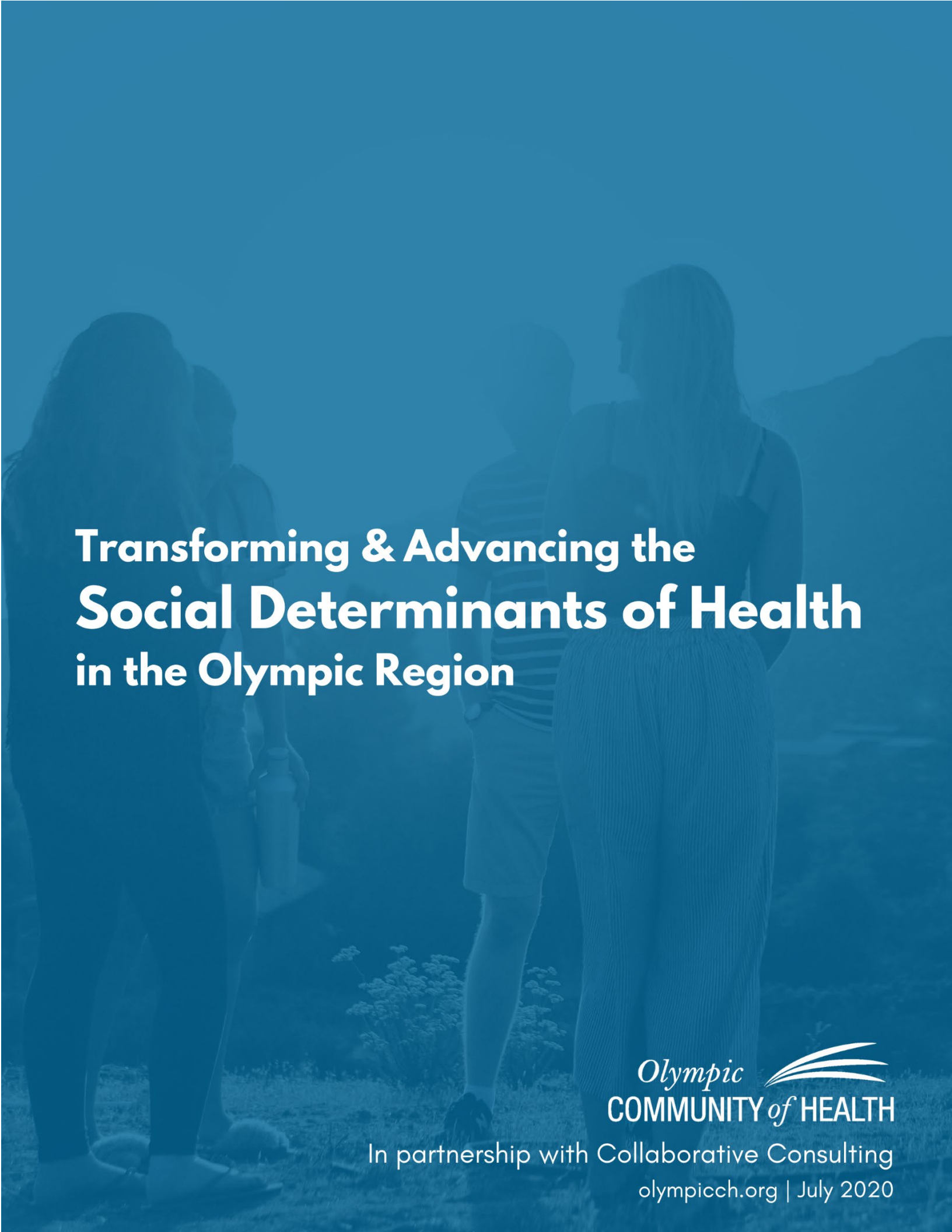

Transforming & Advancing the Social Determinants of Health in the Olympic Region

Olympic COMMUNITY of HEALTH

In partnership with Collaborative Consulting

olympicch.org | July 2020

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Olympic COMMUNITY of HEALTH

BACKGROUND

Olympic Community of Health (OCH) engaged Collaborative Consulting to look at how adverse social conditions across the region are impacting health and explore where there are opportunities for region-wide, collaborative interventions. Our work consisted of:

1) A review of the literature on social conditions and health and evidence-based interventions
2) A profile of multi-partner initiatives aimed at addressing adverse social conditions
3) A survey of OCH partners asking them whether and how they are responding to people's social needs, what challenges they've faced, and what opportunities they see
4) A review of publicly available data on dominant social risk factors in the region

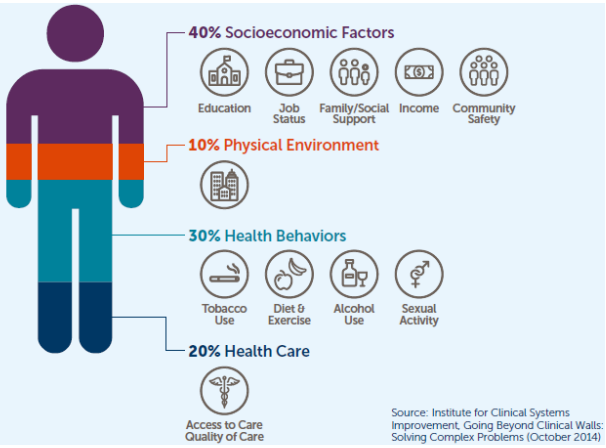
What follows is a summary of what we found.

Identifying and addressing social conditions that negatively impact health is a priority of the Washington Medicaid Transformation Project (MTP) and a potential focus for OCH long-term. This report is one step in a broader palette of work to support OCH partners in addressing issues no single sector or tribe can tackle alone.

HEALTH IS MORE THAN HEALTHCARE: THE IMPACT OF SOCIAL CONDITIONS ON HEALTH

It is estimated that about 20% of what creates health is related to access and quality of health care. The remaining 80% is shaped by the social conditions in which people are born, live, grow, work, and age. These conditions shape health in a way that is beyond the reach of the health system (Figure 1). [1-6]

Figure 1: Factors that contribute to health

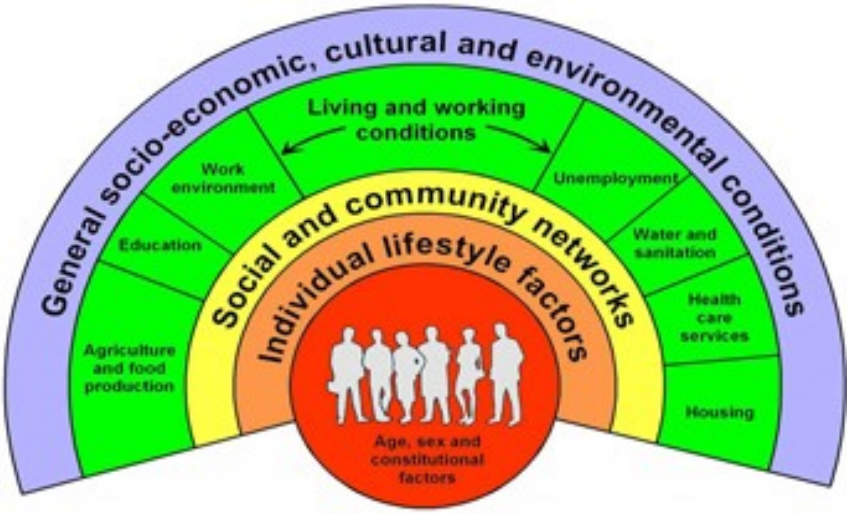


A multitude of interconnected factors shape health

- **Individual genetic factors**: predispositions to health or disease ingrained in our genes. Although many diseases, such as diabetes, cardiovascular disease, and cancers, have some genetic component, risk, morbidity, and mortality are often influenced by environmental exposures and behaviors.
- **Health behaviors:** the daily choices we make that promote or damage health including tobacco use, diet and exercise, substance use, stress coping strategies. Our health behaviors are greatly influenced by culture, socio-economic factors, and environmental conditions.
- **Medical care**: availability, use and quality of medical care influence health. However, improvements in medical care have a relatively small impact on mortality. In the twentieth century life expectancy increased by thirty years, only five of which are attributable to better medical care.
- **Socio-economic factors**: factors including education, employment, income, housing, community safety, social cohesion influence our health.
- **Environmental conditions:** the physical environment influences our health. Environmental pollutants, food and water contaminants, structural and safety hazards in work and living environments all contribute to morbidity and mortality.
- **Power:** power influences decision making, resource allocation, what is acceptable in society, and priorities at the national, state, community, and organization level. It can be described as "upstream of the upstream factors". Imbalances in power can be reinforced in societal systems.

These factors layer over each other and have a cumulative impact over time creating different opportunities to be healthy. The Dahlgren & Whitehead model of health (Figure 2) illustrates this layering. For example, an individual's ability—and motivation—to exercise and eat healthy can be constrained by living in a neighborhood that lacks safe areas and supermarkets. Neighborhood choice can be constrained by income level and employment status, which are, in turn, influenced by education level. Neighborhood conditions, economic opportunity and education quality and access are influenced by decision making and resource allocation by those with power. [1, 7-9]

Figure 2: Layering of the factors that shape health[7]



These factors, social determinants of health, affect everyone

The social conditions that shape our health outcomes are often referred to as the social determinants of health (SDoH), defined by the World Health Organization as "the conditions in which people are born, grow, work, live, and age" (Table 1). The term SDoH is often misinterpreted as being negative or applying to only select groups of people. Everyone's health, however, is shaped by their social conditions. For some it is positive while for others it is negative. At their best, social conditions can improve health, such as through safe, affordable housing, access to good education and healthy foods, and sustainable income. At their worst, social conditions negatively influence health, well-being, and life expectancy. Adverse social conditions create risks to health –so called social risk factors – such as housing instability, inconsistent access to food, exposure to violence and unstable social relationships. [2, 5, 10, 11]

Table 1: Terminology related to SDoH[2]

Social determinants	The conditions in which people are born, grow, work, live, and age that affect a wide range of health, functional, and quality of life outcomes and risks.
Social risk factors	Underlying adverse social conditions that may be associated with negative health outcomes, such as poor housing or unstable social relationships.
Social needs	Social risk factors that consider an individual's preferences and priorities. Social needs differ from social risks by emphasizing the individual's priorities of which social interventions that they most need and want.
Social care	Systems and services, such as housing, food, and education, provided by government and private, profit and nonprofit, organizations for the benefit of the community.

Healthy People 2020 categorizes social conditions into five groups: economic stability, education, social and community context, health and health care, neighborhood and built environment. Table 2 provides examples of underlying factors associated with each group. Systematically identifying and addressing social risk factors can help minimize and reverse their damaging effects on health outcomes.[2, 5, 12-16]

Table 2: Social determinants of health and underlying factors [2,11, 13]

Economic stability	Education	Social and community context	Neighborhood and physical environment	Health and health care
Employment Income Debt Food security Housing	Early childhood education & development Education level High school graduation Language & literacy Vocational training	Civic participation Discrimination Incarceration Social cohesion Support systems Stress	Violence & safety Housing quality Transportation Walkability & Parks Environmental pollutants Air & water quality	Access & coverage to health care Quality of care Provider cultural competency Health literacy

Improving health depends on addressing adverse social conditions

Over two decades of research demonstrates the negative impacts of adverse social conditions on health. Poverty, job insecurity, housing instability, housing quality, environmental pollutants, food insecurity, lack of educational support, social isolation, chronic stress have all been shown to impact health. For more information on the evidence linking adverse social conditions and negative health impacts see *Social Conditions and Health* research report to learn more.[8, 4, 11, 12, 17-22]

Recently research demonstrating the promise of social care to deliver better outcomes at lower cost has increased. Investments in housing, income support, nutrition, education, and coordination are proving to be effective strategies to improve health outcomes and/or reduce costs.[2, 5, 10, 22, 23]

ADDRESSING SOCIAL CONDITIONS THAT IMPACT HEALTH

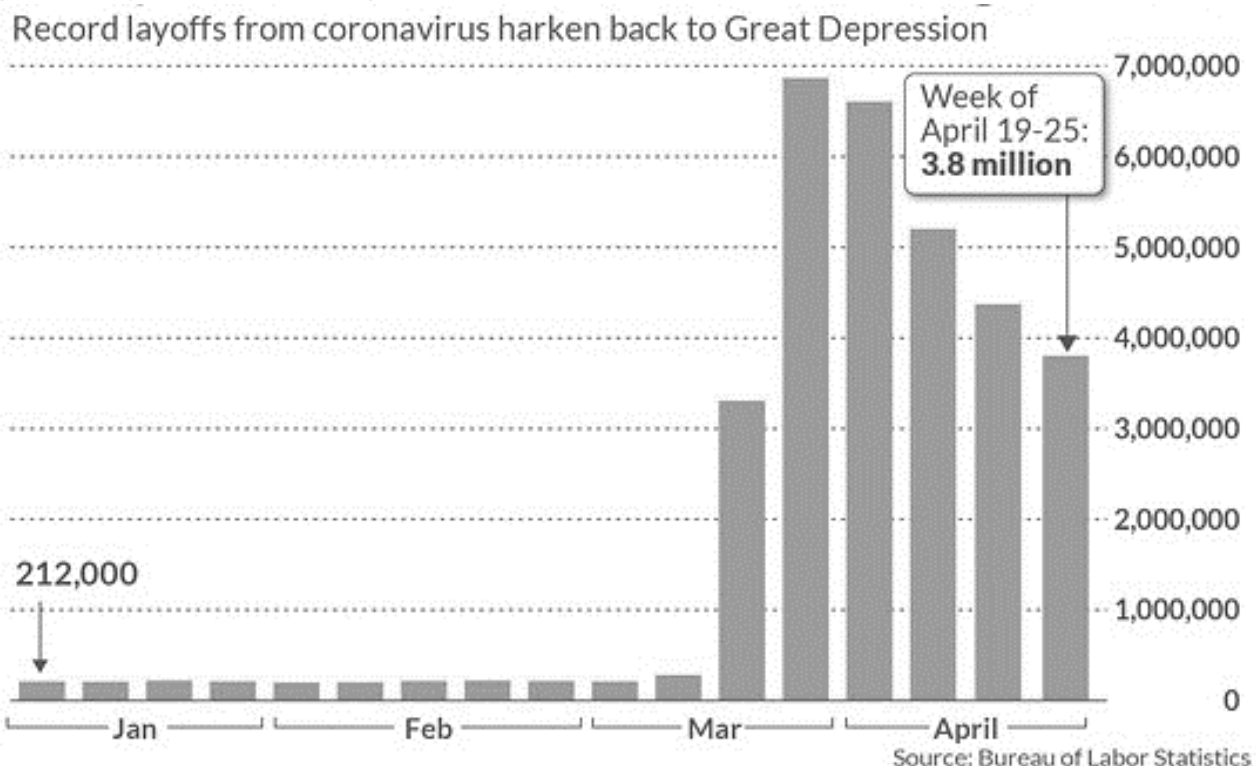
Communities, community-based organizations and social services have long understood the importance of social conditions in shaping health. Additionally, there is a growing focus in healthcare to move towards care systems that integrate health and social care. This shift is being driven by a confluence of factors, including unsustainable health care costs, deteriorating health outcomes and increasing disparities, a push for greater value in health care, and the potential of social care integration to deliver better care at lower cost.

The COVID-19 pandemic is amplifying the need to address social conditions

Across the country the COVID-19 pandemic is exacerbating social risk factors for millions, including the loss of employment (Figure 3), subsequent health coverage loss, worsening food insecurity, and increasing

housing instability. Many marginalized communities have been impacted disproportionately. The pandemic is amplifying and accelerating the need for systems to identify the social risk factors driving poor health and develop local partnerships to address them. [24]

Figure 3: US jobless claims during pandemic [25]



Needs are exacerbating in the Olympic Region while barriers to services increase

Partners surveyed in the Olympic Region (Appendix 1: Survey Respondents) highlighted that the pandemic is causing (and will continue to cause) rising unemployment and increasing financial strain. This in turn is exacerbating related social needs like housing instability, food insecurity, and chronic stress. The fear, stress, and social isolation resulting from the pandemic are leading to an increase in mental health needs and substance use. See *Social Conditions Survey Results* report to learn more about data presented below.

As needs increase, barriers to accessing services such as fear of leaving home, loss of employer provider insurance, and lack of internet or inability to operate technology are preventing individuals from seeking needed medical and social care.

"Families that were struggling with having financial means to meet their needs will see that challenge increase and become a more significant obstacle to success."- CBO

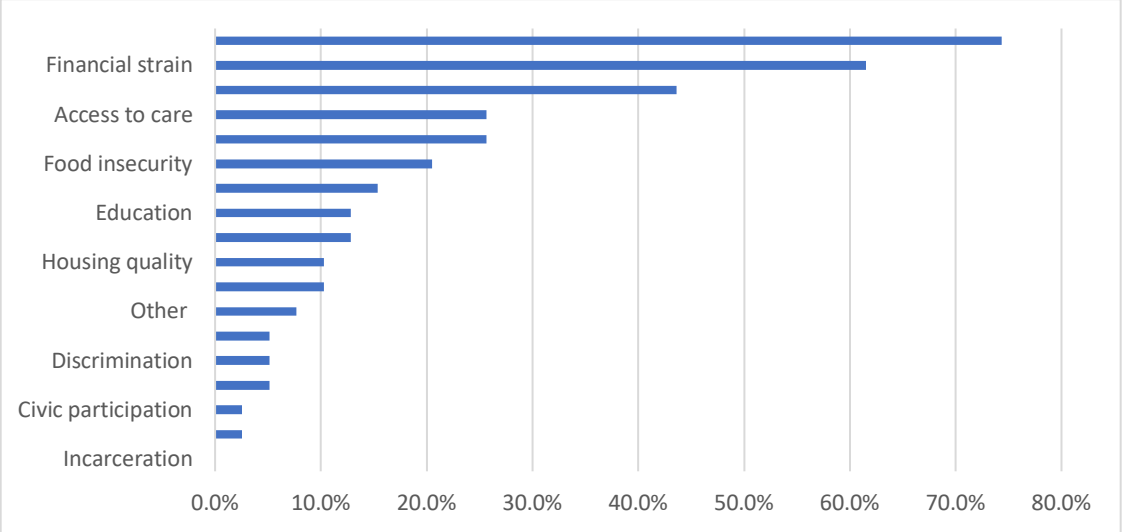
"As unemployment rates increase, financial strain and stressors of families adapting to children and parents being in the home more often will result in the need for more support and services."-Behavioral Health

NEEDS AND CURRENT ACTIVITY IN THE OLYMPIC REGION

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).

Figure 4: Dominant social needs in communities (% of respondents selecting each need)



Employment, sustainable income, and affordable housing are needed in the region

There is a direct link between the top social needs identified by partners and leading SDoH for the region. Publicly available county-level SDoH data indicates that employment, sustainable income and affordable housing are the top areas of need in the county (Table 3). Relative to WA state, unemployment is higher and public assistance income is more prevalent, and at the same time median household incomes are lower. Roughly 1/3 of households spend over 30% of their income on housing. There is an affordable housing shortfall and a small percentage of vacant homes in the region. [26, 27]

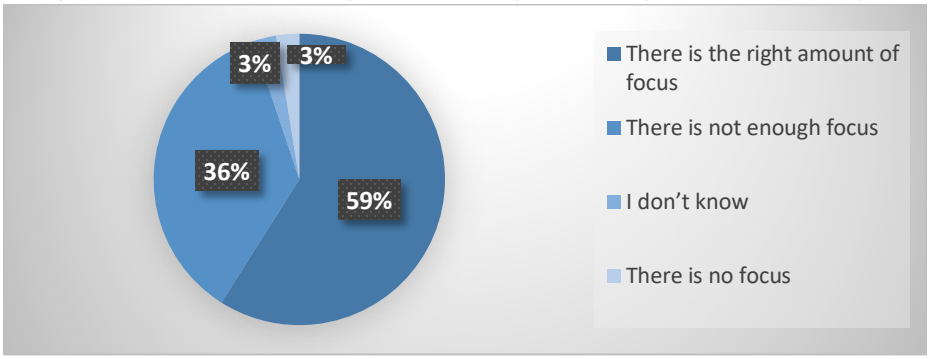
Table 3: Social conditions in the Olympic Region (from publicly available county-level data) [26, 27]

	Data Year	Clallam	Kitsap	Jefferson	WA State	US
Population size	2019	77,331	271,473	31,729	7.6 mil	328.2 mil
Economic Factors						
Median household income*	2017	$49,100	$72,800	$53,400	$70,900	$59,039
Unemployment rate	2017	6.80%	4.90%	6.10%	4.80%	4.40%
% of Households receiving public assistance income	2012-16	7.0%	3.3%	5.0%	3.7%	2.7%
Housing Factors						
Households spending over 30% of income on housing	2012-16	32.7%	33.9%	32.7%	33.9%	33.1%
Work hours needed to pay for affordable housing earning avg. hourly wage	2017	53.8	51.8	59.6	42.5	40.9
Affordable housing shortfall[1]	2012-16	-65.8	-69.2	-62.9	-70.9	-71.8
Vacant houses	2018	1.4%	1.7%	0.0%	1.6%	2.5%

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. Half of partners surveyed said they have programs or projects to address social needs. Most other partners (47.4%) said they were moving in that direction. Responses varied by partner type, with a larger percentage of CBOs (72.7%), behavioral health (50%), and Tribal (50%) partners having programs in place relative to hospital (40%) or primary care (25%) partners.

Figure 5: Addressing social needs is a priority in tribe or organization (% of respondents)



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)

[1] Availability of affordable housing relative to a community's low-income population. Negative numbers indicate a shortfall

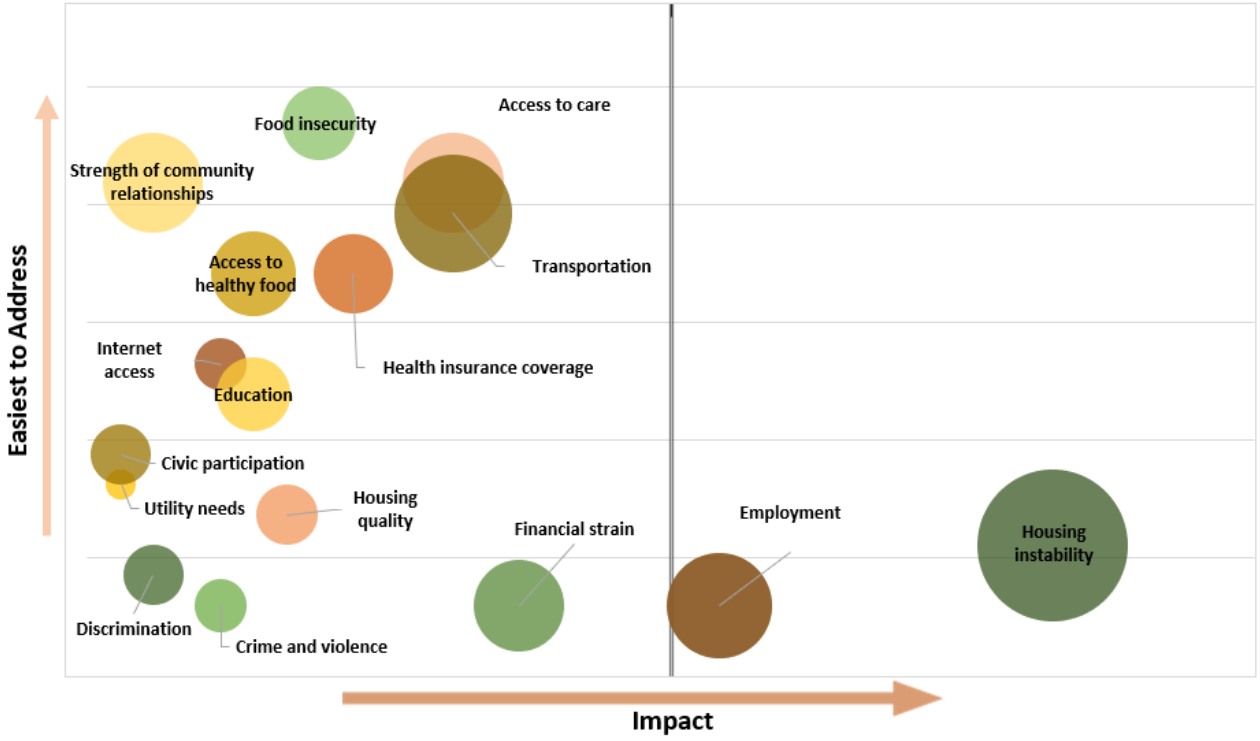
- Health behaviors

PRIORITIES FOR ACTION: MOVING UPSTREAM TO IMPROVE HEALTH

Partners surveyed were asked to describe their vision for the future related to addressing adverse social conditions. What emerged is a picture of using partnerships to enhance existing activity to address immediate needs while simultaneously implementing upstream strategies to address social conditions driving these needs. Figure 6 provides a visual of partner priorities (see Appendix 2 for more details), and what follows is a description of changes partners would like to see as well as the priorities and resources needed. See *Social Conditions Survey Results* report to learn more.

Figure 6: Partner priorities

Partner ranking of social risk factors that would have the greatest impact (horizontal axis), that are easiest to address (vertical axis), and that would benefit most from a regional response (circle size).



Often intervention efforts focus on reacting to immediate social needs such as providing temporary housing or food, without ever making their way further upstream to prevent the needs. While these activities are necessary and will benefit the individual there are a multitude of opportunities to prevent social needs. These opportunities range from action focused on the individuals to action focused on communities. Actions to

address immediate needs can be implemented in concert with upstream actions to prevent the social need. Table 4 provides an example of levels of interventions to address unmet medical transportation needs.

Table 4: Sample interventions to address transportation barrier to health care[2]

Individual	Awareness	Ask people about their transportation needs in the clinical setting
↓	Adjustment	Reduce the need for in-person care appointments by using other options such as telehealth appointments
↓	Assistance	Provide transportation vouchers so patients can travel to and from appointments
↓	Alignment	Invest in community ride-sharing programs
Community	Advocacy	Work to promote policies that fundamentally change the transportation infrastructure within the community

Build on existing activity to address immediate social needs

Opportunity exists to enhance existing activity to better address social needs in the region. Benefits include:

- Evidence based programs and resources already exist that can be expanded with funding and eligibility changes.
- Program infrastructure, relationships, and/or partnerships are already established.
- There is a willingness to rally around the issue.

Specific areas for enhancement:

- Expand eligibility and increase flexible funding for existing programs that are working.
- Enhance referral systems and processes to better connect clients to existing community resources.
- Increase data sharing and communication between clinical and community partners.
- Increase mental health and substance use disorder services; expand eligibility for existing services and increase the amount of services.

"I 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."-Behavioral Health

"Ideally, we create a platform that allows for smooth transitions and coordination of services to help people remain healthy and safe."- CBO

Implement upstream strategies to improve social conditions driving needs

In addition to building on existing activity, it is necessary to simultaneously implement new strategies to improve social conditions in the region. Rationale for concordant action provided as:

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

Specific areas partners wanted to see strategies implemented included:

- Address the underlying conditions of employment, housing, and education as they influence each other and other social needs.
- Increase employment opportunities and establish employment programs including job creation, job training, and support to secure living wage jobs.
- Increase access to and availability of affordable housing.
- Support community driven efforts to address adverse conditions.
- Support local capacity and self-sufficiency to respond to needs of the community.

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

"Employment opportunities that pay living-wages would allow people to better provide for their families, and would greatly address several problems in our region"-Hospital and Primary Care

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

Expand collaborations to implement strategies to improve social conditions

Broad partnerships are needed to focus on 'bigger picture ideas and interventions' that successfully improve social conditions. These partnerships need to expand beyond health and social care to include housing, education, transportation, and other areas. Benefits of this collaborative approach were described as:

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

"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."-CBO

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

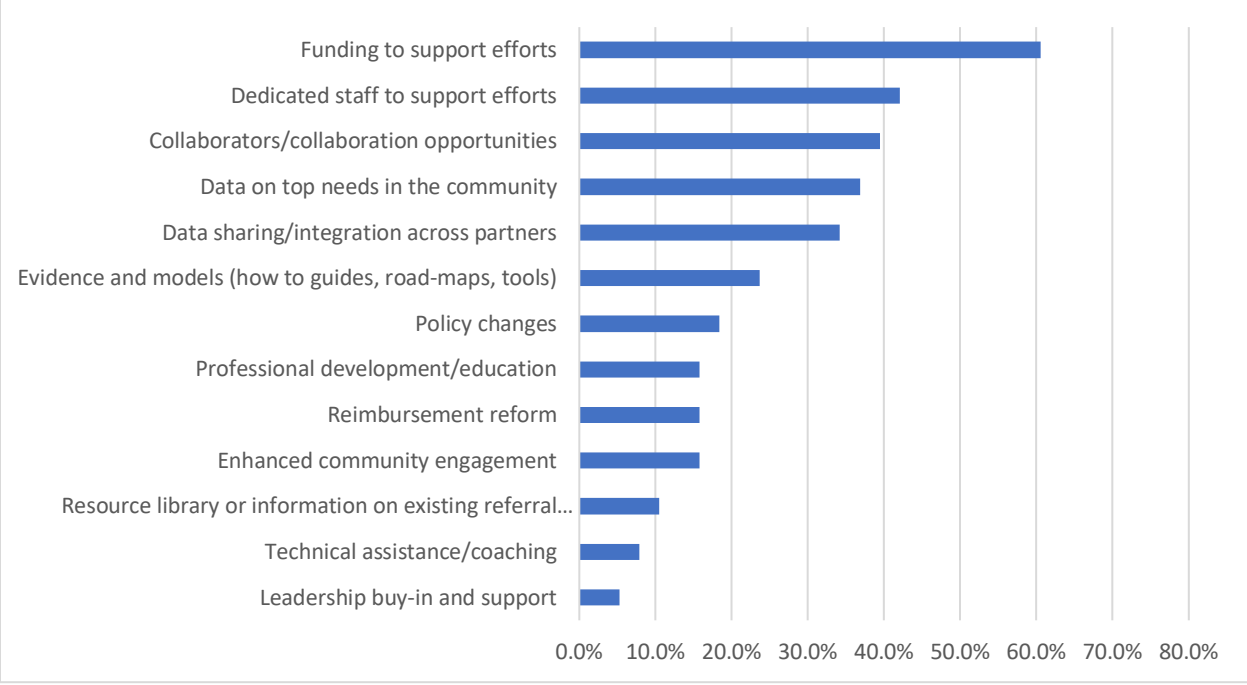
OCH to advance partnership development

Maximize OCH's role in bringing community partners together to enhance current activity and implement upstream strategies. 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"-Primary Care

Figure 7: Resources to increase a social needs focus (% of partner respondents selecting each)



INSIGHTS FROM THE FIELD

Existing multi-partner initiatives offer insight for the Olympic region

Multi-partner initiatives addressing adverse social conditions are emerging across the country and offer many ideas to adapt and apply to the Olympic region. Over 75 multi-partner initiatives were reviewed, 25 of

which were profiled in more depth. The review included understanding partnership type, intervention focus and strategies, social risk factors addressed, funding mechanisms, and outcomes (see *Initiatives to Improve Social Conditions* report to learn more). What follows are the insights that emerged around initiative organizing models and core elements that contribute to success [28-56]. Four categories of organizing structures emerged from the initiatives reviewed:

- **Programmatic Partnership**: Partnerships formed around interventions focused on specific social needs or risk factors such as healthy food access or housing.
- **Community Connectors:** Non-profit organizations that coordinate a portfolio of local interventions, manage a coalition of partners, and leverage funding streams towards unified vision and goals.
- **Anchor Organizations**: Hospitals and universities that use their prominent role in local economies to improve the health of the communities where they are based. Investment strategies include local hiring and procurement, workforce training, living-wage jobs, creating/improving affordable housing, and increasing access to and safety of public spaces.

- **Community-wide Initiatives**: Place-based initiatives that focus on the community from a systems perspective. They address a broad range of upstream social conditions through an integrated portfolio of investments, and often include mobilization and power building among community members as strategies for long-term sustained change.

There is no standard playbook of how best to improve social conditions in a community. Specific initiatives are often customized to local community needs and context, and as a result vary in scope, scale, and factors addressed. Initiatives showing promise, however, share the following common elements: 1) mobilize a broad range of partners, 2) design and partner with community, 3) utilize an integrator organization to align partners, 4) coordinate funding from multiple sources, 5) invest in data sharing, and 6) take a long-term view.

Mobilize a broad range of partners

Adverse social conditions are interrelated and multifaceted. No single organization has the capabilities and authorities necessary to address them alone. Success depends on mobilizing a range of partners. Strategies for partnerships include:

- Align around a shared vision and strategy for change before moving to action.
- Establish shared measures to capture impact of the work, track progress, and ensure accountability.
- Acknowledge differentials in power and resources, and design processes to facilitate shared and transparent decision making.
- Include community members as partners in problem identification, solution design, decision making, implementation, and oversight.
- Dedicate time to relationship and trust building.
- Identify small working groups of people to champion and lead work from partnering organizations.
- Delineate clear and deliberate roles among partners to push work forward.[3, 31, 39, 40-48]

Utilize an integrator organization

Partnerships are critical and they are difficult to establish and maintain. It takes time, effort, and resources. It also often involves navigating differences in goals and incentives; asymmetries in power and resources; and cultural and organizational differences. Successful initiatives often utilize a credible integrator organization that bring partners together and align work. The integrator provides infrastructure to manage cross partner work including: facilitating shared vision and strategy, enabling shared decision making, providing communication and relationship building support; establishing data collection and reporting infrastructure; and monitoring and maintaining momentum of progress.[3,31,39-48]

Healthcare Anchor Network [35]

The healthcare anchor network is a national collaboration of more than 45 leading healthcare systems building more inclusive and sustainable local economies by harnessing their economic power to benefit the long-term health and well-being of the communities they serve. Anchor strategies include inclusive, local hiring and internal workforce development; place-based investing; and local purchasing. The Healthcare Anchor Network helps partners rapidly and effectively advance an anchor mission approach within their institutions, their communities, and within the healthcare sector.

The healthcare anchor network is supported and coordinated by the integrator organization The Democracy Collaborative; they provide a full-time team dedicated to creating productive opportunities for anchor institutions to work together. A platform is provided for the network where member institutions can connect and share with peers; design shared solutions; access and learn from collated evidence base, tools, strategies, and case studies; and build a shared policy and advocacy agenda around addressing upstream social determinants of health.

Design and partner with community

Initiatives that aim to address adverse social conditions are more effective if conducted with the community and reflect the perspectives, preferences, and decision-making of individuals and communities most affected. Achieving partnership with a community is an ongoing process of identifying constituents; inviting underrepresented to the process; repairing and building trust; and building inclusion and shared influence into all processes. Strategies to foster partnership with communities include:

- Commit to and invest in ongoing, long-term community engagement.
- Take time to listen to and learn from community members.
- Incorporate trust building and relationship repair as part of the process.
- Focus on priorities identified by the community.
- Identify and build upon strengths, assets, and solutions that already exist in the community.
- Incorporate community capacity and power building as initiative goals and measures.
- Implement transparent decision making and conflict resolution processes.[39, 41, 46-49]

Community Outreach & Patient Empowerment (COPE) [50]
Native-controlled non-profit focused on healthy, prosperous, and empowered American Indian/Alaska Native communities.

COPE believes that the power to overturn long-standing, historical health inequalities lies inherently in Native communities themselves. Their mission is based on investing in community resources and aligning their work with the vision of tribal leadership. A wide range of programs have been implemented in partnership with community including fruit and vegetable prescription program, health Navajo stores initiative to increase fruit and vegetables and traditional foods in convenience stores and trading posts, connecting local growers to markets, youth leadership and power building, culturally appropriate health education, and community health representative training and outreach program.

Thrive Allen County [51]
Rural health advocacy organization- mobilizing community to improve community health, healthcare access, and economic development

Thrive Allen County is the largest and most prominent rural health advocacy organization in Kansas. The Thrive coalition plays a key role in the county's community improvement journey by catalyzing efforts to improve healthy lifestyles, health care access, and economic development and serving as a connector across efforts. Their work is based in building public and political will and marshalling resources to meet community needs. Initiatives are resident identified and implemented through community mobilizing. Successes include improving healthcare and food access, increasing availability of trails and parks, and establishing statewide rural advocacy coalition to ensure rural voices have a seat at the legislative table.

Coordinate funding from multiple sources

Adequate and sustainable funding is often the most noted challenge for initiatives. Social services funding is often less and delivered through a fragmented patchwork of federal, state, local, and philanthropic sources incentivizing short-term narrowly focused interventions. Additionally, it is difficult to determine return on investment (ROI) due to: short funding cycles mis-matched to longer time horizons necessary to see returns; investments in upstream interventions made by one sector accruing savings or benefits to another sector; lack of accounting for spillover impacts beyond the institution implementing the intervention. Strategies to achieve sustainable financing include:

- Leverage funding streams contributed to by multiple sectors and partners into a pooled financial model (Appendix 3: Funding Examples).
- Pursue multiple funding sources to decrease dependence on any single funder (Appendix 3: Funding Examples).
- Capture 'soft' return on investment to urge initial investment and partner participation. These are initiative benefits not easily quantified in dollar terms such as increased connection to communities; improved collaboration among partners; positive public relations or reputation.

- Reinvest a portion of savings back into efforts to further improve health creating a reinforcing loop of improved health and savings. [5, 13, 19, 52-56]

Housing is Health Initiative [57]
Six health systems to pool resources to build affordable housing

Central City Concern is a non-profit focused on homelessness, poverty, and addiction in Portland, OR. The organization brought together six health care systems to pool resources and invest in affordable housing and support services. The six partners have pooled their community benefit dollars to invest $21.5 million dollars in three affordable housing developments each serving a specific population.

Invest in data sharing

Data and technology play an integral role in cross partner initiatives; they provide infrastructure to identify top social risk factors, populations for intervention, and referral resources; coordinate services between partners; and assess shared outcomes and progress. Many communities, however, lack the data sharing ability necessary to support efforts. Partners are limited by lack of social needs data being collected as well as technical, financial, and legal barriers to data sharing. Integrating data can be expensive, time consuming and prevented by real or perceived legal barriers. Strategies to improve data sharing include:

- Incorporate data sharing as a key component of the partnership.
- Spend time identifying and developing shared data goals.
- Identify a limited set of data fields necessary to start and incorporate into partner data systems.
- Co-design data sharing scope and workflows; include these in data sharing agreements.
- Provide resources and guidance to address real and perceived legal barriers.[2-3, 13,19, 39, 41, 45, 58]

Camden Coalition of Healthcare Providers [59]
Non-profit focused on integrating medical and social care. Integrated data is core to their approach

Camden Coalition of Healthcare Providers is a multidisciplinary non-profit in Camden, NJ that develops person centered programs and models of care that address medical and social barriers to health. The Coalition coordinates a portfolio of local interventions including care management, Housing First, a medical legal partnership, social needs screening and navigation, etc. Core to their approach is using real-time integrated data, community engagement, and convening to inform programs aimed at care redesign. The partnership consists of 20 local non-profits, 4 hospitals, primary care offices, and FQHCs.

The organization established and manages a regional Health Information Exchange (HIE) that provides integrated data to local providers. The HIE is a backbone to care redesign and is used to identify social risk factors in communities, populations for intervention, individuals to enroll in programs, monitor progress, and coordinate services between community and clinical partners. Over 30 sites contribute data to and use the HIE including hospitals, primary care, labs, jails, and other healthcare facilities.

Take a long-term view

Upstream adverse social conditions are not easily solved with short-term, narrowly focused, one-off interventions. Improving social conditions requires long-term commitment and action. Initiatives can take years or decades to become measurable, timeframes that are often at odds with investor and partner expectations. Strategies that help initiatives commit to the long-term include:

- Develop and share narratives that articulate lasting impact, change sought, and progress.
- Develop a portfolio of initiatives aimed at desired change; innovate and adjust as evidence evolves.
- Think of and plan for initiative in phases.
- Embed and embrace learning, iteration, and flexibility into processes and structures.
- Establish short and medium-term objectives that build into the longer-term goals. Track progress along the way to bolster momentum and sustained investment for the long-term.[31, 41, 46, 48]

ProMedica[60]

Community-based anchor institution on 10-year journey to shift from healthcare to integrated health and wellness.

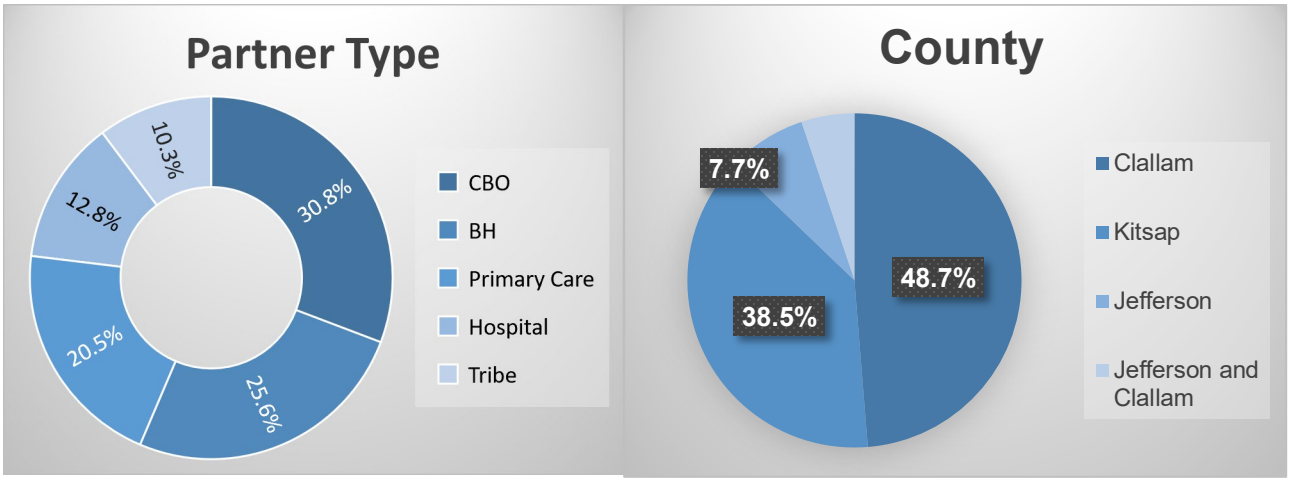
ProMedica has embraced their role as a community-based anchor institution and have been on a 10-year journey to shift their focus from healthcare to integrated health and wellness. In addition to providing traditional healthcare services, they implement a portfolio of broad-based, multifaceted initiatives aimed at improving employment, education, food security and housing in the communities they serve. They take an "all-in" approach to addressing adverse social conditions; connecting traditional interventions like food clinics to strategies that build community wealth such as establishing a grocery store in an areas lacking affordable healthy food and connecting this to employee training programs. Interventions focus on healthy food access, neighborhood improvement, community wealth building, employment.

CLOSING

Employment, sustainable income, and affordable housing are top areas of need in the Olympic Region. The COVID-19 pandemic is causing increasing unemployment, financial strain, and social isolation and subsequently exacerbating housing instability, food insecurity, chronic stress, and mental health in the region. The pandemic is amplifying and accelerating the need to develop local partnerships to identify and address social risk factors driving poor health. Partners surveyed voiced that they do want to do more to address social needs. They described a vision for the future where partnerships and collaborations are expanded to enhance existing activity to address immediate needs while simultaneously implementing upstream strategies to address social conditions driving these needs. This concurrent action is possible as seen in an increasing number of multi-partner initiatives to improve social conditions emerging across the country. These initiatives offer a multitude of ideas that can be adapted and applied to the Olympic region. The OCH partnership can play a key role in fulfilling this vision by serving as a platform to build from to expand cross partner efforts; pool resources; and build power to advocate for funding and change.

Appendix 1: OCH Social Conditions Partner Survey: 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%).



Appendix 2: Priorities for Action

Partners surveyed 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

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

Appendix 3: Funding Model Examples

Following are examples of mechanisms used by initiatives to pool resources

Braided funding	Two or more existing funding streams are coordinated or aligned to pay for interventions. They maintain their connection back to the original source and any applicable constraints on the funds.
Blended funding	Two or more funding sources are put into a collective pool. Funds are more flexible because they are not tracked back to the original source, usually there are not specific requirements or constraints on funds.
Wellness trust or fund	A funding pool raised and set aside specifically to support community health initiatives that improve health outcomes of targeted populations.
Pay for success models/Social Impact bonds	A pooled funding model that uses market-based approach to pay for evidence-based interventions that reduce health care costs by improving social conditions. Relies on investors willing to fund interventions up front and bear risk in return for repayment and reward if the intervention succeeds.
Collaborative Approach to Public Good Investments (CAPGI)	An approach to a fair process for local partners to make joint investments for projects focused on social conditions based on willingness to pay and perceived value. The process includes using data to identify where and how to intervene, partners working with a trusted broker to confidentially bid on and receive an assigned price for selected intervention based on willingness to pay and perceived value, vendors implement intervention while trusted broker oversees implementation.

Following are examples of sources to fund initiatives addressing social conditions

Philanthropy	**Foundation funding**: Philanthropies are increasingly interested in leveraging their funding for greater impact through investments in collective efforts.
	Impact and program specific investment: In addition to charitable giving, many philanthropies invest funds from endowments into programs that align with their mission. These funds require reliable return on investment.
Non-Profit Hospitals	**Community benefit dollars:** Non-profit, tax-exempt hospitals are required to provide community benefit services. These services can include community-building and community health improvement efforts.

Federal Government	**Federal grants:** Identify federal grant opportunities that align with the initiative focus. Grants.gov provides a searchable website of forecasted and open grants, with the ability to search by area of focus.
	Section 1115 waiver: This waiver allows flexibility in use of Medicaid resources to connect to and pay for social care that directly affect an individual's health.
	Delivery System Reform Incentive Payment (DSRIP): Programs provide funding for a finite amount of time to support payment and care delivery transformation. May include funding to support establishment of partnerships.
Providers and Hospitals	**Investment in a portfolio of strategies:** Providers and hospitals may be willing to invest in strategies if there are projected cost savings to their entity from the intervention, interventions help meet quality benchmarks, they operate under value-based payment arrangements, and/or they assume risk for patient populations.
Payers (public, commercial, and self-funding employers)	**Investment in a portfolio of strategies:** Payers may invest in a portfolio of strategies serving their customers in response to real or projected costs savings (via set price, payments for performance targets met, or based on ROI).
Private investors	**Social impact bonds:** Investors provide funding for a specific set of activities with an agreement that their investment will be returned, with interest, if activities result in certain outcomes.
	Community development financial institutions (CDFI): Financial institutions that are committed to providing access to capital and investment for low-income and vulnerable communities. Investments require a return at a low interest rate and must contribute to community development.
Local or state government	**Establish a new local or state tax or fee**: Partners advocate for a new tax or fee earmarked to fund a wellness initiative. Taxes include sales or property tax increases, tax on specific activity (i.e. medical waste disposal) products.
	Redirect existing taxes or fees: Partners advocate to redirect existing tax or fee to support a wellness initiative.
Employers	**Investment in a portfolio of strategies:** Employers may invest in an initiative to improve the health of their employees, reduce absenteeism, working while sick, and/or disability claims.
Crowdfunding	**Small investments or donations:** Large numbers of people contribute to the initiative through crowdfunding platforms like indiegogo.com, startsomegood.com, openideo.com, charity.gofundme.com, fondly.com.

References

1. McGinnis JM, Williams-Russo P, Knickman J. The Case for More Active Policy Attention to Health Promotion. Health Affairs. Mar-Apr 2002;21(2):78-93.
2. National Academies of Sciences, Engineering, and Medicine. 2019. Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health. Washington, DC: The National Academies Press.
3. Murray G, Rodriguez H, Lewis V. Upstream with A Small Paddle: How ACOs Are Working Against The Current To Meet Patients' Social Needs. Health Affairs. Feb 2020; 39(2).
4. Virginia Commonwealth University. Uneven Opportunities: How Conditions for Wellness Vary Across the Metropolitan Washington Region. Oct 2018.
5. Nichols L, Taylor L. Social Determinants as Public Goods: A New Approach To Financing Key Investments In Healthy Communities. Health Affairs. August 2018; 37(8).
6. Norris T, Howard T. Can Hospital's Heal America's Communities? All In for Mission is the Emerging Model for Impact. Democracy Collaborative. Nov 2019. https://healthcareanchor.network/2019/11/can-hospitals-heal-americas-communities/. Accessed March 2020.
7. Dahlgren G, Whitehead M. Policies and Strategies to Promote Social Equity in Health. Stockholm, Sweden: Institute for Futures Studies. 1991.
8. Cubbin C, et al. Where We Live Matters For Our Health: Neighborhoods and Health. Robert Wood Johnson Foundation Commission to Build a Healthier America. Issue Brief 3: Neighborhoods and Health. Sept 2008.
9. Givens M, Kindig D, Tran Inzeo P, Faust V. Power: The Most Fundamental Cause of Health Inequity? Health Affairs Blog. Feb 2018.
10. Dzua VJ, et al., Vital Directions for Health and Health Care: Priorities from a National Academy of Medicine Initiative. National Academy of Medicine Perspectives. March 2017. https://nam.edu/wp-content/uploads/2017/03/Vital-Directions-for-Health-Health-Care-Priorities-from-a-National-Academy-of-Medicine-Initiative.pdf. Accessed March 2020.
11. Healthy People 2020. Social Determinants of Health. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health. Accessed March 2020.
12. Brennan Ramirez LK, Baker EA, Metzler M. Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2008.
13. Artiga S, Hinton E. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. KFF Issue Brief. May 2018. https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/. Accessed April 2020.
14. Healthy People 2020. Social Determinants of Health. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health. Accessed March 2020.
15. Alderwick H, Gottlieb L. Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Systems. Milbank Q. 2019. Jun (2): 407-419.
16. Green K, Zook M. When Talking About Social Determinants, Precision Matters. Health Affairs Blog. Oct 2019. https://www.healthaffairs.org/do/10.1377/hblog20191025.776011/full/. Accessed Feb 2020.
17. Bachrach D, Pfister H, Wallis K, and Lipson M. Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment. New York, NY: The Commonwealth Fund, 2014.

18. Daniel-Robinson L, Moore JE. Innovation and Opportunities to Address Social Determinants of Health in Medicaid Managed Care. Washington, DC: Institute for Medicaid Innovation; 2019.
19. McGinnis JM, et al. Systems Strategies for Better Health Throughout the Life Course: A Vital Direction for Health and Health Care. National Academy of Medicine Perspectives. Sept. 2016. https://nam.edu/systems-strategies-for-better-health-througout-the-life-course-a-vital-direction-for-health-and-health-care/. Accessed March 2020.
20. Adler N, et al. Addressing Social Determinants of Health and Health Disparities A Vital Direction for Health and Health Care. National Academy of Medicine Perspectives. Sept. 2016. https://nam.edu/wp-content/uploads/2016/09/Addressing-Social-Determinants-of-Health-and-Health-Disparities.pdf. Accessed March 2020.
21. OECD. Data. https://data.oecd.org/society.htm. Accessed April 2020.
22. Thornton R, et al. Evaluating Strategies For Reducing Health Disparities By Addressing The Social Determinants Of Health. Health Affairs. 2016 Aug 1;35(8):1416-23.
23. Medicaid and CHIP Payment and Access Commission. State Approaches to Financing Social Interventions through Medicaid. April 2018. https://www.macpac.gov/publication/state-approaches-to-financing-social-interventions-through-medicaid/. Accessed March 2020.
24. Center for Healthcare Strategies. Medicaid's Role in the Next Phase of COVID-19 Response. Part II-Reopening the Healthcare Delivery System. April 2020. https://www.chcs.org/medicaids-role-in-the-next-phase-of-covid-19-response-part-ii-reopening-the-health-care-delivery-system/. Accessed April 2020.
25. Bartash, J. U.S. jobless claims climb 3.8 million in late April to push coronavirus total to 30 million. Marketwatch. Published 30 April 2020. https://www.marketwatch.com/story/us-jobless-claims-climb-38-million-in-late-april-to-push-coronavirus-total-to-30-million-2020-04-30. Accessed June 2020.
26. U.S. News and World Report. Healthiest Communities Rankings 2019: Measuring health and wellness across the U.S. using 81 metrics. Data Explorer. https://www.usnews.com/news/healthiest-communities/rankings. Accessed April 2020.
27. County Health Rankings & Roadmaps: Building a Culture of Health, County by County. Robert Wood Johnson Foundation. https://www.countyhealthrankings.org/explore-health-rankings. Accessed Feb 2020.
28. Take Action to Improve Health. What Works for Health. Robert Wood Johnson Foundation. https://www.countyhealthrankings.org/take-action-to-improve-health. Accessed May 2020.
29. All In: Data for Community Health. https://www.allindata.org/. Accessed April 2020.
30. The Build Health Challenge. https://buildhealthchallenge.org/. Accessed March 2020.
31. Build Healthy Places Network. Principles for Building Healthy and Prosperous Communities. https://www.buildhealthyplaces.org/principles-for-building-healthy-and-prosperous-communities/. Accessed March 2020.
32. Horwitz L, et al. Quantifying Health Systems' Investment In Social Determinants Of Health, By Sector, 2017–19. Health Affairs. Feb. 2020; 39(2).
33. National Academies of Sciences, Engineering, and Medicine. 2017. Communities in Action: Pathways to Health Equity. Washington, DC: The National Academies Press. https://doi.org/10.17226/24624.
34. Health Care Without Harm. Delivery community benefit: Healthy food playbook-case studies. 2018. https://foodcommunitybenefit.noharm.org/. Accessed March 2020.
35. Healthcare Anchor Network. https://healthcareanchor.network/about-the-healthcare-anchor-network/. Accessed March 2020.

36. National Center for Medical Legal Partnership. https://medical-legalpartnership.org/. Accessed March 2020.
37. Robert Wood Johnson Foundation. Culture of Health Prize. https://www.rwjf.org/en/library/features/culture-of-health-prize.html. Accessed March 2020.
38. Social Inerventions Research & Evaluation Network (SIREN). Evidence & Resource Library. https://sirenetwork.ucsf.edu/tools/evidence-library. Accessed March 2020.
39. Humowiecki M, Kuruna T, Sax R, Hawthorne M, Hamblin A, Turner S, Mate K, Sevin C, Cullen K. Blueprint for Complex Care: Advancing the Field of Care for Individuals with Complex Health and Social Needs. Dec 2018. www.nationalcomplex.care/blueprint. Accessed March 2020.
40. Bonnefoy J, et. al. Constructing the Evidence Base on the Social Determinants of Health: A Guide. Nov. 2007. https://www.who.int/social_determinants/knowledge_networks/add_documents/mekn_final_guide_112007.pdfAccessed March 2020.
41. Build Health Places, Prosperity Network, Financial Health Network. Fostering Healthy Neighborhoods. Build March 2020. https://www.buildhealthyplaces.org/whats-new/fostering-healthy-neighborhoods-alignment-across-the-community-development-financial-well-being-and-health-sectors/. Accessed March 2020.
42. De Milto L, Nakashian M. Using Social Determinants of Health Data to Improve Health Care and Health: A Learning Report. Robert Wood Johnson Foundation. May 2016. https://www.rwjf.org/en/library/research/2016/04/using-social-determinants-of-health-data-to-improve-health-care-.html. Accessed March 2020.
43. Erickson J, Branscomb J, Milstein B. Multi-sector Partnerships for Health. 2014 Pulse Check Findings. Cambridge, MA. ReThink Health, 2015. https://www.rethinkhealth.org/wp-content/uploads/2015/09/RTH-PulseCheck.pdf. Accessed March 2020.
44. Hwang A, Miller M. How can Medicaid Transformation Steer Toward Health Equity? A Look at the Evidence. Community Catalyst. Jan 2020. https://www.communitycatalyst.org/blog/how-can-medicaid-transformation-steer-toward-health-equity-a-look-at-the-evidence#.XsaowWhKhPY. Accessed March 2020.
45. Kania J, Kramer M. Collective Impact. Standford Social Innovation Review. 2011.https://ssir.org/articles/entry/collective_impact. Accessed March 2020.
46. Pittman M. Multisectoral Lessons from Healthy Communities. CDC Prev Chronic Dis. Oct 2010; 7(6).
47. Root Cause Coalition. 2020 Status of Health Equity Report. Jan 2020. https://www.rootcausecoalition.org/e_news/2020-status-of-health-equity-report-launch/. Accessed March 2020.
48. Tamber P, Kelly B. Fostering Agency to Improve Health: Twelve Principles Key to Future of Health. March 2017. https://www.pstamber.com/reports/register-to-download-the-full-report-fostering-agency-to-improve-health/. Accessed March 2020.
49. Center for Community Health and Development. Community Toolbox. University of Kansas. https://ctb.ku.edu/en/table-of-contents. Accessed May 2020.
50. Community Outreach and Patient Empowerment Program (COPE). https://www.copeprogram.org/. Accessed March 2020.
51. Thrive Allen County. http://thriveallencounty.org/. Accessed March 2020.

52. HealthLeads. Funding Whole-Person Care: Opportunities to Make Essential Needs Initiatives More Sustainable. http://healthleadsusa.org/wp-content/uploads/2019/05/Funding-Whole-Person-Health_GUIDE.pdf. Accessed March 2020.
53. Taylor L, et al. Leveraging the social determinants of health: What works? Public Library of Science One. 2016. 11(8).
54. Cantor J, Tobey R, Houston K, Greenberg E. Accountable Communities for Health: Strategies for Financial Sustainability. JSI Research and Training Institute. May 2015. https://publications.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=15660&lid=3. Accessed March 2020.
55. Mays G, Mamaril C, Timsina L. Preventable Death Rates Fell Where Communities Expanded Population Health Activities Through Multisector Networks. Health Affairs. Nov. 2016; 35(11).
56. Williams D, Costa M, Odunlami A, Mohammed S. Moving Upstream: How Interventions That Address the Social Determinants of Health Can Improve Health and Reduce Disparities. Journal of Public Health Management Practice. 2008 Nov; 14Suppl. S8-17.
57. Central City Concern. Housing is Health. https://www.centralcityconcern.org/housingishealth. Accessed March 2020.
58. Play: Initiating Health Care Data Sharing with a Social Service Organization. Better Care Playbook. https://www.bettercareplaybook.org/plays/play-initiating-health-care-data-sharing-social-service-organization. Accessed March 2020.
59. Camden Coalition of Healthcare Providers. https://camdenhealth.org/. Accessed March 2020.
60. Oostra R. Embracing an Anchor Mission: ProMedica's all-in strategy. May 2018. https://democracycollaborative.org/learn/publication/embracing-anchor-mission-promedicas-all-strategy. Accessed March 2020.