connectedness:

- Reduce stigma associated with disability, mental illness, and substance use.
  - Develop and distribute surveys to the public, and healthcare providers, to assess attitudes and awareness around mental illness, disability, and substance use to inform trainings.
  - Assess how colleges are supporting stigma training and identify opportunities to support (what are they doing & how can we support).
  - Support training for healthcare professionals and students (middle school – college). Training topics will include cultural competence, stigma, and implicit bias.
  - Conduct a social media campaign to inform public of stigma and how to reduce stigma.
- Enhance accessible and efficient transportation services.
  - Build relationships with transportation partners.

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- Share environmental scan data (inclusive of resident data collected) with transportation partners.
- Build a shared understanding of barriers and opportunities between transit authorities, community partners, and residents.
- Partner with community members to serve as community transportation advocates.
- Advocate for local transportation authorities to utilize software to improve user experience.
- Advocate for extended transportation hours.
- Collective advocacy for improved broadband to support technology improvements.

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Describe the number and types of evidence-based practices identified and tailored to improve SDOH for the selected population(s).

This plan includes evidence-based practices within the strategies and activities to address community clinical linkages and social connectedness.

Evidence-based practices embedded within the workplan to address the community-clinical linkages include:

- To increase Community Health Worker capacity to address chronic disease this plan uses the Care Coordinator/Manager Model identified in the Rural Health Information (RHI) Hub Evidence-based Toolkits. (https://www.ruralhealthinfo.org/toolkits/community-health-workers/2/manager).
- To increase awareness and coordination of SDOH resources this plan will use the RHI Care Coordinator Model https://www.ruralhealthinfo.org/toolkits/care-coordination/2/care-coordinator-model
  - CHWs as care coordinators will provide a range of services to help patients overcome barriers to receiving care or treatment. Care coordinators can help to address barriers related to language and culture, communication, transportation, bias (e.g., based on culture, race, or age), and fear. Care coordinators can also help patients transition between healthcare providers and healthcare settings.
- To establish shared understanding and effective communication for SDOH across the region this plan identified the Partnership Model from the RHI Hub. https://www.ruralhealthinfo.org/toolkits/care-coordination/2/partnerships-model
  - Partnerships between different healthcare organizations can improve care coordination, care transitions, and patient outcomes. Programs can arrange partnerships to achieve care coordination goals by sharing resources and data, making referrals for their patients, enhancing communication, and exchanging best practices. Using a systems approach for these activities may increase quality of care delivered to patients.
- To facilitate community-led interventions addressing barriers to care this plan will use the asset-based community development (ABCD) approach. https://www.ruralhealthinfo.org/toolkits/sdoh/2/social-and-community-context/asset-based
  - This model builds on the assets that are already found in the community and mobilizes individuals, associations, and institutions to come together to build on their assets, not concentrate on their needs.
  - Community-led interventions are also referenced in the Healthy Places by Design *Socially Connected Communities* guide: https://healthyplacesbydesign.org/wp-content/uploads/2021/03/Socially-Connected-Communities_Action-Guide-for-Local-Government-and-Community-Leaders.pdf

Evidence-based practices embedded within the workplan to address social connectedness include:

- Improve the accessibility of events, programs, services, and community spaces
  - From the CDC Promising Approaches to Promote Social Connectedness and Reduce Loneliness and Isolation we will use the Built Environment recommendation of design features that increase mobility and facilitate community participation and creation, expansion, and improvements made to safely access green spaces. https://www.cdc.gov/emotional-wellbeing/social-connectedness/partners.htm
- Make social connectedness a community norm.
  - From the Healthy Places by Design *Socially Connected Communities* the plan includes strategies from Recommendation # 5 - Make Social Connectedness a Community Norm. https://healthyplacesbydesign.org/wp-content/uploads/2021/03/Socially-Connected-Communities_Action-Guide-for-Local-Government-and-Community-Leaders.pdf
    - Use a Social in All Policies framework.
    - Implement trauma- and resilience-informed practices.
    - Declare community values.

Evidence-based practices for hybrid strategies include:

- Reduce stigma associated with disability, mental illness, and substance use.
  - *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change* from the National Academies of Science. Activities include educational campaigns and programs, contact-based anti-stigma interventions, peer support services, and advocacy campaigns
  - From the Rural Health Information Hub: https://www.ruralhealthinfo.org/toolkits/health-equity/2/inclusive-non-stigmatizing-language
  - Using Inclusive, Non-Stigmatizing Language to Better Communicate about Health Equity

- Enhance accessible and efficient transportation services
  - Coordinated Services Models https://www.ruralhealthinfo.org/toolkits/transportation/2/models-to-improve-access/coordinated-services-models

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This model involves the coordination of individual service programs in a community to improve the efficiency of limited transportation resources. Agencies work together to share resources, knowledge, and funding to increase the number of people being served. The overarching goals of coordinated planning models are to provide more rides for the same or lower cost, to simplify how services are accessed, and to improve the rider's satisfaction with services.

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Describe the types of community and systemic barriers encountered and addressed during the plan development process.

Individuals living with a disability and/or struggling financially have long experienced health inequities leading to health disparities. Through seven in-person focus groups, the Leadership Team identified numerous community and systemic barriers encountered by the priority population related to the domain areas of social connectedness and community clinical linkages.

Barriers in forming or maintaining social connections: Recognizing barriers to social connectedness is crucial because it enables us to address and overcome the factors that hinder meaningful relationships, fostering a more inclusive and supportive society where individuals can thrive together. Focus group participants addressed the following barriers they experience in forming or maintaining social connections.

- **Limited Spaces for Gatherings** - rural counties have fewer community centers, recreational facilities, and gathering places where people can meet and interact. This lack of physical spaces for socializing can hinder connectedness.
- **Economic Challenges** - rural areas may face higher levels of poverty and unemployment, which can limit residents' ability to participate in social activities or access resources that promote connectedness.
- **Limited Access to Technology** - people living in rural communities may have limited access to high-speed internet and digital technology, making it difficult for residents to connect with others online or access information and services.
- **Stigma and Mental Health Challenges** - there is greater stigma surrounding mental health issues, which can discourage individuals from seeking support when needed, leading to social isolation.
- **Transportation Challenges** - limited public transportation options and long travel distances can make it difficult for rural residents to attend social events or visit friends and family.

Barriers in accessing transportation: Recognizing barriers to accessing transportation is essential as it allows for the development of solutions that can bridge gaps in mobility, ensuring that everyone, regardless of their circumstances, can access vital services, employment opportunities, and community engagement, thereby promoting social equity and inclusivity. Participants identified various barriers to accessing transportation.

- **Vehicle Ownership Costs** - most individuals are more likely to rely on personal vehicles for transportation. However, the cost of owning and maintaining a car, including fuel, insurance, and repairs, can be a significant burden for low-income residents.
- **Limited Bus Operating Hours** - buses in rural areas may have limited operating hours, making it challenging for people who work non-standard hours or need transportation outside of regular service times.
- **Healthcare Access** - limited transportation options can be a barrier to accessing healthcare services, especially for those who need to travel long distances to reach medical facilities.

Barriers in access healthcare: Access to healthcare is vital because it not only preserves and enhances individual health but also promotes social equity and well-being by making sure that all members of a society can receive essential medical services and treatments when needed. When looking specifically at rural communities, access to healthcare ensures that residents in these areas can receive timely and quality medical services, reducing health disparities and improving overall well-being despite the challenges of geographic isolation and limited healthcare infrastructure. Participants identified various barriers to accessing healthcare services.

- **Limited Healthcare Facilities** - these rural counties have fewer healthcare facilities, leading to overcrowding, long wait times, and difficulty in accessing immediate care.
- **Healthcare Provider Shortages** - these rural counties frequently suffer from a shortage of healthcare professionals, including doctors, nurses, and specialists. This shortage limits the availability of healthcare services.
- Financial Barriers- residents in these counties may have lower income levels, making it harder to afford healthcare services.
- **Transportation Challenges** - these counties often lack reliable public transportation, and individuals may not have access to private vehicles. This can make it difficult to travel to healthcare facilities, especially for routine check-ups or follow-up appointments.
- **Stigma and Beliefs** - some residents experienced stigma in the healthcare setting, which can discourage them from seeking necessary care or preventive services.
- **Health Literacy** - limited health literacy and awareness can affect residents' ability to understand and navigate the healthcare system, including knowing when and where to seek care.

These trends underscore the complex interplay between healthcare, social dynamics, and transportation challenges in rural Michigan, highlighting the need for tailored solutions to address these multifaceted issues. Barriers listed above can be explored in full in the SDOH Accelerator Plan Focus Group Report. Barriers that emerged from the focus groups were incorporated in the SDOH Accelerator Plan development through a barrier busting workshop to develop powerful strategies that tied directly to the barriers identified.

See attachment: NCCHIR SDOH Accelerator Plan Focus Group Report.

APPROACH

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Describe how policy, systems, environmental, programmatic and infrastructure activities build on each other to sustain health improvements and the achievement of selected outcomes.

The Leadership Team took an asset-based approach to developing the SDOH Accelerator Plan by conducting an inventory of programs, services, and initiatives that aligned with priority domains (community clinical linkages and social connectedness) as a method to sustain community change efforts and improvements. The SDOH Accelerator Workplan encompasses policy, systems, environmental, programmatic, and infrastructure activities (reflected below) that synergistically align towards improving social connectedness and community clinical linkages.

Community Clinical Linkages Strategies: Strategies targeting the community clinical linkages domain are interlinked in that each strategy builds off existing social determinants of health programs and services, aligns with existing care coordination models including 2-1-1 and Community Health Workers, works across sectors to amplify change efforts, and shifts system conditions by closing the gap between traditional decision-makers and those experiencing the problem, barrier, or inequity.

- Establish shared understanding and promote effective communication for social determinants of health across sectors: Activities target systems and programmatic changes.
- Increase awareness and coordination of social determinants of health resources: Activities target systems, programmatic, and infrastructure changes.
- Increase Community Health Worker capacity to address chronic disease: Activities target policy, systems and programmatic change.
- Facilitate community-led interventions addressing barriers to care: Activities target policy, environmental, programmatic, and infrastructure change.

Social Connectedness Strategies: Strategies targeting the social connectedness domain are mutually reinforcing in that each strategy targets different system conditions with the shared outcome of improving social connectedness.

- Improve the accessibility of events, programs, services, and community spaces: Activities target policy, environmental, programmatic, and infrastructure change.
- Make social connectedness a community norm: Activities target systems change.

Hybrid Community Clinical Linkages & Social Connectedness Strategies: Strategies targeting both priority domains are interlinked in that each strategy targets a different “slice” of the problem with the ultimate aim of improving chronic disease outcomes by reducing barriers to care, specifically, reducing stigma and improving transportation.

- Reduce stigma associated with disability, mental illness, and substance use: Activities target systems change.
- Enhance accessible and efficient transportation services: Activities target policy, environmental, systems, programmatic, and infrastructure change.

Anticipated Reach of the Activities

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Describe the potential reach of the activities for the selected population(s).

The SDOH Accelerator Plan aims to make meaningful impact on individuals residing, employed, or seeking resources within the 10-county NCCHIR encompassing Arenac, Clare, Gladwin, Isabella, Lake, Mason, Mecosta, Newaygo, Oceana, and Osceola counties. Specifically targeting those who live with disabilities and/or are financially struggling. By strategically utilizing strategies that build off existing community assets, there's a noteworthy opportunity to actively engage and benefit not only the target population but also individuals already accessing services and programs beyond the priority group. Additionally, these planned initiatives aim to bring about enhancements in system conditions, promising positive impact that extend beyond the identified priority population, thereby fostering widespread improvements in the region's overall well-being. To summarize, the anticipated reach can be categorized as follows: intended audience, service users that fall outside of the intended audience, and the community at large.

Anticipated Policy, Systems, Environmental, Programmatic, and Infrastructure Outcomes

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Describe sustainable outcomes that will result from implementation of the SDOH Accelerator Plan strategies and activities.

By implementing the SDOH Accelerator Plan, the following sustainable outcomes will be achieved:

- Policy:
  - Policy improvements related to accessibility, transportation, and broadband.
  - Development of a regional coordinated transportation model.
- Systems:
  - Increased opportunities for residents to be referred to social determinants of health services in the community.
  - Integration of connectedness principles into existing services and programs.
  - Power dynamic shifts as a result of facilitating community led interventions to address barriers to care.
- Environmental:
  - Improved accessibility for events, programs, services, and community spaces.
- Infrastructure:
  - Improved opportunities for residents to access services and connect with the community via improved transportation options.
- Programmatic:

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- Strengthened capacity for Community Health Workers to address chronic disease through prevention and management education and navigation.
- Increased motivational interviewing capacity across partners.

In addition to sustainable outcomes as a result of the SDOH Accelerator Plan strategies, lessons learned from the resident voice and engagement method used will be scaled to the NCCHIR Steering Committee through the following recommendations.

Key Resident Voice & Engagement Recommendations:

1. Commit to engaging people with lived/living experience.
2. Create meaningful opportunities for engagement.
3. Pay people with lived/living experience for their time.
4. Eliminate financial barriers to participation.
5. Diversify Steering Committee representation to reflect the demographics of the region.
6. Ensure community engagement is a standard budget line item in future grant applications.

The aim of these recommendations will be to move the NCCHIR resident engagement efforts from an ad hoc approach to fully embedded into the NCCHIR's work.

EVALUATION OF THE SDOH ACCELERATOR PLAN STRATEGIES

Describe how the SDOH Accelerator Plan strategies and outcomes will be measured, with particular focus on the social and public health impact on the selected population(s).

Reduce stigma associated with disability, mental illness, and substance use.

- There is limited existing data around stigma, the team will need to conduct a stigma assessment using pre-existing surveys to gather a baseline of community stigma. Currently there are 4 assessments developed to look at stigma within specific groups: the general public, individuals in recovery, healthcare staff, and law enforcement. This strategy will utilize the general public and healthcare staff assessment to learn more about internalized stigma, social stigma, knowledge of overdose signs, and thoughts towards harm reduction within the population. Additionally, pre and post tests will be conducted during the stigma trainings to monitor a change in awareness, knowledge, and skills within our target populations. The social media campaign will provide engagement metrics such as views, likes, and shares that will aid in tracking the reach of a stigma education campaign. Lastly, this strategy will track all process metrics related to number of partners, meetings, and trainings while developing relationships with healthcare and college partners.

Improve the accessibility of events, programs, services, and community spaces.

- In the first part of this strategy, we will conduct an assessment of existing community spaces to measure accessibility using the Disability Networks accessible spaces tool. The number of locations assessed will be recorded for this activity. As well as the number of accessibility improvements identified for each location. In addition, we will track the number of individuals with disabilities that were able to use these spaces before and after accessibility improvements were completed. In addition, we would partner with the Disability Network to conduct trainings on accessible events and receive process metrics for the number of events hosted and attendees. Education and advocacy will be monitored through process metrics such as number of viewers or participants and number of outreach opportunities.

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Establish shared understanding and promote effective communication for social determinants of health across sectors.

- Community Connections collects data on the number of residents that interact with the Community Connections referral program and number of social determinants of health risks individuals are facing. A baseline can be set using the current number of SDOH-related referrals and this metric can be monitored after implementing the activities within this strategy. In addition, the number of staff trained to be community health workers within the Community Connections program will be monitored. As the number of trained community health workers increases, we should see an increase in the number of referrals being completed. An assessment will be completed by clients after staff have implemented the SDOH-related referrals screening to gather feedback on the usefulness of the tool and the ability to refer individuals to services. The second activity of this strategy is to develop partnerships and train partners on motivational interviewing which will serve as process metrics for this strategy. The team will collect data on the number of partner interactions, the number of partners trained in SDOH screening/referrals, and the number of motivational interviewing training courses completed.

Increase community health worker capacity to address chronic disease.

- Community Connection data will also be used to assist in monitoring the success of the chronic disease strategy. Our team can see how many residents are currently being referred to chronic disease services as a baseline and if this number increases during the implementation of this strategy. Process metrics will be used to track the completed learning modules the community health workers finish in order to improve their ability to promote chronic disease education and programs. Our team will track the number of staff that participate in the modules and the percentage completed. As for educating the community on chronic disease, process metrics including the number of flyers or presentations disseminated into the community will be tracked. In addition to social media outreach metrics including likes, views, and shares.

Make social connectedness a community norm

EVALUATION OF THE SDOH ACCELERATOR PLAN STRATEGIES

- An assessment will be completed during this strategy to determine the root cause of social connectedness barriers and learn more about community members' reasons for not engaging in available activities. Mostly process metrics will be used to measure the completion of this strategy. The number of partnerships, identification of partners outreach strategies, and meetings to support central location of social events occurring in the community will be tracked. In addition, the reach of education campaigns explaining the benefits of social connectedness will be measured by views, likes, shares on social media. As well as any deliverables such as flyers, infographics, or presentations that are disseminated out the community.

Facilitate community-led interventions addressing barriers to care

- The number of partners connected with, the number of intervention opportunities identified, and number of community resources identified will be process metrics collected for monitoring the success of developing community-led interventions. Securing funding to support resident led interventions would indicate success for this strategy. Ripple effect mapping will be used to evaluate the impact of interventions on the community and its members. The outcomes of ripple mapping will highlight success stories from this strategy.

Increase awareness and coordination of SDOH resources

- An environmental scan will be used at the beginning of this strategy to identify the coordination groups within the area that are providing SDOH resource referrals and connections to NCCHIR residents. By utilizing community connections referral data, 2-1-1 referral data, and other care coordination groups, the team will find barriers to care coordination and advocate for a warm hand off. The number of barriers and number of advocating opportunities will be measured for this strategy. This strategy will utilize process metrics to track the implementation of an environmental scan that will find care coordination groups and barriers to coordination.

Enhanced accessible and efficient transportation services

- Since there is sparce publicly available data on transportation, the team's first step will be identifying metrics from the completed transportation environmental scan. Process metrics such as the number of partnering transportation authorities and number of meetings will be collected to show progress on this strategy. The number of policy changes related to transportation operations (i.e. hours, usability, & locations) will be monitored.

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Describe the evaluation purpose, goals, evaluation questions, data collection and methods.

Reduce stigma associated with disability, mental illness, and substance use disorder.

- **Purpose:** The evaluation purpose of this strategy is to develop a baseline and demonstrate a reduction of stigma in populations that work with individuals with a disability, mental illness, and substance use disorder.
- **Questions:** Evaluation questions will include survey assessment, pre-tests, and post-tests previously used by the NWCHIR BHI Reduce Stigma Against Substance-use Disorder Action Team.
- **Data Collection Methods:** Data collection for this strategy will include a community survey with data collected by the health department. In addition to pre and post test data collected by the facilitators during stigma trainings.

Improve the accessibility of events, programs, services, and community spaces.

- **Purpose:** In the second strategy, the purpose of evaluation is to demonstrate an improvement in accessibility of local events, programs, services, and community spaces for individuals with disabilities.
- **Questions & Data Collection Methods:** By partnering with local organizations and disability networks, assessments can be completed on community spaces to ensure their accessibility. Additionally, the number of meetings with local organizers on hosting accessible events can provide an opportunity to educate people on accessibility needs as well as track the impact of our programming.

Establish shared understanding and promote effective communication for social determinants of health across sectors.

- **Purpose:** The evaluation goal of this strategy is to demonstrate an increase of referrals for community connections, a program that connects individuals to both clinical and SDOH-related needs. In return, the long-term goal is to have both partners and residents develop a culture of recognizing the relationship between SDOH and improved health outcomes.
- **Questions & Data Collection Methods:** The methods and data collection for this strategy will include tracking process metrics while implementing trainings and developing relationships with partners that can refer residents to local services and resources.

Increase community health worker capacity to address chronic disease.

- **Purpose:** Similar to the strategy above, the evaluation goal of this strategy is to see an increase in chronic disease referrals to services or resources that address chronic disease.
- **Questions & Data Collection Methods:** Data will be collected by the team to track the number of staff that participate in the modules and the percentage completed.

Make social connectedness a community norm.

- **Purpose:** The purpose of evaluation for this strategy is to show that partnerships are being formed to increase awareness of events, as well as increase the number of residents that are aware of the importance of social connections.
- **Questions & Data Collection Methods:** The number of partnerships, identification of partners outreach strategies, and meetings to support central location of social events will demonstrate the partnership building.

Facilitate community-led interventions addressing barriers to care.

- **Purpose:** Evaluation for this strategy will consist of monitoring the progress of seeking out partners who can connect us with residents in need and the ability to identify resources to address the barriers of care.

EVALUATION OF THE SDOH ACCELERATOR PLAN STRATEGIES

- **Questions & Data Collection Methods:** The number of partners connected with, and number of resources identified will be process metrics collected for monitoring the success of developing community-led interventions. The ability to secure funding to support resident led interventions would indicate success for this strategy.

Increase awareness and coordination of SDOH resources.

- **Purpose:** The goal of this strategy is to increase the number of SDOH referrals, find resident's barriers while obtaining those resources, and improve hand-offs between partners. This strategy will utilize process metrics to track the implementation of an environmental scan that will find care coordination groups and barriers to coordination.
- **Questions & Data Collection Methods:** Tracking this objective will include recording the number of meetings, number of barriers found within the community, and 211 tracking metrics.

Enhanced accessible and efficient transportation services.

- **Purpose:** The evaluation goal of this strategy is to demonstrate relationship building between the NCCHIR and the transportation authorities within each county. These relationships will lead to transportation barriers being resolved for residents.
- **Questions & Data Collection Methods:** Process metrics such as the number of partnering transportation authorities and number of meetings will be collected to show progress on this strategy.

DATA INTEGRATION

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Describe the existing data sources across partners.

In the past few years, there have been various data collection efforts within the community that would aid in the integration of these strategies. The main data assessment is the MiThrive Community Health Assessment which spans over 31 counties and collects data on various health indicators. Other major health data sources include the Northwest CHIR regional Behavioral Health Initiative Stigma Assessment and Intervention and the existing SNAP-Ed Parks & Recreation Assessment. Community Connections referral data is going to be essential to multiple strategies and activities. In addition to Community Connections learning module data, inventory data collected by the committee and 2-1-1 referral data. Partnership will be essential for collecting data related to social connections and central promotion of events. Chamber of Commerce, schools, and other organizations will be vital to these strategies. Furthermore, partnership with transportation authorities will be necessary for the transportation strategy with plans to share previously collected data from the transportation environmental scan, resident voice focus groups, and disability inclusion survey data. Other data sources that will be useful for strategies in this workplan include poverty and disability data from the census and ALICE data from United for ALICE.

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Describe the process for monitoring and integrating data elements to create a comprehensive system for tracking selected population(s) resource utilization.

For most strategies, data assessments will be conducted at the beginning and be used while implementing the following activities. For example, the stigma reduction strategy utilizes an assessment to guide the training. Additionally, in other strategies such as facilitating community-led interventions, poverty and disability data will be used to identify areas of need within the community before implementing the strategy. While these strategies are being implemented, their progress will be monitored within a VMSG performance management dashboard and each activity will have a designated lead that will enter in the data.

RESPONSIBLE PARTY

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Describe how each partner will participate in the planning, implementation, and reporting process.

The NCCHIR will serve as the coordinating entity responsible for supervising further planning, executing, and reporting of SDOH Accelerator Plan efforts. Upon securing funding for implementation, the NCCHIR Steering Committee will determine the most suitable approaches to execute the strategies and activities outlined in the workplan. Additionally, critical community partners pivotal for the success of each strategy have been identified and are documented in the workplan. The NCCHIR backbone staff will ensure these partners are informed and engaged in the work to ensure alignment and coordination of efforts across the 10-county region.

IMPLEMENTATION PLAN

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Provide a budget for implementing the strategies and activities.

See attachment: NCCHIR SDOH Accelerator Plan Implementation Budget.

IMPLEMENTATION PLAN		
☐		Provide a work plan with a timeline to complete proposed strategies and activities. **See attachment:** NCCHIR SDOH Accelerator Plan Workplan.

SUSTAINABILITY/ FUNDING STRATEGY		
☐		Describe strategies to expand, diversify, and sustain implementation efforts, including funding. The cornerstone for advancing, diversifying, and maintaining the execution of the SDOH Accelerator Plan centers around securing sufficient funding. Efforts will be directed towards sourcing potential funding opportunities at the local, state, and national level. The NCCHIR has a successful history securing funds from the Michigan Health Endowment Fund, HRSA, CDC, and MDHHS. A comprehensive work plan and implementation budget have been strategically crafted, allowing for the phased implementation of strategies and activities based on the funds acquired—whether in full or partially. The NCCHIR is committed to seeking and pursuing implementation and sustainability funds that will uphold the increased cross-sector collaboration that resulted from the development of the SDOH Accelerator Plan.

SUCCESS STORY		
☐		Complete a success story on establishing, expanding, and coordinating multisector partners. The success story is required to include the following components. The success story will be submitted within 90 days of submitting the CDC Accelerator Plan.

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