# SMALL GROUP DISCUSSION THEMES

## OVERVIEW

In March 2025, The WHI HSSI Summit convened diverse stakeholders across the health and social services landscape to explore strategies for integrating systems and improving service delivery in Washtenaw County and surrounding regions. A core component of the summit involved small group discussions addressing three key questions. This report synthesizes themes and insights from all small group discussions, post-session summaries, and supplemental notes provided after the event.

## QUESTION 1: What health needs could be improved by better integration of health and social services? What are the common cross-sector issues and biggest obstacles?

**Key Health and Social Needs Identified:**

- **Social Isolation**: Especially acute among seniors, new mothers, and post-pandemic populations. Often lacks dedicated services to address needs.
- **Mental and Behavioral Health**: Long waitlists for some services, insufficient post-crisis response infrastructure, and a need for front-line mental health training.
- **Housing Instability**: Shortage of affordable, safe, and permanent housing options. Coordination with social supports is limited.
- **Food Insecurity**: Persistent issue despite strong food distribution models. Need for tighter coordination among providers.
- **Transportation**: Non-emergency medical transportation remains fragmented, underfunded, and difficult to access.
- **Preventive Care**: Underutilized due to reactive service models and limited cultural and financial accessibility.
- **Workforce Development**: Frontline social service and navigation workers are underpaid, overburdened, and in short supply.
- **Childcare and Eldercare**: Families lack access to comprehensive and affordable support systems.
- **Health Literacy**: Widespread confusion regarding how to access services. Public materials often lack plain-language clarity and cultural relevance.
- **Dental and Primary Care Access**: Remain peripheral in integration efforts despite clear ties to overall well-being.

**Cross-Cutting System Challenges:**

- **System Fragmentation**: Clients often must repeat their stories across disconnected providers. Services are duplicated or missed entirely.
- **Ineffective Communication**: Overreliance on internet-based navigation tools excludes many users. Limited awareness of existing services.
- **Lack of Trust and Cultural Competence**: Particularly among marginalized groups; need for person-centered and trauma-informed care.
- **Underinvestment in Prevention**: Systems remain crisis driven. Financial models do not support proactive care.
- **Organizational Competition**: Scarcity of funding fosters territorial behavior among community-based organizations (CBOs).

## QUESTION 2: What health needs could be improved by better integration of health and social services? What are the common cross-sector issues and biggest obstacles?

**Desired Design and Functions:**

- **Facilitator, Not Owner**: A neutral administrative entity should support coordination and communication without monopolizing control.
- **Inclusive Governance**: Co-op models with multi-sector representation (CBOs, health systems, government, community) were favored over single-entity control.
- **Service Navigation and Integration**: A central hub could organize referrals, manage warm handoffs, and track care continuity; promoting inter-agency communication for persons with complex needs; and provide training and advancement resources for community health workers.
- **Support for CBO Capacity**: Back-end administrative support (e.g., becoming a qualified provider, grant compliance, data systems) would enable smaller organizations to develop new health services and payment flow (e.g. Medicare / Medicaid services and community health workers).
- **Data Stewardship**: Shared databases should offer opt-out flexibility and strong privacy controls. Proposals included individual-owned data cards. Provide a common database for community needs assessment and planning.

**Existing Models and Examples:**

- **MiCommunityCare (MiCC)** and **CHRT** were cited as strong local models.
- **Jackson Community Care Hub** was recognized for its small, agile, and data-informed approach.

**Gaps and Risks:**

- Power imbalances between large institutions and grassroots organizations
- Risk of excluding smaller or under-resourced providers from new funding or systems
- Mistrust among stakeholders
- Regulatory and funding silos across sectors

**Success Measures:**

- **Health Outcomes**: Reduced emergency department utilization, increased preventive care uptake, improved behavioral health access
- **Operational Metrics**: Referral volume, turnaround time, number of CBOs engaged
- **Equity and Community Engagement**: Inclusive governance, community satisfaction, warm handoff effectiveness
- **Data Quality and Use**: Standardized SDOH metrics, effectiveness measures, and anecdotal reports from stakeholders

## QUESTION 3: What are the best next steps for individuals or organizations to pursue better integration? Who should be meeting with whom, and about what?

**Immediate Action Steps:**

- **Conduct Comprehensive Resource Assessment**: Use shared templates to map services, organizational values, and populations served.
- **Establish Shared Value Propositions**: Develop clear messaging about mutual benefits for healthcare providers, CBOs, and funders.
- **Promote Cross-Sector Relationship Building**: Align expectations and clarify roles across partners through regular convenings.
- **Pilot a Hub**: Start in 3–5 communities to test governance, data systems, and funding strategies.

**Strategic Engagements Needed:**

- **MDHHS and State Policymakers**: For policy reform and sustainable funding commitments
- **Private Sector and Philanthropy**: Engage funders in match-based or long-term investment strategies
- **Natural Community Hubs**: Libraries, schools, and senior centers can host navigators or service kiosks
- **Regional Collaborators**: Coordinate with existing initiatives like HAWC, CMH, United Way, and other local systems

**Community Engagement Priorities:**

- Involve residents with lived experience in planning and oversight
- Develop feedback mechanisms that reflect end-user experience
- Build systems that recognize and accommodate cultural, linguistic, and logistical needs

## SUMMARY

Across all discussions, participants expressed strong alignment on the need for a more coordinated, community-informed, and sustainable approach to integrating health and social services. While there is no one-size-fits-all model, the themes summarized in this report provide a strong foundation for developing shared infrastructure, funding mechanisms, and governance models that are inclusive, efficient, and centered on the needs of the people they serve.

The WHI and its partners are well-positioned to build on this momentum and take the next steps in advancing a community care hub strategy for Washtenaw County and beyond.