Background

Olympic Community of Health (OCH) engaged Collaborative Consulting to conduct an environmental scan focused on Social Determinants of Health (SDOH) within the Olympic region. Identifying and addressing adverse social conditions that negatively impact health is a priority of OCH's collaborative work and of Medicaid Transformation. The purpose is to better understand needs in the region, the relationship between social conditions and health, and opportunities for intervention and collaboration.

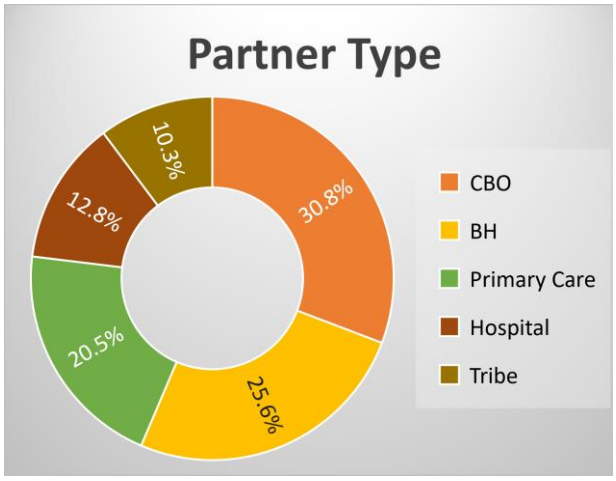
In May 2020, OCH distributed a survey to OCH partners in the community to gain their perspectives on adverse social conditions negatively impacting health and identification of potential regional opportunities to improve community health. The survey contained 16 questions (Appendix 1) around:

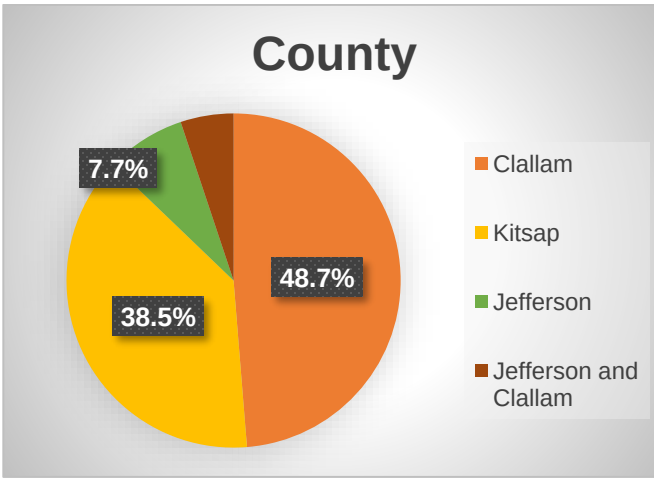
- Social conditions that are negatively impacting health in the Olympic Region,
- Perceptions of dominant social needs,
- Current activity focused on addressing adverse social conditions, and
- Priorities for intervention and collaboration

What follows is a synthesis of survey results.

Respondent Characteristics

A survey was sent out to OCH partners in May of 2020. Overall, 39 individuals completed the survey. Most respondents were from OCH partners representing community-based organizations (CBOs) (30.8%), behavioral health organizations (BH) (25.6%), and primary care organizations (20.5%). Almost half of the respondents were from Clallam County (48.7%). Full respondent data is summarized in Appendix 2: Respondent Data Table.





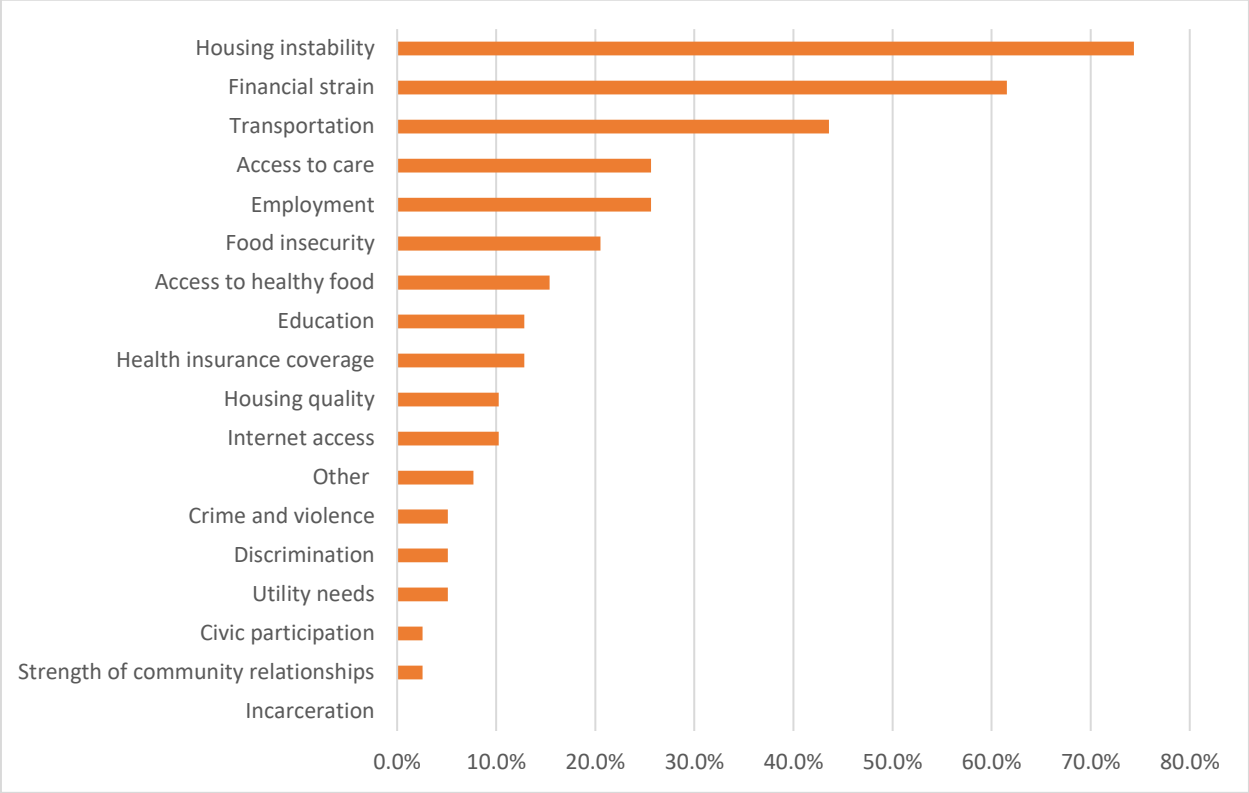
Adverse Social Conditions Impacting Health

Partners were asked to describe the prominent social conditions negatively impacting the health of the communities they serve and how they think needs will change because of the COVID-19 pandemic.

Housing instability and financial strain are the dominant social needs in the Olympic Region

Most partners identified two interrelating social needs as the most important: housing instability (75%) and financial strain (62%). This persisted whether the data was sorted by county (Clallam, Kitsap, Jefferson) or by partner type (behavioral health, community-based organization, hospital, primary care, or tribe).

Dominant social needs in communities (% of respondents selecting each need)



COVID-19 Pandemic: needs are exacerbating while barriers to services increase

Partners believe the COVID-19 pandemic is already and will continue to exacerbate existing social needs, and at the same time barriers to accessing services will increase.

Financial strain increasing and exacerbating other social needs

- Seeing more people are needing services.
- Unemployment is rising which is increasing housing instability and food insecurity.
- Loss of employment leads to loss of employer provided insurance coverage.
- Seeing challenges accessing childcare which can limit work and education.
- Those already struggling financially and overtaxed will be most impacted.

"Our families that were struggling with having the financial means to meet their needs will see that challenge increase and become a deeper and more significant obstacle to success"

"The needs in our community are even more dire. People that were already on the brink have now become unemployed with bills piling up"

Social isolation is increasing which may negatively impact community connection

- Established social connections through schools and community institutions are breaking down.
- There is a need for social outlets and connections that are safe.

Pandemic related fear, stress, and social isolation leading to an increase in mental health needs and substance use likely to get worse in the coming months

- Increase in anxiety and depression due to the isolation.
- Increase in behavioral health crisis.
- Increase in drug using and overdose (Clallam in particular).

"As unemployment rates increase, financial strain and stressors of families adapting to children and parents being in the home more often will result in the need for more support and services."

Needs increase while barriers to services also increase

- Fear of leaving home prevents individuals from seeking needed care or services.
- Lack of internet access or inability to operate technology needed to virtually access services.
- Loss of employer provider insurance.

"Community members may need to utilize more resources for food, transportation, and care but many are scared to go out and seek medical care. Don't want to be in crowds, may not be able to make senior shopping times."

Universal internet access and related technology increasingly important

- Access to high quality stable internet and related technology is becoming increasingly important**.**
- Increasingly important for employment, accessing services and healthcare, give/receive support, and connect with others.

Partners are innovating to continue and expand services in the face of COVID-19

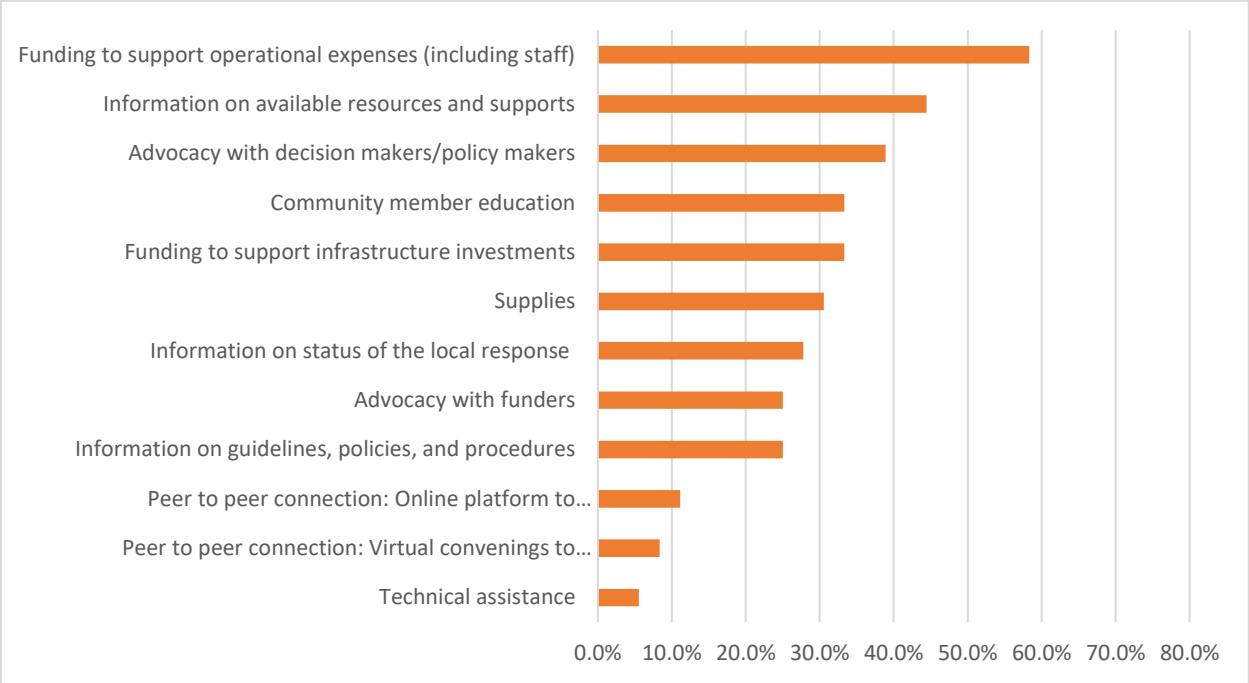
Many partners highlighted success in ability to innovate and continue services, including:

- Online groups and social events via zoom.
- Supporting clients in getting needed services (housing, employment, unemployment, and stimulus benefits, getting food and masks to community members).
- Transferring existing services to video and telephone.
- Providing phones, iPads, or computers so clients can access telehealth and other services virtually.

Funding, information on available resources, and advocacy with decision makers top supports needed in responding to COVID-19

Partners shared resources and supports needed to help them with their COVID-19 response. Funding to support operational expenses (58%), information on available resources (44%), advocacy with decision makers (38.9%), Funding to support infrastructure (33%), and community member education (33%) were the top resources and supports needed.

Help needed with COVID-19 response (% of respondents selecting each support)



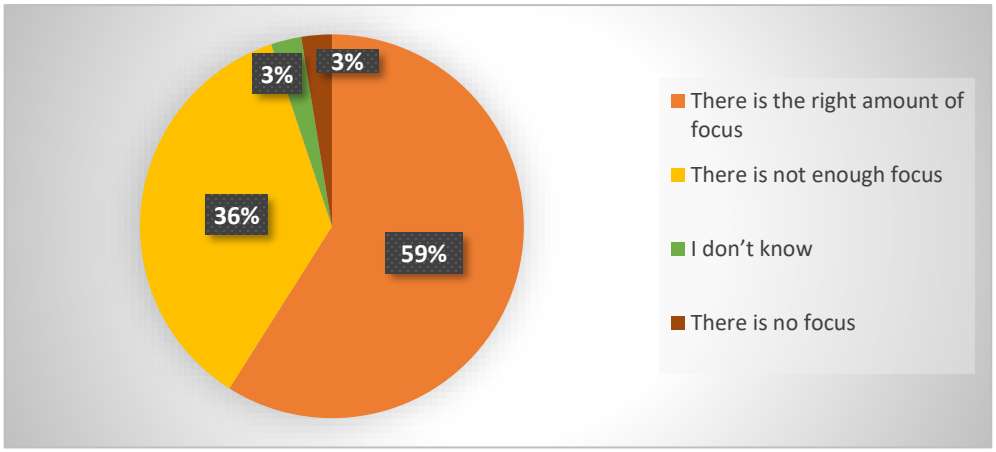
Current Activity to Mitigate Adverse Social Conditions

Partners were asked to describe how much a priority addressing social needs is in the communities they serve. Additionally, they were asked to describe actions they are currently taking to address social needs within their tribe/organization.

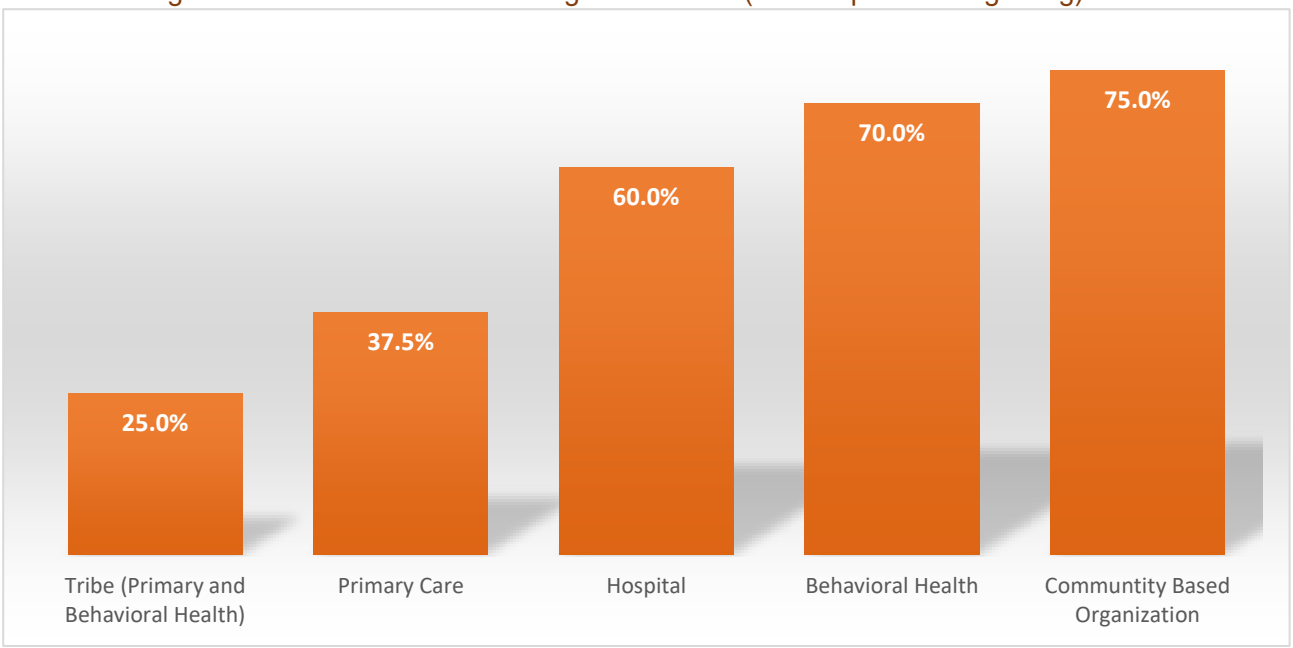
Partners want to do more to address social needs

Almost 40% of partners think there is not enough focus on addressing social needs in their tribe or organization. This perception varies greatly by partner type with over 70% of CBOs (75%) and behavioral health (70%) partners thinking there is the right amount of focus on addressing social needs in their organization, followed by 60% of hospitals. Less than half primary care (37.5%) and Tribe (25%) partners however think there is the right amount of focus on addressing social needs.

Addressing social needs is a priority in tribe or organization (% of respondents)



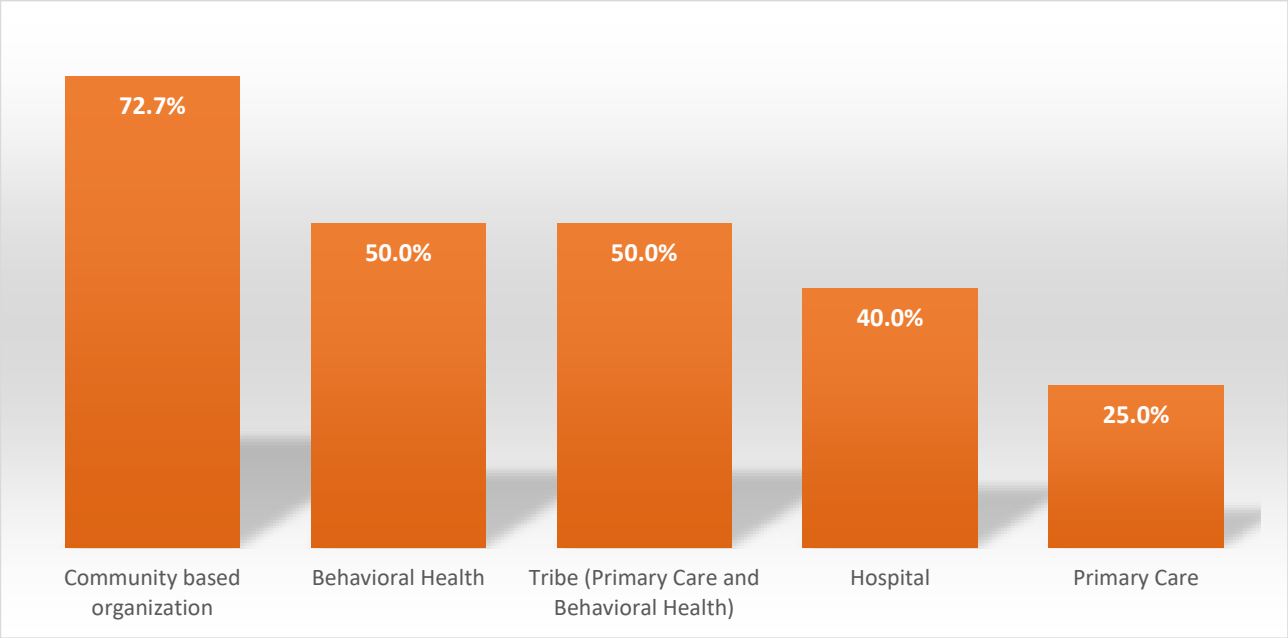
There is the right amount of focus on addressing social needs (% of respondents agreeing)



50% of partners have programs in place to address social needs in their tribe/organization

Only half (50%) of partners responding said they have programs or projects in place to address social needs. Most remaining partners (47.4%) however stated they were moving in that direction towards addressing social needs. Again, the responses varied by partner type, with a larger percentage of CBOs (72.7%), behavioral health (50%), and Tribe (50%) partners having programs in place than hospital (40%) or primary care (25%) partners.

Projects/Programs focused on social needs exist in tribe or organization (% of respondents agreeing)



Programs are focusing on the following needs/areas:

- Care coordination/care management
- Screening for social needs and referral to services
- Increasing access to care
- Early childhood development
- Food security (emergency food, food pantries, meals, and food bags)
- Housing instability (emergency, transitional, and some permanent supportive housing)
- Health behaviors

Specific Programs

Following is a detailed list of the types of programs in place and indicators of which partners referenced these programs. If programs are missing from this list it indicates that no partner referenced the program in the survey, not that a program is missing from the community. Similarly, if a partner is not indicated next to a program it means the partner did not reference it in their survey response.

Programs	BH	CBO	Hospital	Primary Care	Tribe
Access to care (physical, mental, dental, substance use disorder, social)					
Screening for social needs	X	X	X	X	
Referral to resources in community	X	X	X	X	
Care Coordination/Care Management/Case Management	X	X	X	X	
Substance use disorder services (support groups, MAT, syringe exchange)	X	X			X
Mobile medical services (physical, dental, or behavioral health)				X	
School based health clinics					X
Chronic disease management programs (diabetes, hypertension)		X		X	
Cultural competency training- Trauma informed care, SDoH training				X	
Financial assistance in paying medical bills (payment plans, loans, support in signing up for insurance)			X		
Advocacy for adequate funding for rural health care			X		
Economic Stability					
Food bags/meals for students, patients, elders		X	X		X
Food vouchers/ food prescriptions		X	X		
Emergency food assistance, food pantries		X	X		
Food rescue and redistribution program		X			
Housing programs, permanent supportive housing, low-income housing	X	X	X		
Emergency shelters/transitional housing		X	X	X	
Housing First Model for Veterans		X			
Utility and rent support		X			X
Income support- filing unemployment and direct cash transfers					X
Employment program	X				
Employee childcare support			X		
Education and Early Childhood Development					
Home visiting programs: Variety mentioned including Nurse Family Partnership, Parents as Teachers, Parent-Child Assistance Program (PCAP), Maternity support services	X	X			
Parenting classes		X			

Clothing, equipment and supplies for maternity and infant		X	X		
Early childhood education		X			
Educational opportunities for low income families		X			
Social and Community Context					
Support groups and social activities (parents, older adults, youth)	X	X	X		
Legal support	X	X			
Healthy Eating and Cooking classes		X			
5210 healthy living and eating Campaign		X			
COVID-response PPE, housing, food, goods, information line		X	X		
Youth leadership group		X			
Neighborhood and Physical Environment					
Internet access connection to fiber optics					X
Transportation for low income families		X			

Lack of long-term flexible funding is a challenge to program implementation

Some partners described their sources of funding for programs, these included:

- Self-funded by partner
- Medicaid, Medicare
- Foundation or donor funding
- State funding (grants and department specific funding)
- Federal agency funding and grants beyond Medicaid/Medicare (i.e. HUD, Title VI)
- Private insurance

Challenges related to funding were described as:

- Lack of funding for programs,
- Need more state and federal dollars for programs,
- Funding that is not flexible enough,
- Funding that is not consistent or long-term, and
- Increasing competition for available funding.

Existing programs and infrastructure can be leveraged to further progress

Partners highlighted a variety of successes in addressing social needs. The successes themed into areas that indicate an infrastructure is being built that can be leveraged to further progress. Successful efforts included increasing knowledge and energy around SDoH, screening to identify needs in the community, curating resources available to address needs, establishing partnerships and collaborations, and establishing and implementing programs to address needs.

Efforts partners highlighted as successes	BH	CBO	Hospital	Primary Care	Tribe
Increasing awareness and energy around addressing social determinants		X			
Implementing screening to identify specific needs of clients and connecting/ refer to community supports	X	X		X	
Care managers/navigators developing care plans and supporting clients in meeting needs	X	X		X	X
Collation and sharing of available resources in resource lists		X			
Training staff on SDoH, trauma informed care, and available resources		X			
Establishing relationships, collaborations, and partnerships with other organizations and sectors to assist clients in meeting needs	X	X		X	X
Integration of/expanding behavioral health in primary care setting				X	X
Implementing programs to address clients' social needs	X	X	X	X	X

Future Action and Priorities

Partners were asked to describe their vision for the future as it relates to addressing adverse social conditions that negatively impact health. They were asked to highlight what they would like to see changed or improved, their priority areas of focus, and what resources they need to increase focus on addressing social needs.

Vision for the future

Address underlying conditions of employment, housing, and education

Most partners underscored the need to address the underlying conditions of employment, housing and education highlighting how they influence each other and other social needs.

- Increase employment opportunities and establish employment programs including job creation and programs that focus on job training and securing living wage jobs. A few mentioned childcare supports for parents working or in school.

- Place a collective focus on addressing housing needs and increasing affordable housing including increasing access to and availability of stable, affordable housing. Others mentioned implementing housing programs, a Housing First Model, and increasing funding to support clients secure housing.

- Improve educational pathways and supports including more educational and career pathways for low resource families, enhancing education for children especially early childhood education.

"We believe the risk factors that would have the greatest impact on our region are financial strain, employment, and housing instability."

"The housing shortage in our area is real- and the housing in the community is poor-community efforts to repair and provide safe housing is sorely needed."

"Employment opportunities that pay living-wages would allow people to better provide for their families, and would greatly address a number of problems in our region."

"Lack of education will continue to repeat family cycles of poverty and financial strain impacts most areas of SDOH."

Expand collaborations and partnerships; focus on bigger ideas and interventions

Many partners wanted to expand collaborations and partnerships having them focus on bigger picture ideas and interventions and include other sectors including:

- Leverage OCH as a vehicle to bring the community together.
- Partner and centralize resources in a collective approach around 'bigger picture ideas and interventions' to address adverse social conditions.
- Bring in more partners from other sectors including housing, transportation, and education.
- Ensure partners value each other as 'true equal partners.'

"I do think there has to be a collective approach within the community. Coming together and working on the same goals. Need consensus on the priorities."

"Cross-sector partnerships are often the only effective way to tackle complex social problems."

Enhance referral systems and processes to better connect clients to existing community resources

Many partners would like to see referral systems and processes enhanced. Recommendations included:

- Increase the number of social workers and other staff with specialized skills for linking individuals to resources.
- Make information on available community resources easier to find.
- Develop more streamlined and robust referral systems.
- Develop a 'hub' or 'one stop shop' where individuals can get screened for and connected to multiple resources in one place.

"Hope that client's families can access services much earlier in their process. They can go to someone in the community, sit down, discuss what is going on, come up with a plan, and receive appropriate referrals. And much sooner."

Increase data sharing and communication between clinical and community partners

Some partners want to see more data sharing and communication:

- Establish coordinated data systems and platforms that allow data sharing across agencies.
- Increase data sharing and communication among partners around shared clients.
- Establish MOUs between partners
- Provide education around HIPAA rules and what is allowed when communicating on shared clients.

"And Ideally creating that platform that allows for smooth transitions and coordination of services needed to help people remain healthy and safe."

"We have to have a system where we can communicate with each other, at both a local and state level to get MOUs to communicate… The ability to communicate with each other is big."

Support community driven efforts to address social conditions

Some partners expressed the importance of community leading efforts to address social conditions and the need to support and facilitate these efforts including:

- Improve local capacity to respond to needs of the community.
- Support self/community driven efforts to address adverse conditions.
- Develop initiatives that consider local context, history, and historical trauma in communities.
- Support the sovereignty and self-sufficiency of communities.

"I think that there are a number of factors that need to be addressed… and that truly would have the greatest impact if it were a self-driven effort"

Expand flexible funding for existing programs

Some partners expressed a desire to have more funding and more flexible funding for efforts including:

- Establish a pool of flexible funds to support programs.
- Secure long-term funding for initiatives.
- Increase state or federal dollars for employment and housing programs.
- Financial reform that allows hospitals to engage in addressing social conditions in communities.
- Establish a single-payer system focused on health improvement.

Increase availability and amount of mental health and substance use disorder services

Some partners highlighted a need to increase availability of and access to mental health and substance use disorder services

- Improve availability and amount of mental health services (mental health providers, crisis intervention, expanded access for Medicaid, uninsured, and underinsured).
- Improve availability and amount of substance use disorder services (inpatient drug treatment, community supports, sober living housing).
- Expand eligibility for resources and services that already exist.

Implement initiatives that improve neighborhood and physical environments

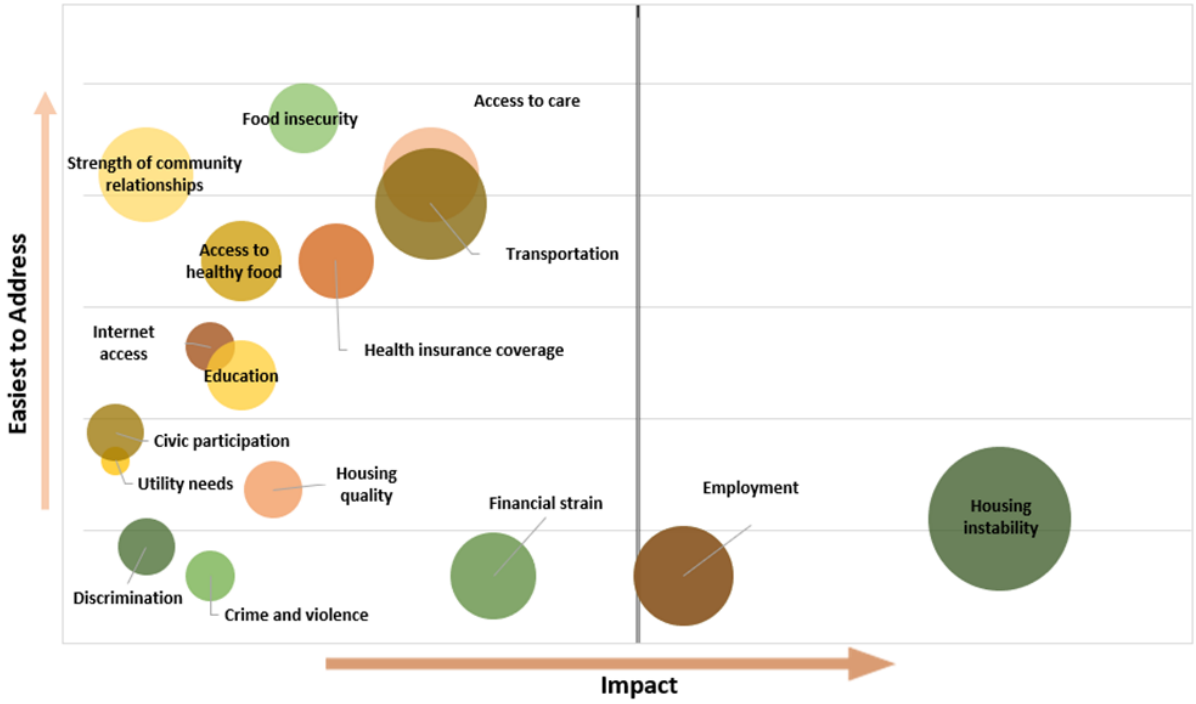
Some partners highlighted programs to implement that improve neighborhood environments including

- Increase access to healthy food and recreational activities for youth and families.
- Increase internet access stability and quality.
- Increase transportation options.

Priorities for Action

Partners were asked to prioritize areas of focus based on which underlying risk factors would have the greatest impact if addressed, which would be the easiest to address, and which would benefit most from a collective regional response. Based on these rankings:

- **Housing instability, employment, financial strain** emerges as top greatest impact factors.
- **Food Security, strength of community relationships, access to care** emerge as factors easier to address.
- **Housing instability, transportation, and employment** emerge as factors that would benefit from a collective regional response.



Rationale for Priority Selection
Partners provided rationale for why they selected various factors as the most impactful, easiest to address, and would benefit most from a regional response.

The most selected responses for each question are below (>25% of respondents selected factor)

Greatest Impact		Collective Regional Response		Easiest	
Risk Factor	**%**	**Risk Factor**	**%**	**Risk Factor**	**%**
Housing instability	75	Housing instability	64	Food security	41
Employment	49	Transportation	39	Strength of community relationships	36
Financial strain	33	Employment	31	Access to care	36
Transportation	28	Strength of community relationships	28	Transportation	33
Access to care	28	Access to care	28	Health insurance coverage	28
				Access to healthy food	28

Greatest impact:

- Improving social conditions helps address and prevent other social needs.
- Adverse social conditions are interconnected and underlying drivers of social risk factors.
- These issues have a significant impact on a large percentage of the county population.

Regional response:

- Issues are complex and take working together collectively to address them.
- Increased infrastructure, resources, skills, and innovation that comes from partnering.
- Issues are not unique to one county; they cut across the region.
- Pooled resources and increased leverage to advocate for funding changes.

Easiest to address:

- Programs resources already exist that can be expanded with funding and eligibility changes.
- Program infrastructure, relationships, and/or partnerships are already established.
- Significant body of research exists arounds solutions to address factor.
- Interventions are less expensive relative to other factors.
- There is a willingness to rally around the issue.

OCH to advance partnership development

Partners were asked what resources/supports are needed to increase focus on adverse social conditions in the communities they serve. Funding to support efforts (61%), staff dedicated to efforts (40%), collaborators/collaboration opportunities (40%), data on top needs in the community (37%), and data sharing/integration across partners (34%) were top resources selected by partners overall.

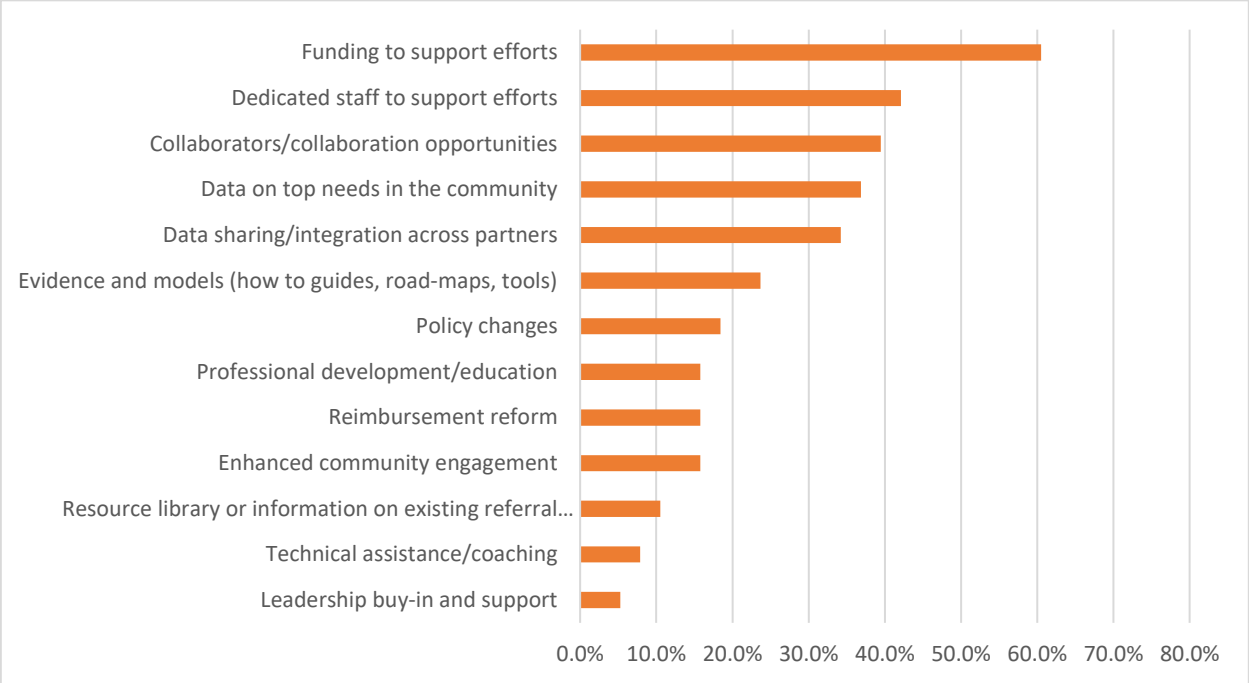
A centralized organization such as OCH is well positioned to address the resource needs voiced by partners that are preventing them from increasing focus on social needs (Figure 7). OCH can serve as a vehicle to:

- Identify collaboration activities.
- Align partners around shared vision and strategy.
- Pool resources and build collective power to advocate for funding.
- Facilitate communication and decision making among partners.
- Provide staff, infrastructure, and data support to manage cross partner efforts.

"We believe that the continued support of community collaboration provided by the OCH is integral to improving the social and health needs of community members in our region."

"One of the greatest strengths of OCH is getting partners together and strengthening community relationships."

Resources to increase a social needs focus (% of partner respondents selecting each)



Appendix 1: Survey Questions

#	Question	Answered	Skipped	Question Type
Q1	Organization Name	39	0	Open-Ended
Q2	Which best describes your role in your organization?	39	0	Select from list
Q3	What are the most important social needs that negatively impact the health of the communities you serve?	39	0	Select from list
Q4	How do you think social needs in your community might change considering the COVID-19 pandemic?	35	4	Open-Ended
Q5	What help does your organization need with its response to COVID-19?	36	3	Select from list
Q6	Is addressing unmet social needs a priority for your organization?	39	0	Select from list
Q7	Does your organization have projects/programs focused on addressing social needs?	38	1	Select from list
Q8	If yes, please list the projects/programs related to addressing social needs?	30	9	Open-Ended
Q9	What resources/supports are needed to help overcome barriers and increase focus on addressing social needs in the communities you serve?	38	1	Select from list
Q10	What success has your organization had in addressing social needs in the communities you serve?	34	5	Open-Ended
Q11	What would you like to see changed to improve social conditions in your community? What interventions or policies would you like to see implemented to address social needs	37	2	Open-Ended
Q12	Which risk factors if addressed would have the greatest impact in our region?	39	0	Select from list
Q13	Which risk factors would benefit most from a collective regional response?	39	0	Select from list
Q14	Which risk factors would be the easiest to address?	39	0	Select from list
Q15	Please describe why you selected the answers you did for the three previous questions on priorities	31	8	Open-Ended
Q16	Is there anything else that you would like to add that we did not address in the survey already?	23	16	Open-Ended

Appendix 2: Respondent Information

	Respondent Group N=*39*
Respondent County, n (%)	
Clallam	19 (49%)
Kitsap	15 (39%)
Jefferson	3 (8%)
Jefferson and Clallam	2 (5%)
Partner Type, n (%)	
Community Based Organization	12 (31%)
Behavioral Health	10 (26%)
Primary Care	8 (21%)
Hospital	5 (13%)
Tribe	4 (10%)
Role in Organization, n (%)	
Senior management (unit or program lead)	15 (39%)
Leadership team	9 (23%)
Administrative staff	7 (18%)
Supervisor (not senior management)	3 (8%)
Front line staff	2 (5%)
Other	3 (8%)
Relationship to OCH, n (%)	
Implementation Partner	37 (95%)
Other, non-contracted	2 (5%)