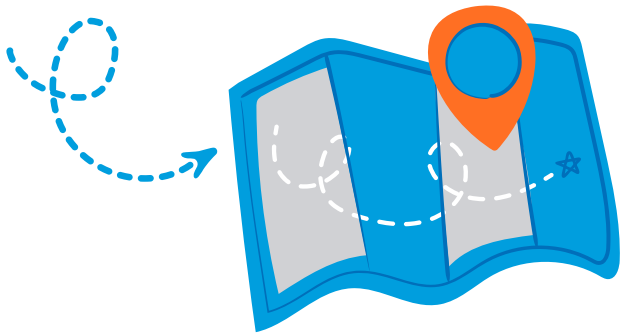
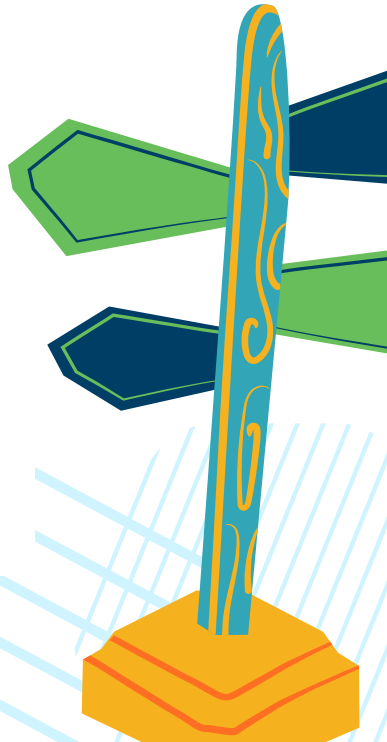


# Driving SDOH Strategies by Amplifying Community Voice:

# A Rural Health Roadmap to Collaborative Planning

Erin Barrett, MPH, MCHES, Regional Public Health Systems Specialist
Chandra Gunjak, PhD, Regional Health Planner
Emily Pokorski, MPH Epidemiologist
District Health Department #10



# TRAVEL GUIDES:

Erin Barrett, MPH, MCHES
She/her
Regional Public Health Systems Specialist
District Health Department #10

NORTH CENTRAL COMMUNITY HEALTH INNOVATION REGION

Chandra Gunjak, PhD
She/her
Regional Health Planner
District Health Department #10

NORTH CENTRAL COMMUNITY HEALTH INNOVATION REGION

Emily Pokorski, MPH
She/her
Epidemiologist
District Health Department #10

NORTH CENTRAL COMMUNITY HEALTH INNOVATION REGION

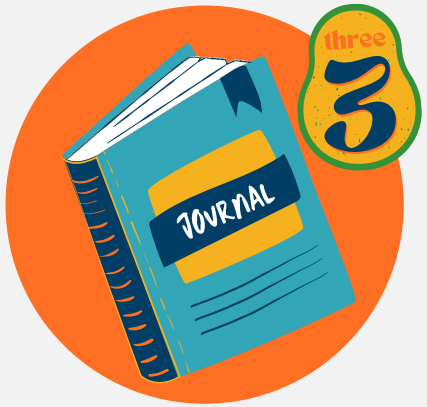
# OBJECTIVES:


## Objective #1

Understand the role of shared learning in collaborative settings.


## Objective #2

Identify practical strategies for amplifying community voice in collaborative community-based work.




## Objective #3

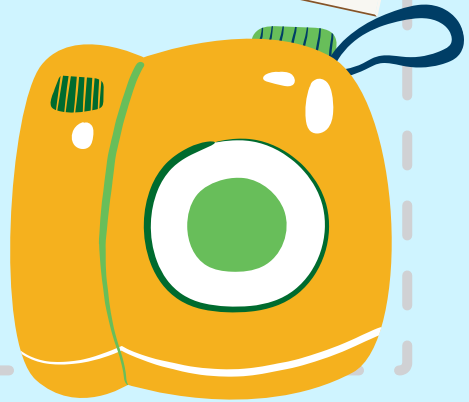
Identify synchronous and asynchronous community partner engagement strategies.

# PROJECT MATERIALS


Resource List


Focus Group Report

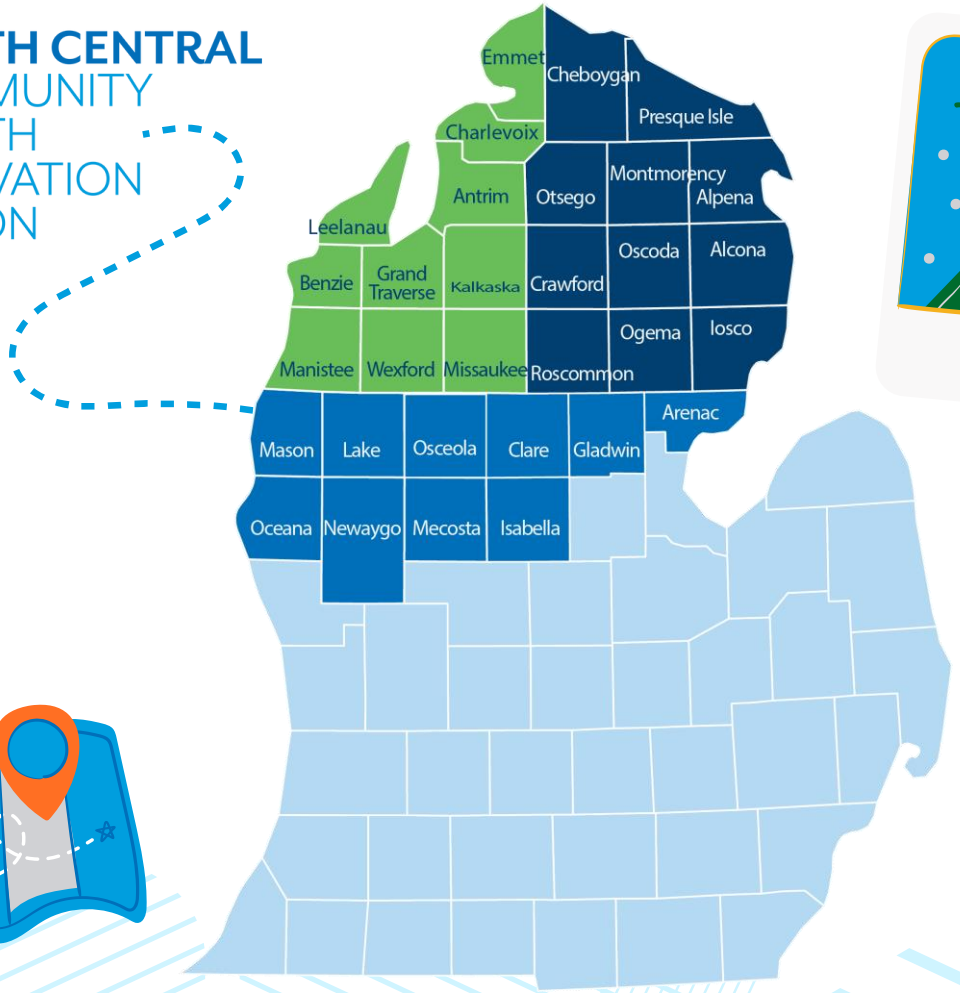
# TRAVEL COMPANIONS

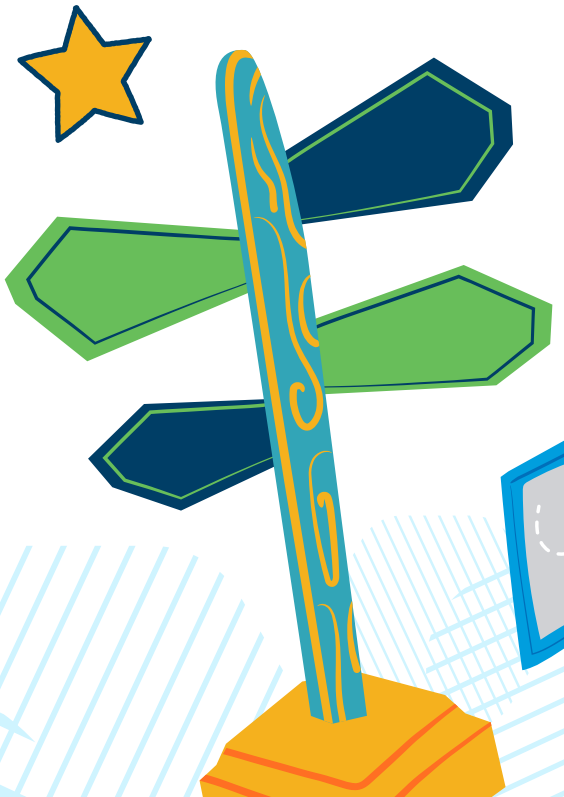
# VISION VIDEO

# GEOGRAPHIC INFRASTRUCTURE

NORTH CENTRAL COMMUNITY HEALTH INNOVATION REGION







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# NORTH CENTRAL COMMUNITY HEALTH INNOVATION REGION

**HEALTHY PEOPLE**
***in Equitable Communities***

## Our VISION

## Our NETWORK

- Steering Committee
- Clinical Community Linkages Workgroup
- SDOH Planning Committee
- MiThrive Roundtable
- Community Members
- Community Partners

## Our FUNCTIONS

- mithrive
- COMMUNITY connections
- SYSTEMS change

## Our MISSION

**IMPROVE**
***Population Health***

**REDUCE**
***Unnecessary Medical Expenses***

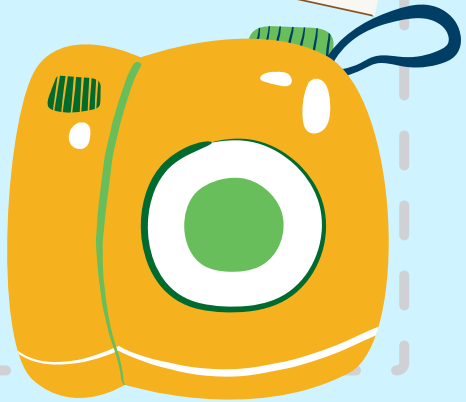
**INCREASE**
***Health Equity***

## Our BACKBONE

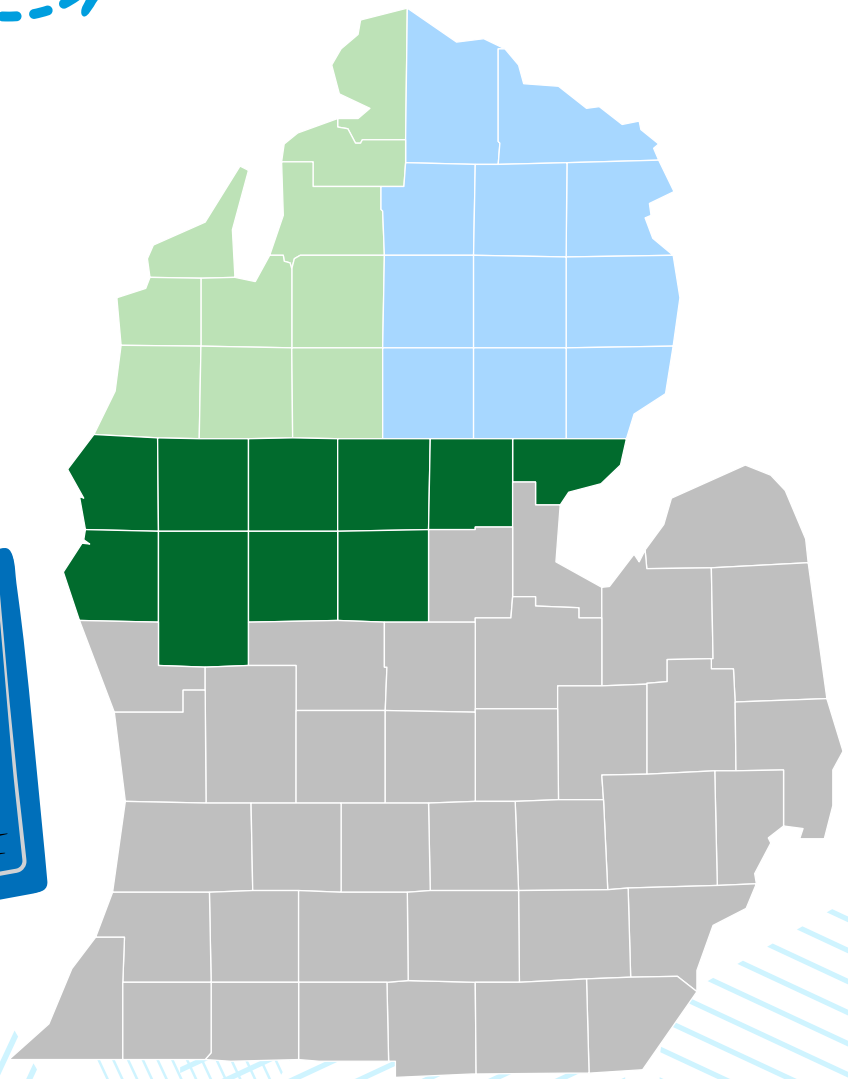
NORTHERN MICHIGAN PUBLIC HEALTH ALLIANCE

www.northernmichiganchir.org

# DECIDE ON YOUR DESTINATION

# OVERVIEW | PROJECT APPROACH




**SDOH Planning Committee**

**Selected Population(s): Poverty, ALICE, Disability**

**Social Connectedness**

**Community-Clinical Linkages**

**Short-Term Outcomes**

Increased collaboration and engagement across multisectoral partners.
Completed implementation ready SDOH Accelerator Plan.

**Grant Completion**

**Intermediate Outcomes**

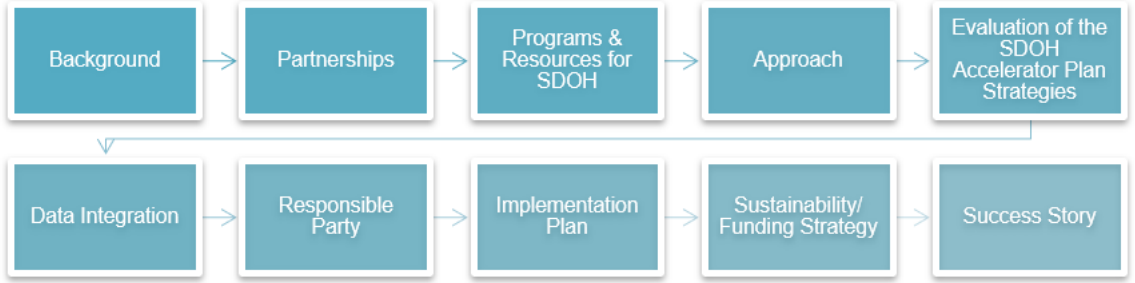
Establishment of infrastructure & funding to support SDOH Accelerator Plan implementation.
Implementation of the SDOH Accelerator Plan among multisector partners.

**Long-Term Outcomes**

Improved chronic disease outcomes among priority population.

# PROJECT APPROACH

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





**SDOH Planning Committee**

**Selected Population(s): Poverty, ALICE, Disability**

**Social Connectedness**

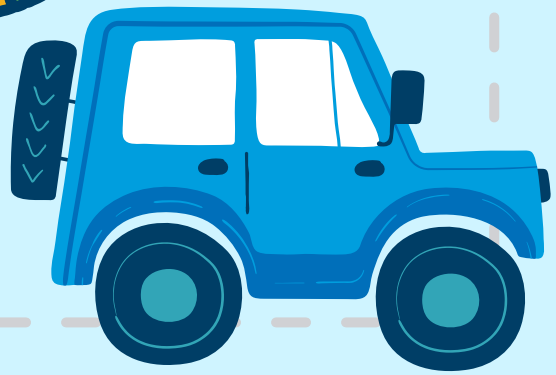
**Community-Clinical Linkages**

| | |
|---|---|
| **Short-Term Outcomes** | Increased collaboration and engagement across multisectoral partners.<br>Completed implementation ready SDOH Accelerator Plan. |

**Grant Completion**

| | |
|---|---|
| **Intermediate Outcomes** | Establishment of infrastructure & funding to support SDOH Accelerator Plan implementation.<br>Implementation of the SDOH Accelerator Plan among multisector partners. |
| **Long-Term Outcomes** | Improved chronic disease outcomes among priority population. |

# CONSIDER YOUR VEHICLE

# SDOH PLANNING COMMITTEE:

- Executive Director, **2-1-1 of Northeast Michigan**
- Health Promotion Supervisor, **Central Michigan District Health Department**
- Director, **Community Connections**
- Chief Quality and Compliance Officer, **Community Mental Health for Central Michigan**
- Community Health Manager, **Corewell Health**
- Community Education and Outreach, **Disability Network of Mid-Michigan**
- Advocacy & Certified ADA Coordinator, **Disability Network of West Michigan**
- Deputy Health Officer, **District Health Department #10**
- Community Affairs**, DTE Energy**
- President and CEO, **Family Healthcare**
- SNAP-Ed Coordinator, **Gratiot Isabella RESD**
- Vice President of Health Services, **McLaren Health**
- Director of Community and Partner Engagement, **Michigan 2-1-1**
- Community Health Supervisor, **MyMichigan Health**
- Director of Health Home Coordination, **West Michigan Community Mental Health**

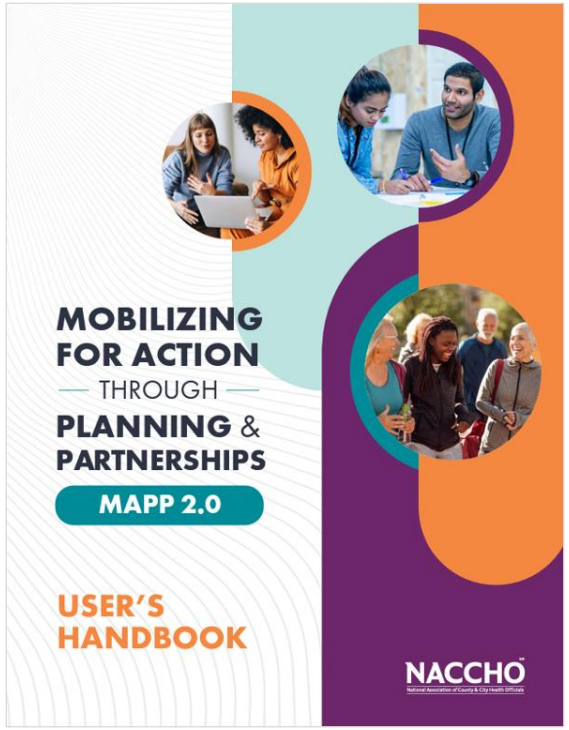
**Project Staff:**

- Project Manager
- Epidemiologist
- Project Facilitators (x3)

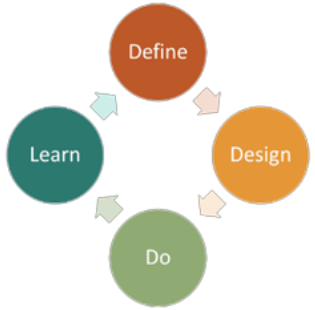
# COLLABORATION & PLANNING METHODS

## ABLe Change Process

## Mobilizing for Action Through Planning and Partnerships 2.0



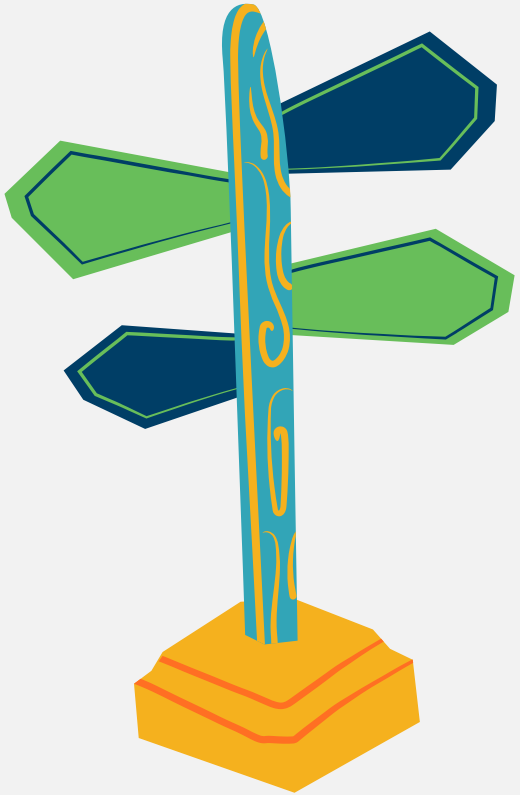

| ABLe Process | | |
|---|---|---|
| Define | 1 | Define a Shared Vision |
| | 2 | Determine System Boundaries |
| | 3 | Understand the Community System |
| | 4 | Adopt a Shared Agenda |
| Design | 5 | Design Powerful Strategies |
| Do | 6 | Promote Quick Wins |
| | 7 | Support Effective Implementation |
| Learn | 8 | Learn for Continuous Improvement |




# COLLABORATIVE INFRASTRUCTURE – HOW WE WORKED TOGETHER

## Synchronous Engagement Options:

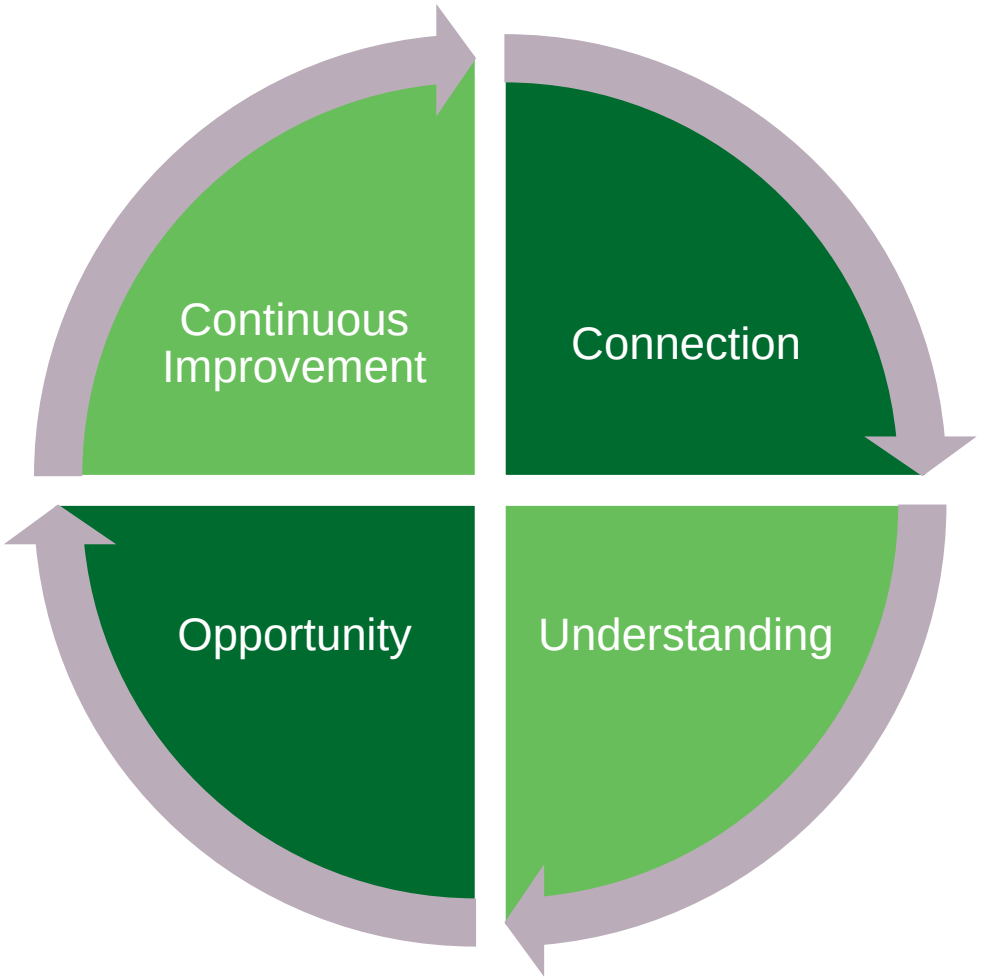
- Virtual Meetings
- 12 Meetings Held



## Asynchronous Engagement Options:

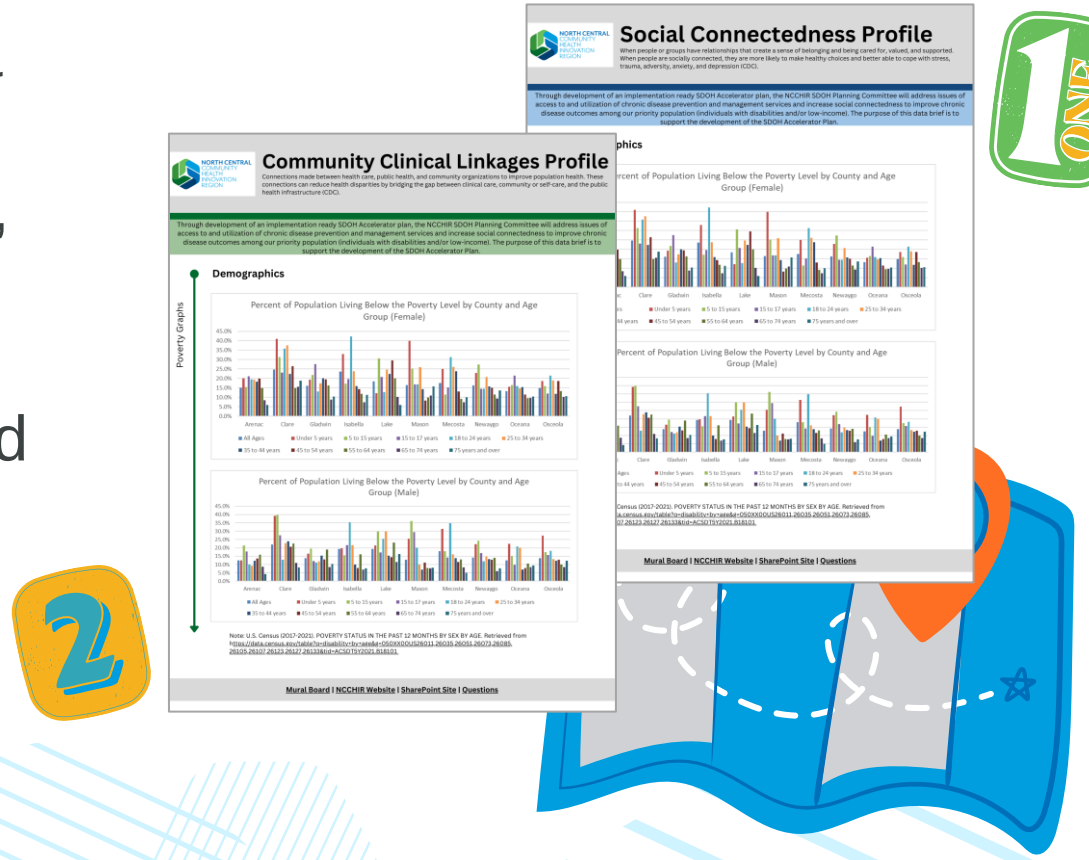
- Email
- SharePoint
- Feedback Surveys
- Mural
- Padlet

# DESIGNING EFFECTIVE MEETINGS

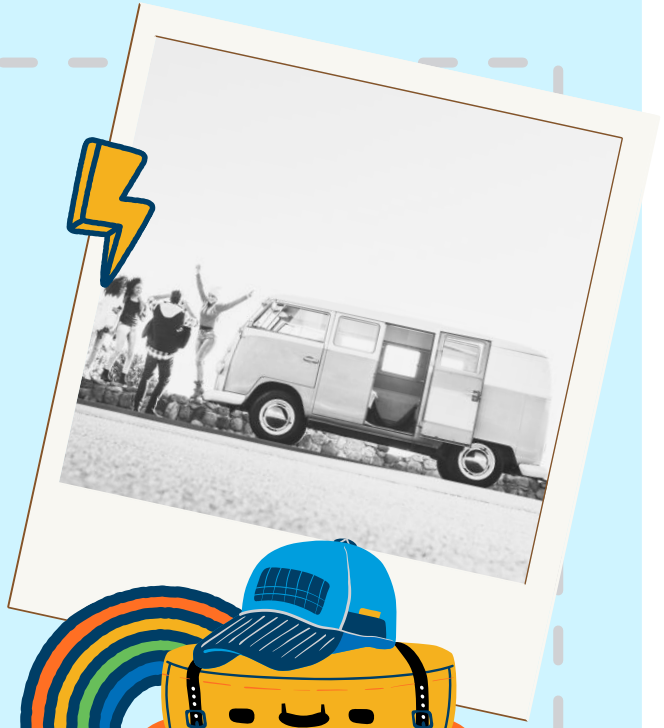


# INITIAL COLLABORATIVE PLANNING EFFORTS

- Identifying a community voice & engagement approach.
- Completing a SWOT (strengths, weaknesses, opportunities, & threats) analysis.
- Existing services, programs, and initiatives inventory.
- Secondary data collection



# CHOOSE YOUR ROUTE & GET ON THE ROAD

# WHY ENGAGE COMMUNITY?

1. **Increase the likelihood that projects or solutions will be widely accepted.**
   - Community Input | Community Buy-in | Community Power

2. **Create more effective solutions.**
   - Drawing on local knowledge from a diverse group creates solutions that are practical and effective and rooted in the realities of the community.


*Adapted from Center for Wellness and Nutrition.


*Adapted from Center for Wellness and Nutrition.

# FUNDING COMMUNITY ENGAGEMENT

Community Partner Stipends

Community Member Funds

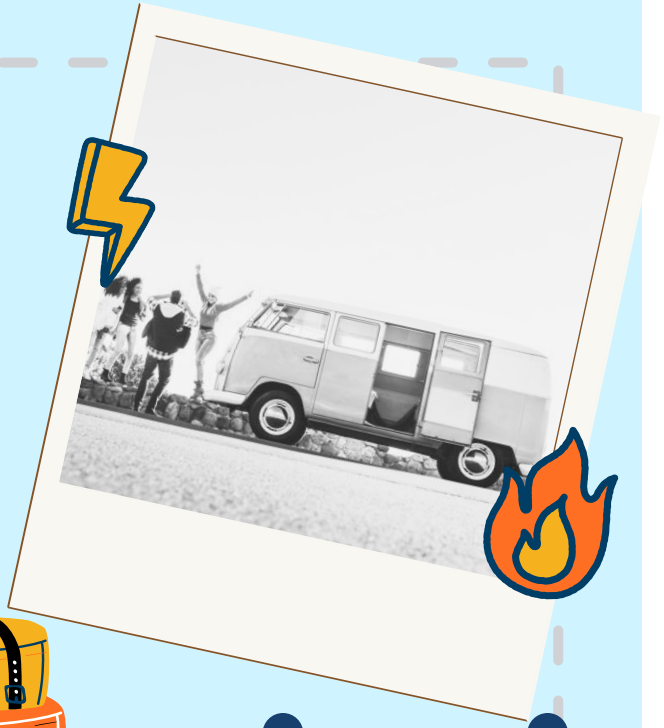
# COMMUNITY ENGAGEMENT METHODS

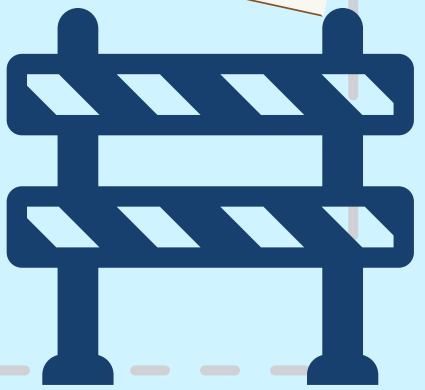
RESIDENT VOICE SURVEY

+

FOCUS GROUPS

# DETOUR FOR CONSTRUCTION & ATTRACTIONS



# DATA WALK PROCESS

**Part 1**

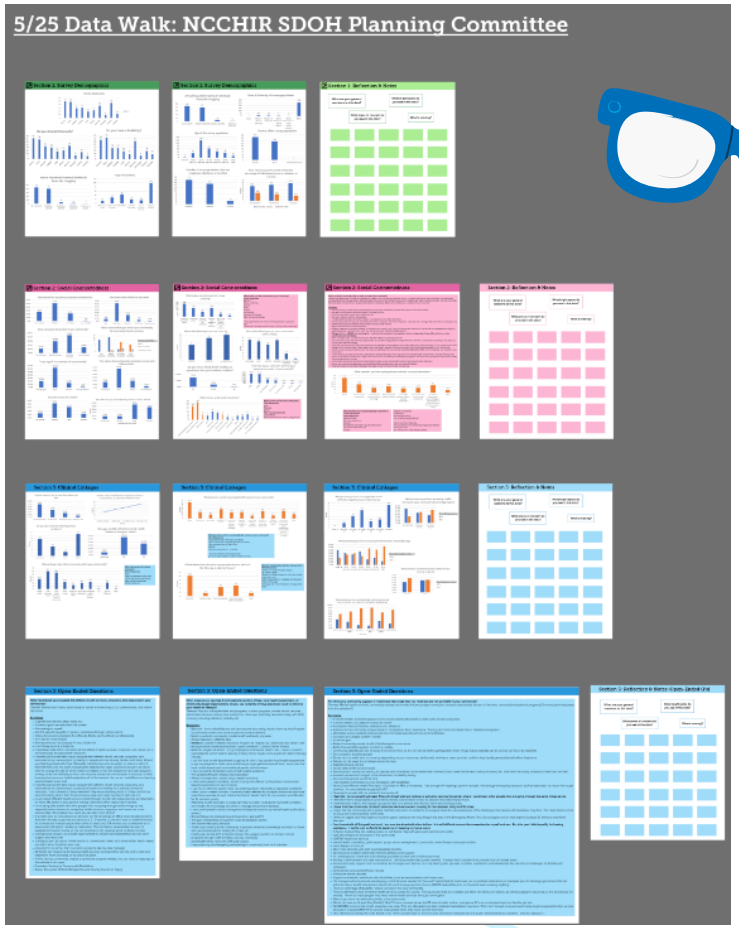
- Presentation of sections 1 & 2 (survey demographics & social connectedness
- Q & A
- Quiet time to reflect & note-taking
- Large group discussion

**Part 2**

- Presentation of sections 1 & 2 (survey demographics & social connectedness
- Q & A
- Quiet time to reflect & note-taking
- Large group discussion

**Part 3**

- Move into topic-specific breakout rooms for small group reflection & discussion

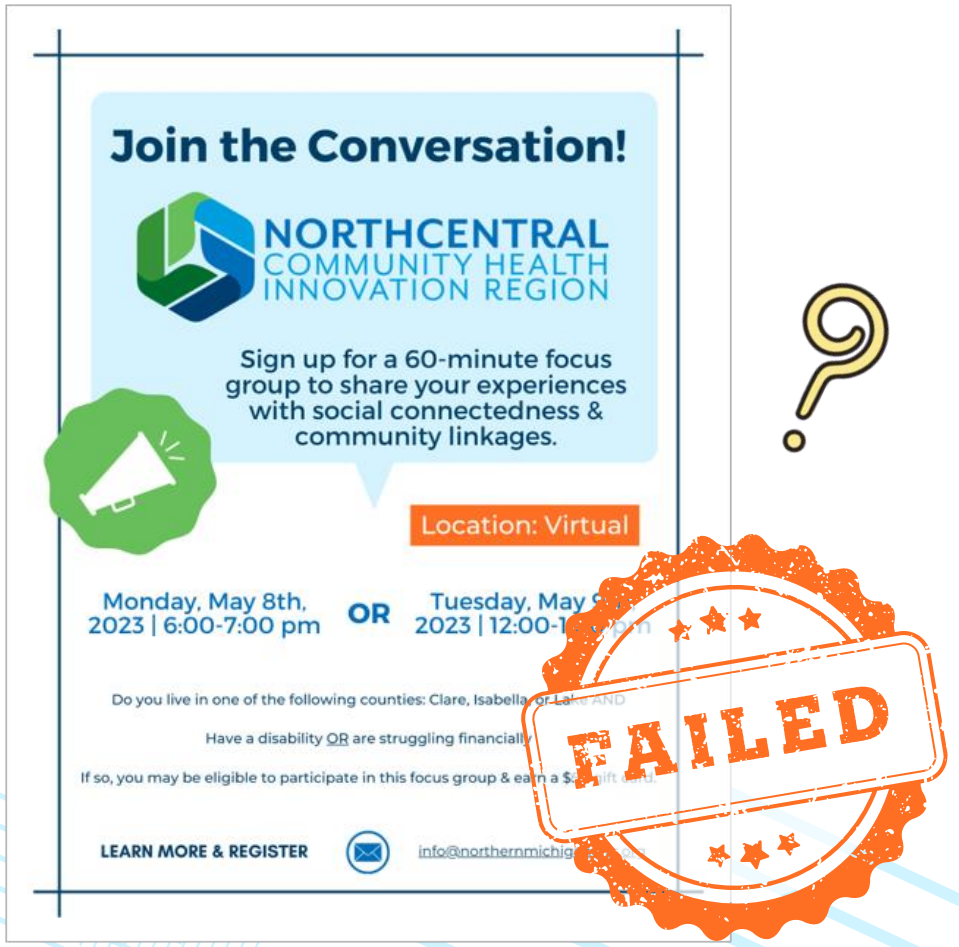


# RESIDENT VOICE
# FOCUS GROUP OVERVIEW

**Focus Group Purpose:**

- Connect & listen deeply
- Deep dive priority areas
- Understand barriers and solutions
- Use focus group data to inform strategy selection in the SDOH Accelerator Plan

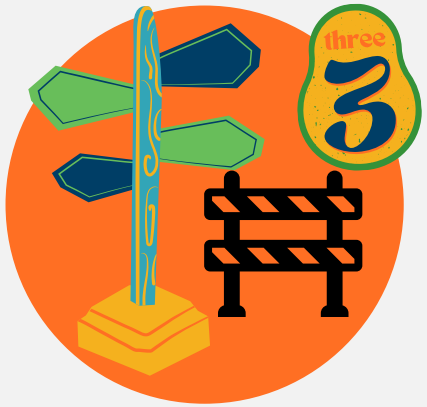
# VIRTUAL FOCUS GROUPS
# TOTAL PARTICIPANTS = 0



# PREPARE FOR ROADBLOCKS & DETOURS


Survey Scammers


Focus Group Low Engagement

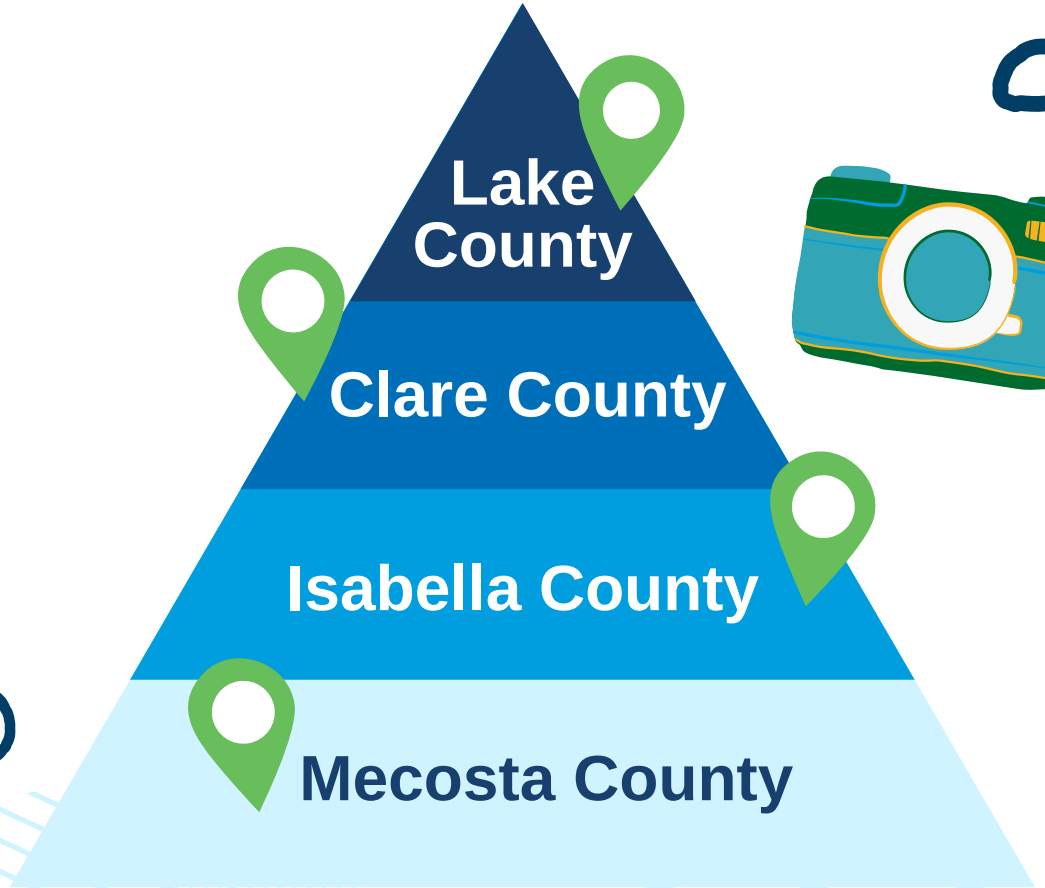



Project Changes

# IN A FEW WORDS, PLEASE DESCRIBE SOME OF THE CHALLENGES YOU'VE EXPERIENCED WHILE COLLECTING RESIDENT VOICE OR WHILE IMPLEMENTING A PROJECT.

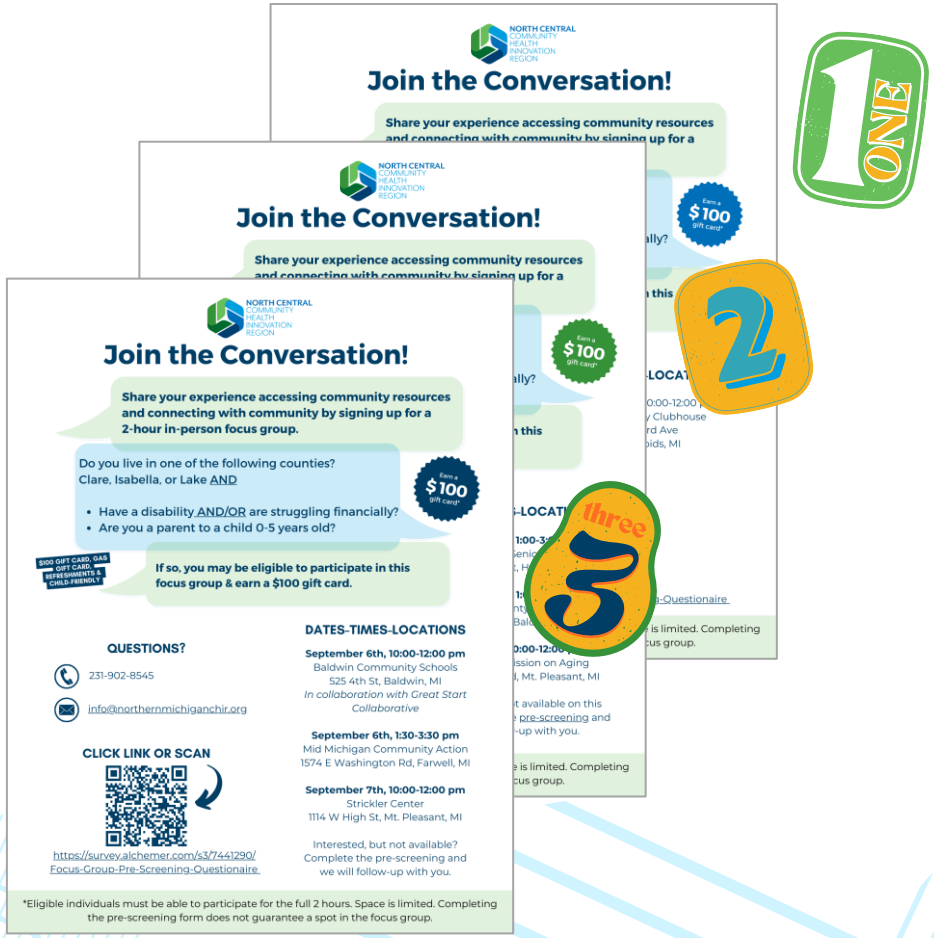
# DATA INDICATORS

- % of Households below ALICE Threshold
- % of Residents below Federal Poverty Level
- % of Residents with One or More Disabilities
- % of Residents without Health Insurance



# FOCUS GROUP PROCESS & IMPLEMENTATION

| Location | Total |
|---|---|
| New Journey Clubhouse | 19 |
| Clare County Senior Services | 5 |
| St. Ann's Lake County Senior Services | 7 |
| Isabella Commission on Aging | 3 |
| Baldwin Community Schools | 4 |
| Mid Michigan Community Action | 2 |
| Strickler Center | 4 |
| Peterson Farms | N/A |
| Virtual "Catch All" | N/A |
| **Total** | **44** |



# IN-PERSON FOCUS GROUP BRIGHT SPOTS


**LESSON LEARNED:** Allocate funds for community-based organization support stipends.

# FOCUS GROUP QUOTES

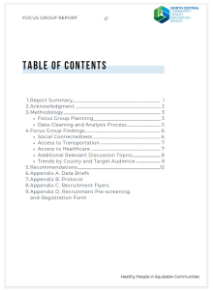
**Stigma: “You must be dumb, you must be an addict, you must be criminal, you must be almost homeless just because you have a mental disorder.”**

**Accessibility of Social Events: “There are days because of my disability I just can't participate (in social events) and that's frustrating for me.”**

**Cost of Transportation: “You may have access to a vehicle, but if you are very low income and with gas prices being the way they are, you can't take yourself. You can't afford to do that, that run to Grand Rapids is going to kill you.”, “Do I eat, or do I go?”, “Yep, I just miss the appointment. (I) don't have a choice.”**

**Lack of Providers: “That left me with having to drive to Lansing, which is tough, especially if I have like 4 different appointments in one week. So, the gas and the distance and everything… there is a shortage of doctors.”**

# BARRIERS:


## Forming & Maintaining Social Connections

- Limited spaces for gatherings
- Economic Challenges
- Limited access to technology
- Stigma
- Transportation

## Barriers Accessing Healthcare

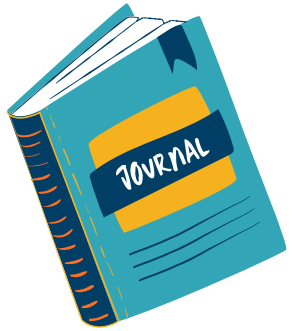
- Limited health facilities
- Healthcare provider shortages
- Transportation
- Stigma
- Health Literacy

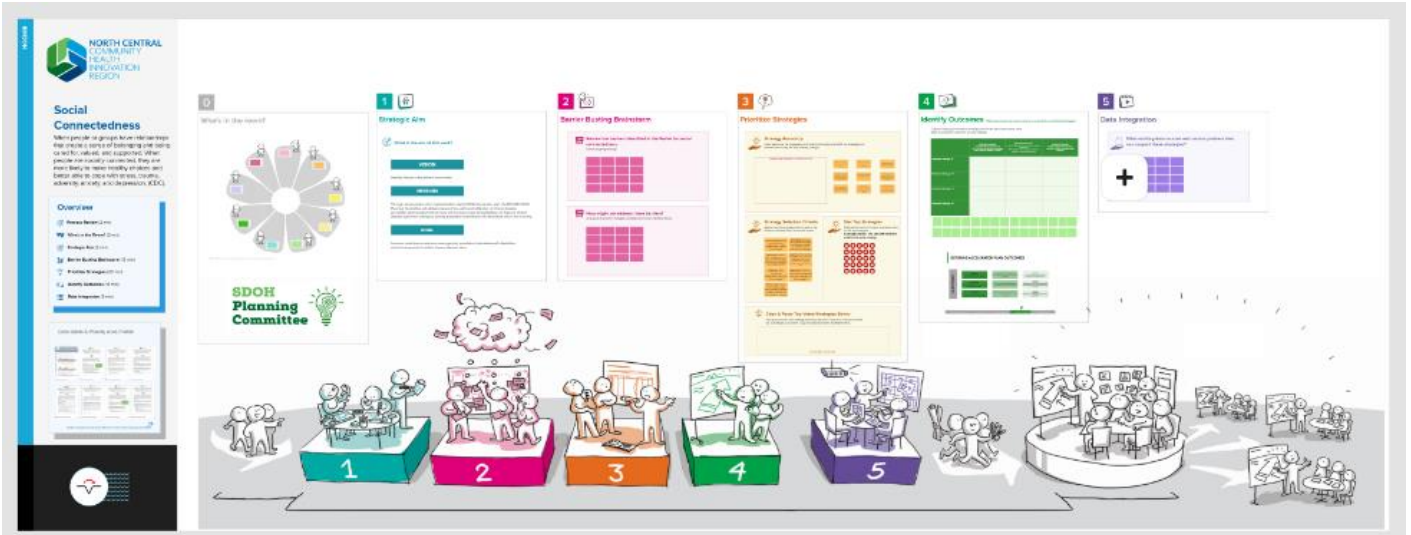
## Barriers Accessing Transportation

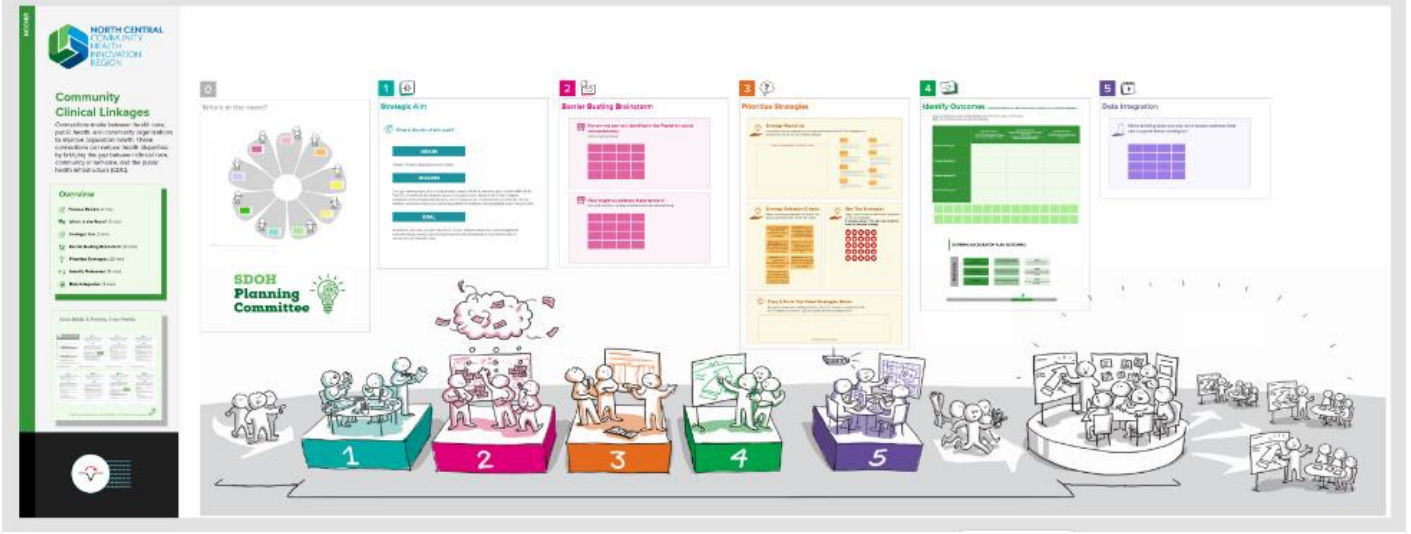
- Vehicle ownership costs
- Limited bus operating hours
- Lack of coordination across services
- User experience

# FUEL UP


# ACCELERATOR PLAN WORKSHOPS

# FOLLOW YOUR GPS


# RECAP:CONTINUED COMMUNITY ENGAGEMENT

## Resident Feedback Questions:

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?


**$25 INCENTIVE**

# PROCESS REFLECTION: CONTINUED COMMUNITY ENGAGEMENT

What's exciting you about this feedback?

What surprised you about this feedback?

What is this feedback telling us?

# KEY TAKEAWAYS & RECOMMENDATIONS

## Key Takeaways:


- Commitment to resident voice and engagement from the SDOH Planning Committee.
- Residents shared their experience/ideas and felt like their voice mattered.
- Created a resident voice & engagement feedback loop.
- Overall, the feedback revealed that we are on track with the prioritized strategies.

## Recommendations:

- Residents provided implementation ideas on the strategies and how we can implement them in their community. *This feedback was incorporated into the SDOH Accelerator Workplan.*
- Residents felt appreciated and would be interested in additional engagement opportunities.
- Residents want to see action.
- Opportunities to enhance strategies: lack of providers, cost of healthcare, diversified outreach methods, lack of trust in community change processes (need to support transparency).

# PROCESS: COMMUNITY ENGAGEMENT

**Leadership Commitment**

- Prioritized resident voice & engagement in SDOH Accelerator Plan development.
- Allocated partner stipends for community engagement

**Community Engagement Aim**

- Reviewed Community Engagement Continuum
- Benchmarks: Inform, Consult, Involve Priority Population

**Engagement Methods**

- Resident Voice Survey
- In-Person Focus Groups
- Post-Focus Group Strategy Questionnaire

**Outcome of Engagement**

- Increased community buy-in, participants felt heard and valued, facilitated connections among residents facing similar challenges.

# REACH YOUR DESTINATION


# OUTCOMES | PRIORITIZED STRATGIES

## Community Clinical Linkages:

- Establish shared understanding and promote effective communication for social determinants of health across sectors.
- Increase awareness and coordination of social determinants of health resources.
- Increase Community Health Worker capacity to address chronic disease.
- Facilitate community-led interventions addressing barriers to care.

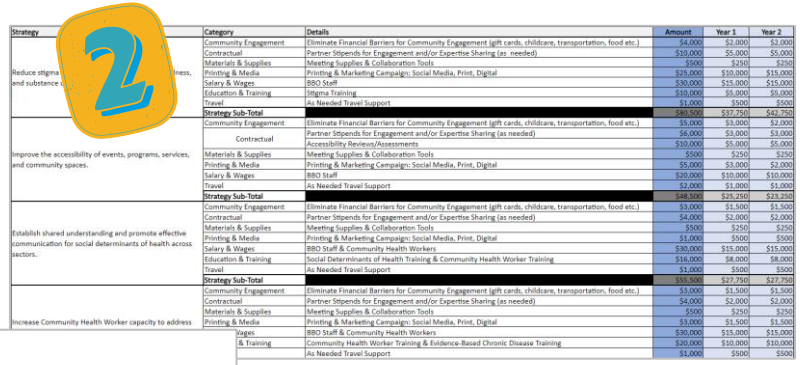
## Social Connectedness:

- Improve the accessibility of events, programs, services, and community spaces.
- Make social connectedness a community norm.

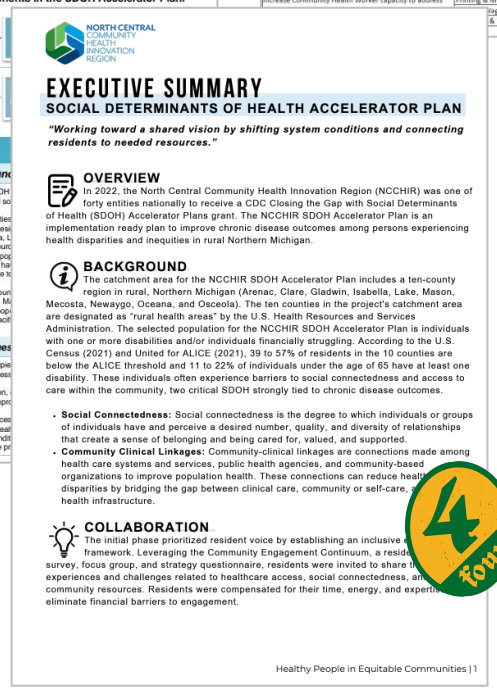
## Both:

- Reduce stigma associated with disability, mental illness, and substance use.
- Enhance accessible and efficient transportation services.

# PROJECT DELIVERABLES

| Strategy | Category | Details | Amount | Year 1 | Year 2 |
|---|---|---|---|---|---|
| Reduce stigma associated with disability, mental illness, and substance use. | Community Engagement | Eliminate Financial Barriers for Community Engagement (gift cards, childcare, transportation, food etc.) | $4,000 | $2,000 | $2,000 |
| | Contractual | Partner Stipends for Engagement and/or Expertise Sharing (as needed) | $10,000 | $5,000 | $5,000 |
| | Materials & Supplies | Meeting Supplies & Collaboration Tools | $500 | $250 | $250 |
| | Printing & Media | Printing & Marketing Campaign: Social Media, Print, Digital | $25,000 | $10,000 | $15,000 |
| | Salary & Wages | BBO Staff | $30,000 | $15,000 | $15,000 |
| | Education & Training | Stigma Training | $10,000 | $5,000 | $5,000 |
| | Travel | As Needed Travel Support | $1,000 | $500 | $500 |
| | **Strategy Sub-Total** | | $80,500 | $37,750 | $42,750 |
| Improve the accessibility of events, programs, services, and community spaces. | Community Engagement | Eliminate Financial Barriers for Community Engagement (gift cards, childcare, transportation, food etc.) | $5,000 | $3,000 | $2,000 |
| | Contractual | Partner Stipends for Engagement and/or Expertise Sharing (as needed) | $6,000 | $3,000 | $3,000 |
| | | Accessibility Reviews/Assessments | $10,000 | $5,000 | $5,000 |
| | Materials & Supplies | Meeting Supplies & Collaboration Tools | $500 | $250 | $250 |
| | Printing & Media | Printing & Marketing Campaign: Social Media, Print, Digital | $5,000 | $3,000 | $2,000 |
| | Salary & Wages | BBO Staff | $20,000 | $10,000 | $10,000 |
| | Travel | As Needed Travel Support | $2,000 | $1,000 | $1,000 |
| | **Strategy Sub-Total** | | $48,500 | $25,250 | $23,250 |
| Establish shared understanding and promote effective communication for social determinants of health across sectors. | Community Engagement | Eliminate Financial Barriers for Community Engagement (gift cards, childcare, transportation, food etc.) | $3,000 | $1,500 | $1,500 |
| | Contractual | Partner Stipends for Engagement and/or Expertise Sharing (as needed) | $4,000 | $2,000 | $2,000 |
| | Materials & Supplies | Meeting Supplies & Collaboration Tools | $500 | $250 | $250 |
| | Printing & Media | Printing & Marketing Campaign: Social Media, Print, Digital | $1,000 | $500 | $500 |
| | Salary & Wages | BBO Staff & Community Health Workers | $30,000 | $15,000 | $15,000 |
| | Education & Training | Social Determinants of Health Training & Community Health Worker Training | $16,000 | $8,000 | $8,000 |
| | Travel | As Needed Travel Support | $1,000 | $500 | $500 |
| | **Strategy Sub-Total** | | $55,500 | $27,750 | $27,750 |
| Increase Community Health Worker capacity to address | Community Engagement | Eliminate Financial Barriers for Community Engagement (gift cards, childcare, transportation, food etc.) | $3,000 | $1,500 | $1,500 |
| | Contractual | Partner Stipends for Engagement and/or Expertise Sharing (as needed) | $4,000 | $2,000 | $2,000 |
| | Materials & Supplies | Meeting Supplies & Collaboration Tools | $500 | $250 | $250 |
| | Printing & Media | Printing & Marketing Campaign: Social Media, Print, Digital | $3,000 | $1,500 | $1,500 |
| | Salary & Wages | BBO Staff & Community Health Workers | $30,000 | $15,000 | $15,000 |
| | Education & Training | Community Health Worker Training & Evidence-Based Chronic Disease Training | $20,000 | $10,000 | $10,000 |
| | | As Needed Travel Support | $1,000 | $500 | $500 |



NORTH CENTRAL COMMUNITY HEALTH INNOVATION REGION

## EXECUTIVE SUMMARY

### SOCIAL DETERMINANTS OF HEALTH ACCELERATOR PLAN

***"Working toward a shared vision by shifting system conditions and connecting residents to needed resources."***

**OVERVIEW**

In 2022, the North Central Community Health Innovation Region (NCCHIR) was one of forty entities nationally to receive a CDC Closing the Gap with Social Determinants of Health (SDOH) Accelerator Plans grant. The NCCHIR SDOH Accelerator Plan is an implementation ready plan to improve chronic disease outcomes among persons experiencing health disparities and inequities in rural Northern Michigan.

**BACKGROUND**

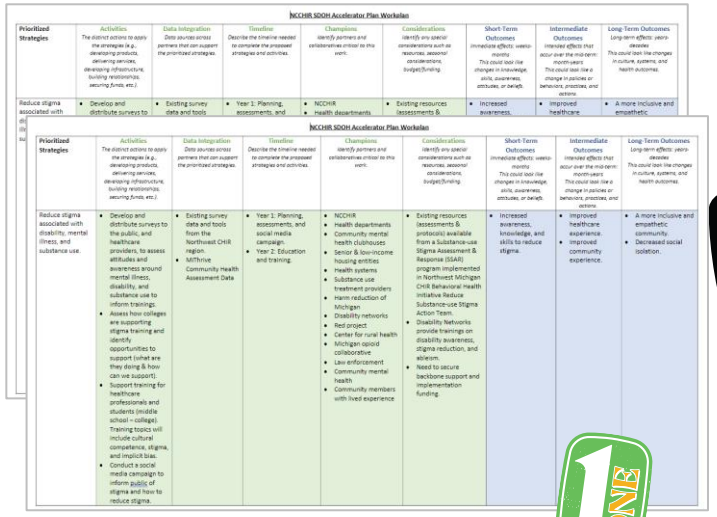
The catchment area for the NCCHIR SDOH Accelerator Plan includes a ten-county region in rural, Northern Michigan (Arenac, Clare, Gladwin, Isabella, Lake, Mason, Mecosta, Newaygo, Oceana, and Osceola). The ten counties in the project's catchment area are designated as "rural health areas" by the U.S. Health Resources and Services Administration. The selected population for the NCCHIR SDOH Accelerator Plan is individuals with one or more disabilities and/or individuals financially struggling. According to the U.S. Census (2021) and United for ALICE (2021), 39 to 57% of residents in the 10 counties are below the ALICE threshold and 11 to 22% of individuals under the age of 65 have at least one disability. These individuals often experience barriers to social connectedness and access to care within the community, two critical SDOH strongly tied to chronic disease outcomes.

- **Social Connectedness:** Social connectedness is the degree to which individuals or groups of individuals have and perceive a desired number, quality, and diversity of relationships that create a sense of belonging and being cared for, valued, and supported.
- **Community Clinical Linkages:** Community-clinical linkages are connections made among health care systems and services, public health agencies, and community-based organizations to improve population health. These connections can reduce health disparities by bridging the gap between clinical care, community or self-care, and health infrastructure.

**COLLABORATION**

The initial phase prioritized resident voice by establishing an inclusive framework. Leveraging the Community Engagement Continuum, a resident survey, focus group, and strategy questionnaire, residents were invited to share lived experiences and challenges related to healthcare access, social connectedness, and community resources. Residents were compensated for their time, energy, and expertise to eliminate financial barriers to engagement.

Healthy People in Equitable Communities | 1



NCCHIR SDOH Accelerator Plan Workplan

| Prioritized Strategies | Activities | Data Integration | Timeline | Champions | Considerations | Short-Term Outcomes | Intermediate Outcomes | Long-Term Outcomes |
|---|---|---|---|---|---|---|---|---|
| | The distinct actions to apply the strategies (e.g., developing products, delivering services, developing infrastructure, building relationships, securing funds, etc.) | Data sources across partners that can support the prioritized strategies. | Describe the timeline needed to complete the proposed strategies and activities. | Identify partners and collaboratives critical to this work. | Identify any special considerations such as resources, seasonal considerations, budget/funding. | Immediate effects: weeks-months. This could look like changes in knowledge, skills, awareness, attitudes, or beliefs. | Intended effects that occur over the mid-term: month-years. This could look like a change in policies or behaviors, practices, and actions. | Long-term effects: years-decades. This could look like changes in culture, systems, and health outcomes. |
| Reduce stigma associated with | • Develop and distribute surveys to | • Existing survey data and tools | • Year 1: Planning, assessments, and | • NCCHIR<br>• Health departments | • Existing resources (assessments & | • Increased awareness, | • Improved healthcare | • A more inclusive and empathetic |



NCCHIR SDOH Accelerator Plan Workplan

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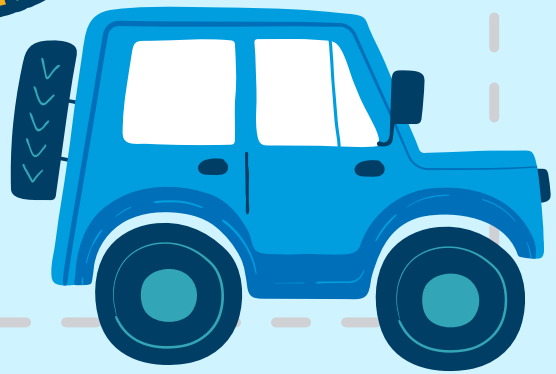
| Reduce stigma associated with disability, mental illness, and substance use. | • Develop and distribute surveys to the public, and healthcare providers, to assess attitudes and awareness around mental illness, disability, and substance use to inform trainings.<br>• Assess how colleges are supporting stigma training and identify opportunities to support (what are they doing & how can we support).<br>• Support training for healthcare professionals and students (middle school – college). Training topics will include cultural competence, stigma, and implicit bias.<br>• Conduct a social media campaign to inform public of stigma and how to reduce stigma. | • Existing survey data and tools from the Northwest CHIR region.<br>• MiThrive Community Health Assessment Data | • Year 1: Planning, assessments, and social media campaign.<br>• Year 2: Education and training. | • NCCHIR<br>• Health departments<br>• Community mental health clubhouses<br>• Senior & low-income housing entities<br>• Health systems<br>• Substance use treatment providers<br>• Harm reduction of Michigan<br>• Disability networks<br>• Red project<br>• Center for rural health<br>• Michigan opioid collaborative<br>• Law enforcement<br>• Community mental health<br>• Community members with lived experience | • Existing resources (assessments & protocols) available from a Substance-use Stigma Assessment & Response (SSAR) program implemented in Northwest Michigan CHIR Behavioral Health Initiative Reduce Substance-use Stigma Action Team.<br>• Disability Networks provide trainings on disability awareness, stigma reduction, and ableism.<br>• Need to secure backbone support and implementation funding. | • Increased awareness, knowledge, and skills to reduce stigma. | • Improved healthcare experience.<br>• Improved community experience. | • A more inclusive and empathetic community.<br>• Decreased social isolation. |

# OVERVIEW | PROJECT OUTPUTS

- SDOH Accelerator Plan Executive Summary
- SDOH Accelerator Plan
- SDOH Accelerator Plan Focus Group Report
- SDOH Accelerator Plan Social Media Post
- NCCHIR March Quarterly Newsletter
- NACCHO 360 Conference
- SDOH Accelerator Plan Workplan
- SDOH Accelerator Plan Implementation Budget
- SDOH Accelerator Plan Inventory
- CDC Success Story
- Community Clinical Linkages Priority Area Profile
- Social Connectedness Priority Area Profile
- 7 Focus Group Data Briefs
- Transportation Environmental Scan
- Secondary Data
- Landscape Analysis
- Resident Voice Survey
- SWOT Analysis

# FUTURE TRIPS

# COMMUNITY ENGAGEMENT STANDARDS

- Create meaningful opportunities for community engagement.
- Commit to engaging people with lived/living experience.
- Eliminate financial barriers to NCCHIR community engagement including but not limited to compensating people with lived/living experience, offering childcare, transportation, food, training opportunities, and multi-modal engagement options.
- Diversify Steering Committee representation to reflect the demographics of the region.
- Ensure community engagement is a standard budget line item in future grant applications.

*A community member refers to an individual who resides, learns, works, plays, worships, or accesses services within a specific community.

# FUNDING SECURED

**Opportunity:** Michigan Health Endowment Fund Community Health Impact Fund

**Amount:** $150,000

**Focus (prioritized by Steering Committee):**

- Enhance accessible and efficient transportation services.
- Increase awareness and coordination of social determinants of health resources.

**Geographic Region:** Clare, Isabella, Lake, & Mecosta Counties

**Timeline:** 1 Year


# TRANSPORTATION PLANNING EFFORTS

## NCCHIR Transportation Ecosystem (Existing Transportation Resoures Map)

The purpose of this map is to better understand the transportation ecosystem by identifying existing services, programs, and resources that support access to healthcare and social determinants of health services. This map will help to identify barriers and opportunities for support, problem-solving, growth, and capacity building between transit partners, community partners, and community members.

**Aim:** Improved access to healthcare and social determinants of health services.

**Important:** This ecosystem is complicated & complex. This map will never be 100% accurate. This is not an empathy map. This map only shows the visible elements in the system - not the invisible.

**Layer 1: Existing Transportation Resources Map**

**Layer 2: Resource Coordination & Accessibility**

**Layer 3: Empathy Map (User Experience)**


**Next Steps:**

- **Continue to identify existing research and best practices.** Explore existing transportation models.
- **Document existing resource coordination & navigation resources.**
- **Build relationships with transportation providers.** Formally introduce project & existing work completed. Explore perspectives of transportation providers.
- **Conduct a transportation empathy map in partnership with transportation providers.** An empathy map is a collaborative visualization used to articulate what we know about a particular type of user. It externalizes knowledge about users in order to 1) create a shared understanding of user needs, and 2) aid in decision making. We want to understand where community members are already traveling and want to travel and what barriers they experience.
- **Develop layer 2 of the map:** Resource coordination & accessiblity. Coordination/connection, cost, access, and availability.

**Reference Documents**

- Resident Voice Data
- Partner Reflection Questions
- Transportation Scan Excel Spreadsheet

**Transportation Understanding Questions:**

1. Which services are on demand, appointment, or fixed route? **Answer:** TBD
2. Are these services on 211? **Answer:** TBD
3. Which services provide curb to curb service vs which services provide door through door services? **Answer:** TBD
4. How do health plans logistically provide transportation for Medicaid clients? **Answer:** McLaren has verified transportation partners (example: Dial a Ride) that clients can call and utilize the service. Alternatively, clients can get reimbursed for personal mileage. Can be used for social determinants of health resource access like a food pantry.
5. What is the capacity of these existing resources? If limited capacity, how do we build this? **Answer:** TBD
6. Are transportation services/resources being under-utilized? **Answer:** TBD

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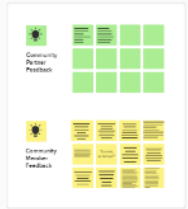

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**Root Causes:** What factors are causing the problem.

- Lack of awareness of available resources/services.
- Difficult to navigate resources/services.
- Resources/services not convenient for user.
- Not enough buses and drivers.
- Transportation rarely crosses county lines.
- Securing licenses is difficult for migrant individuals.

**Strategy Ideas:** Design strategies to solve problems and leverage opportunities.

1. How might we improve awareness of available resources?
2. How might we improve navigation of these resources - as a community member & as a community partner
3. How might we build capacity within existing services and resources? - providers & vendors
4. How might we improve the coordination and alignment of existing services/resources? **Ideas:** Build CHW, navigator, and 211 capacity to support transportation navigation.

10%

# REFLECTIONS & QUESTIONS