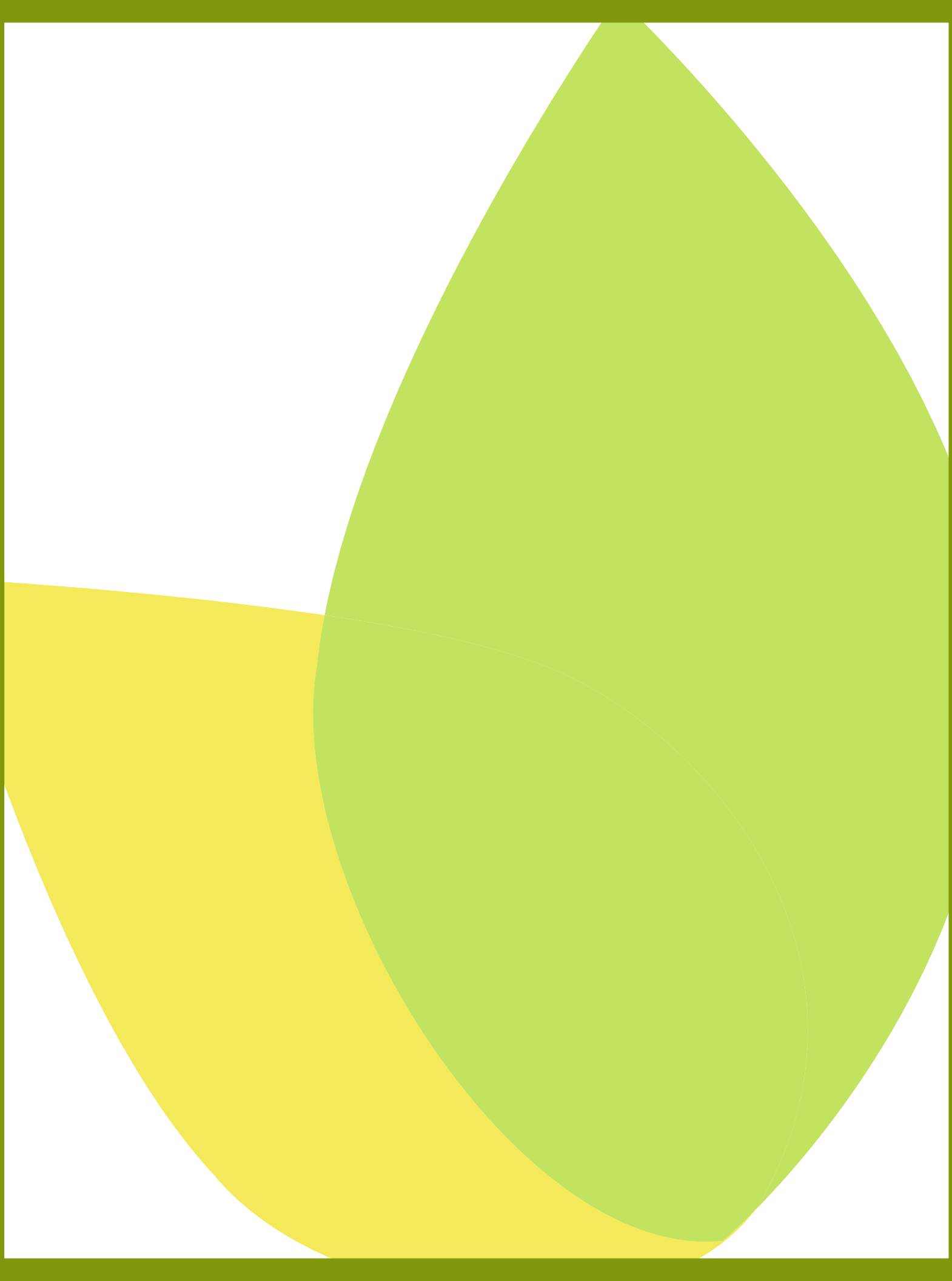
THE ROOT CAUSE COALITION™

STATUS OF HEALTH EQUITY REPORT



Over the last 75 years, as a nation, we created our current health care model with the best of intentions. We built thousands of hospitals with the Hill-Burton Act, created Medicare and Medicaid to help provide care and assistance to many, and made tremendous advancements in the science of disease treatment. Recent advancements in technology put resources for health care— literally— in the hands of millions. Yet, even with such progress, there are many consequences we did not anticipate: We understood the importance of prevention, but placed enormous emphasis on treating symptoms and diseases versus the root causes of illness and poor health, which led to the creation of more work and spiraling costs that, today, are out of control. Until recently, we did not take time to examine or fully understand the underlying socioeconomic factors that have such a significant influence on health and well-being. If an individual lives in a dwelling that is not safe, if they do not have transportation or hold a job, or if their social network has collapsed and they are isolated, then their ability to achieve optimum health and well-being is compromised. And, when a person's ZIP code— or ZNA— is more of an indicator to overall health and well-being than their DNA, we know the current model of health care is badly broken.

The questions we must push to the forefront include, *"How do we completely remodel our broken health system while still ensuring appropriate access to care?"* and *"How do we include other sectors— social service, education, funders, business and industry, faith-based groups, and government in the development a new model?"* Working together, we must disrupt and begin a simultaneous *deconstruction* and *reconstruction* of health care in this country, while maintaining and protecting components that are solid. We must work thoughtfully, but with a sense of urgency as well as appreciation for maintaining a balance of appropriate care, while rebuilding a new model of delivery.

To have a significant impact on long-term health outcomes, we must consider factors such as transgenerational poverty, economic stability, safe and accessible housing, food security, inclusion, the elimination of social isolation, dependable transportation, and— perhaps most important— training and education that provides a pathway for all individuals to attain their best self.

Together, we can achieve this goal. And we can gain insight and lessons from those organizations already devoted to addressing the social determinants. With a mission to achieve health equity at its core, The Root Cause Coalition is pleased to present this ***Status of Health Equity Report*** that examines both the progress— and the gaps— in addressing the health disparities and socioeconomic factors influencing individual and community health and well-being. This report identifies Actionable Strategies that can be implemented by organizations and communities across the country, as well as provide examples of the extraordinary work being undertaken nationally, regionally and locally in an effort to address the root causes that affect health and well-being. And, ultimately, it is a call to action for the work that must continue— in greater alignment and collaboration— so that, as a nation, health equity can be achieved in our time.

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TABLE OF CONTENTS

5 INTRODUCTION

7 EXECUTIVE SUMMARY

11 PROVIDER SURVEY

17 ACTIONABLE STRATEGY #1

37 ACTIONABLE STRATEGY #2

53 ACTIONABLE STRATEGY #3

60 CALL TO ACTION

62 ACKNOWLEDGEMENTS

64 GLOSSARY

INTRODUCTION

The evidence is painfully clear that our current system of providing health care in the United States is not working:

- The Institute of Medicine (IOM) concluded in 2013 that Americans live shorter lives, are in poorer health throughout their life course and experience no compression of disease. For the first time in over a century, life expectancy has declined for the past three consecutive years.
- The IOM concluded in 2012 that approximately one-third of health care costs do not improve our health status.
- Health care coverage expansion has been offset by significant increases in out-of-pocket spending that is particularly problematic since the U.S. suffers the largest income-based health disparities in the developed world.
- Individuals cannot afford basic care. The cost of health care is the number one cause of bankruptcy in the U.S.; more than one-third of people skip care and or prescriptions they need due to the cost of care; and bankruptcy for 65-year-olds is three times higher today than in 1991, due at least in part to skyrocketing health care costs.

The evidence continues to build that health and well-being does not begin in a doctor's office, a hospital, or other clinical setting. Health and well-being begin where we live, learn, work, and play. Unfortunately, socioeconomic factors such as hunger, job security, transportation, education, and isolation are ever-present in our society. One in 10 seniors in the United States lives below the federal poverty level, and 40 percent of American families struggled in the last 12 months to meet basic needs of food, healthcare, housing, or utilities.

Health care professionals understand the need to address the social determinants of health that create health inequity, and are willing to help do so. And increasingly, the health care sector understands the importance of collaborating and partnering with organizations from a variety of cross-sectors, including social services, educators, faith-based groups, funders, business, and government, to ensure all individuals can achieve their best self. But in an online survey of primary care physicians, nurse practitioners and physician assistants conducted by The Root Cause Coalition (and published in this report), the top three barriers to addressing socioeconomic factors included: not enough time during an office visit; limited resources; and community resources not being integrated with clinical resources to provide help effectively.

TOP THREE BARRIERS TO BEING MORE INVOLVED IN ADDRESSING NONCLINICAL SOCIAL AND ECONOMIC FACTORS INFLUENCING HEALTH OUTCOMES

PCP	NP	PA	
71%	69%	76%	Not enough time during an office visit.
63%	69%	65%	Limited resources to provide help effectively.
69%	58%	51%	Community resources are not integrated with clinical resources to provide help effectively.

In this **Status of Health Equity Report**, based on interviews with 28 member organizations of The Root Cause Coalition, and original research including primary care physicians, nurse practitioners and physician assistants, **Three Actionable Strategies** are identified as to how members of The Coalition are currently addressing issues related to socioeconomic factors influencing health and well-being. These strategies are closely integrated into The Root Cause Coalition areas of focus and priority:

FOCUSING ON COMMUNITY CHANGE

The Coalition focuses on changing policies and systems in order to effect widespread and lasting improvements that lead to health equity. This includes addressing myriad basic needs as well as equity, inclusion, and bias in organizations and communities.

ADVANCING AUTHENTIC COLLABORATION

The Coalition inspires leaders to prioritize cross-sector solutions that address the root cause of health inequities and advances the practice of collaboration by supporting organizations in identifying shared interests, respecting diverse perspectives, sharing authority and responsibility, and working effectively.

SCALING INNOVATIVE SOLUTIONS

The Coalition efficiently and effectively facilitates shared learning across sectors and geographies, and cultivates new partnerships and bold solutions that have the potential to drive sustainable change.

ENGAGING AND LEARNING FROM COMMUNITIES

The Coalition recognizes that those most affected by inequities in health and social conditions are the experts on their experiences, and welcomes and elevates these voices and prioritizes solutions that are identified by those communities.

Based on the Actionable Strategies, and consistent with The Coalition's Mission and Vision to reverse and end the systemic root causes of health inequities for individuals and communities in this country, this report concludes with a comprehensive **Call to Action** to be implemented by 2025. Once achieved, this will significantly focus care and prevention more directly on socioeconomic factors influencing health, which in turn will enhance individual and community health outcomes while reducing costs.

We must change the health care model to have a greater focus on social factors influencing health outcomes. We must dig deeper. We must be decisive in creating a more comprehensive model.

This report shows our current trajectory in addressing these issues, and a pathway on how to move forward.

EXECUTIVE SUMMARY

Based on the definition by the Robert Wood Johnson Foundation, health equity means that everyone has a fair and just opportunity to be as healthy as possible. Achieving this means removing socioeconomic barriers to ensure housing, food security, financial stability, and a quality education.

The Actionable Strategies outlined in this report came from two distinct but connected components. First, a survey of primary care providers (physicians, nurse practitioners and physician assistants) was conducted to gain perspective of these key stakeholders related to their role in addressing health equity and societal factors that influence health and well-being. The research also points out barriers— real and perceived— to achieving health equity.

Second, 28 members from The Root Cause Coalition were interviewed to attain a national perspective on how communities and organizations are addressing health disparities through the social determinants of health, what challenges they face and what the critical next steps are in improving health outcomes and creating greater health equity for all populations. The interviews included a broad range of representatives from hospitals and health care systems, payors, funders, and community-based organizations.

The good news is that there is an increasing commitment by individuals, organizations and communities to work collectively— to do the hard work necessary that will help reverse and end systemic root causes of health inequities. There are examples of this work happening on all levels: locally, statewide, regionally, and— in growing cases—nationally. But, for all the awareness and effort, there is great work to be done in embracing and addressing the issues, so as to achieve appropriate and sustainable solutions.

Along this line, there were three key implications from the provider survey:

- Primary care providers including physicians, nurse practitioners and physician assistants agree that there is a need to address health disparities, but they feel it will require increased access to resources and more effective integration of clinical and community resources for the primary care provider to feel their involvement will be productive. For example, access to clinical pathways in the electronic health record was an important motivator.
- There needs to be an increased effort in educating/training providers about health equity and the role health care providers play in addressing these issues – and how to effectively integrate that role into their current practice. This is particularly true of primary care physicians and physician assistants.
- Primary care physicians, nurse practitioners and physician assistants are more divided on who/which organizations should take ownership of health equity in their community. They are more likely to think it is the responsibility of institutions/organizations traditionally responsible for health disparities (e.g., public health departments, government, social services), and less likely to think it is the responsibility of health care professionals (e.g., health care providers, hospitals, health systems).

From interviews with members of The Root Cause Coalition, as well as the information and data from the provider survey, this report focuses on three major actionable strategies that will help achieve health equity. Below is a summary of these strategies along with related processes being implemented by members of The Root Cause Coalition to help achieve them. As the Coalition is recognized as the collective voice in how we can achieve health equity, we present these strategies as guideposts to all who have a passion, commitment and understanding of this critical work.

ACTIONABLE STRATEGIES TO ACHIEVE HEALTHY EQUITY

Actionable Strategy #1
Scale innovative solutions to drive a new and sustainable model of care that improves health outcomes as it ensures health equity through:

- Connecting clinical and community non-clinical services through technology to address health outcomes related to societal factors influencing health and well-being.
- Embedding social determinants of health into organizational processes to ensure reimbursement for non-clinical services.

- Scaling innovative programs from local to national environments.
- Evolving and expanding the role and impact of funding organizations.
- Continuing to evolve metrics and measurements to more effectively track and evaluate outcomes addressing health equity and social determinants of health across sectors.
- Among the critical challenges identified in the provider survey conducted by The Root Cause Coalition (including primary care physicians, nurse practitioners and physician assistants) is the need to create an infrastructure that allows the clinical/health care sector and community to connect, and to ensure that this connection results in payment for non-clinical services rendered by providers and community-based organizations.

The sentiments expressed by care providers were echoed and validated by the member organizations interviewed for this Status of Health Equity report, including hospitals and health systems, payors, funders, technology innovators, and community-based organizations. Many of these same members are in the process of evolving to meet these challenges. Technology companies are actively creating innovative platforms to allow non-clinical services to be paid through medical claims, and are receiving funding to scale these efforts. Health insurance companies are in the process of embedding non-clinical services into strategic plans, care integration and benefits programs.

During the interviews with members of the Coalition, it was clear that health providers and payors cannot truly address health inequities and social determinants of health unless there is a shift in the payment model. While a shift is important because it allows payors to focus on social determinants, members also indicate that downstream payment models must change around organizational belief systems.

As are other member organizations of The Root Cause Coalition, funders are evolving to be more effective in addressing the social determinants of health and health inequities. Many of the organizations who fund research and community-based organizations related to health inequity and social determinants of health are looking to have fewer grants with greater overall measurable impact. Alignment in community work, and collaboration is key.

Similar to funders, foodbanks that were interviewed are evolving as they address the social determinants of health. This sector is looking to have even greater impact in their communities by transitioning from focusing on one aspect of addressing the social determinants of health— food distribution and food access— to addressing broader issues related to health equity, with access to food and proper nutrition as the entry point.

Another key implication from the care provider survey was a need for an increased effort in educating and training providers about health equity and the role health care providers play in addressing these issues— and how to effectively integrate that role into their current practice. Members of the Coalition interviewed for this report echoed this need repeatedly.

All organizations interviewed are conducting various forms of measurements and metrics. But many of the organizations are evolving as they strive to measure health outcomes longitudinally. Being able to successfully measure health outcomes is critical to having meaningful relationships among cross-sector partnerships, and in demonstrating value and receiving payment for services rendered.

Actionable Strategy #2
Align communities and advance authentic collaboration to address the root causes of health inequities, through:

- Implementing place-based and community revitalization strategies that address geographical health inequities.
- Helping ensure financial stability through workforce development.
- Expanding beyond traditional (or current) food access and food distribution strategies to address broader issues related to social determinants of health and equity.
- Support community-based organizations.

Research has indicated that where you live can have a greater impact on your health and well-being than your DNA. Members of The Root Cause Coalition are implementing place-based strategies that address these geographic-based inequities.

As members of the Coalition meet within their respective communities, financial stability is often identified as a significant issue. And Coalition members are responding with a variety of workforce development programs.

Community-based organizations (CBOs) want to care for the most vulnerable, and want to see that impact and achievement toward health and well-being. But many of these organizations are severely stressed. A national study found that nearly half of CBOs participating in the report had a negative operating margin over three years; 30 percent have reserves covering less than one month of expenses; and one in eight human services CBOs are technically insolvent, which emphasizes the need to find new and sustainable funding models to support these non-medical services.

Currently, many community-based organizations are funded largely by grants. But as research on social determinants and health equity expands, the next step is for CBOs to be able to demonstrate value so that payors can pay for services provided. Members of The Root Cause Coalition are working to meet this challenge locally and regionally and are looking to scale nationally.

Actionable Strategy #3
Engage and learn from communities most affected by inequities of health and social conditions.

- Establish and expand programs to enhance cultural sensitivity and cultural competency in an organizational and community context.
- Create communications programming that adds context to the community narrative.

One of the most significant challenges in addressing social determinants of health and health equity is to create cultural competency internally and in the community. Achieving greater cultural competency is critical to building meaningful relationships at all levels in a community to achieve impact.

Members of The Root Cause Coalition are passionate about this, and many are implementing organizational policy assessment through an equity lens, working to be more inclusive in employment and procurement with increased opportunities for minority-owned, women-owned and veteran-owned businesses across the state. Still another initiative highlighted in detail in this report focuses on standardizing the collection of patient race, ethnicity and language (REAL) data, which is essential for identifying and addressing disparities in quality of care. Based on gap analysis of the REAL data, recommendations to reduce disparities have been made.

Members interviewed recognized that sometimes organizations are so eager to fix problems that they don't listen, and try to fix things they don't understand. But the process is very nuanced. Virtually all of the individuals interviewed for this report discussed the critical importance of listening and meeting the community in its space. A top-down approach will only serve to create trust barriers. Hearing the individual's voice early in the process is essential to the success of the project.

It is important to understand how people self-identify and build that into the community narrative. Individual community members are great experts, but all too often are the missing element in discussions about social determinants and health inequities.

To achieve change in a community, it is critical to build context and change the narrative. That means spending time in the community space and listening. The language in any given community can be culturally loaded. The need to spend time to listen and support community engagement is very much a process and organizations must be prepared to invest the time to do this.

This report provides additional details about the findings and implications from the provider survey, as well as examples of how members from The Root Cause Coalition are addressing health equity through the social determinants of health utilizing the actionable strategies identified above. They are strategies that create frameworks and opportunities enabling organizations to embrace and implement health equity interventions.

Our nation is at a crossroads with an opportunity to choose a path that provides a dignified, accessible and compassionate way forward for all. We invite you to join us in pursuing these strategies so that, in our time, health equity can be achieved.

CHAPTER 1

PROVIDER SURVEY

PROVIDER SURVEY

Provider attitudes, behaviors, barriers, and motivations related to addressing nonclinical social and economic factors in patients in an office setting

Health care providers including primary care physicians, nurse practitioners and physician assistants, are a critical stakeholder in addressing socioeconomic factors influencing health and well-being. With that in mind, and as part of the Status of Health Equity Report, The Root Cause Coalition conducted an online survey of health care providers to understand the attitudes, opinions and behaviors of this key group in addressing health equity through the social determinants of health.

Two-hundred (200) providers, including primary care physicians, nurse practitioners and physician assistants, participated in this online national survey. Participants are members of a national, opt-in survey research panel. Primary care physicians represented 48 percent of the survey respondents, nurse practitioners represented 28 percent and physician assistants came in at 25 percent. Ages ranged from 45 years and under to 56 years of age and over. Years practicing ranged from five or fewer years to more than 31 years in practice. The respondents were 50 percent female and 50 percent male. Respondents included those in private practice, or employed by a physician-owned medical group, health system, hospital, health clinic, or self-employed. The profile of the survey participants also included a breakdown of primary payment method including commercial pay, Medicare, Medicaid, and private pay. The survey was conducted by Great Lakes Marketing Research, based in Toledo, Ohio.

OBJECTIVES OF THE ONLINE SURVEY INCLUDED

- To understand attitudes and opinions about the role of professional caregivers in addressing health equity issues among primary care physicians and advanced care practitioners.
- To identify differences in attitudes, opinions and behaviors between primary care physicians and advanced care providers with respect to addressing health equity issues.
- To identify barriers to engaging in health equity conversations with patients.
- To prioritize potential motivators that may encourage more involvement in addressing health equity issues with patients.

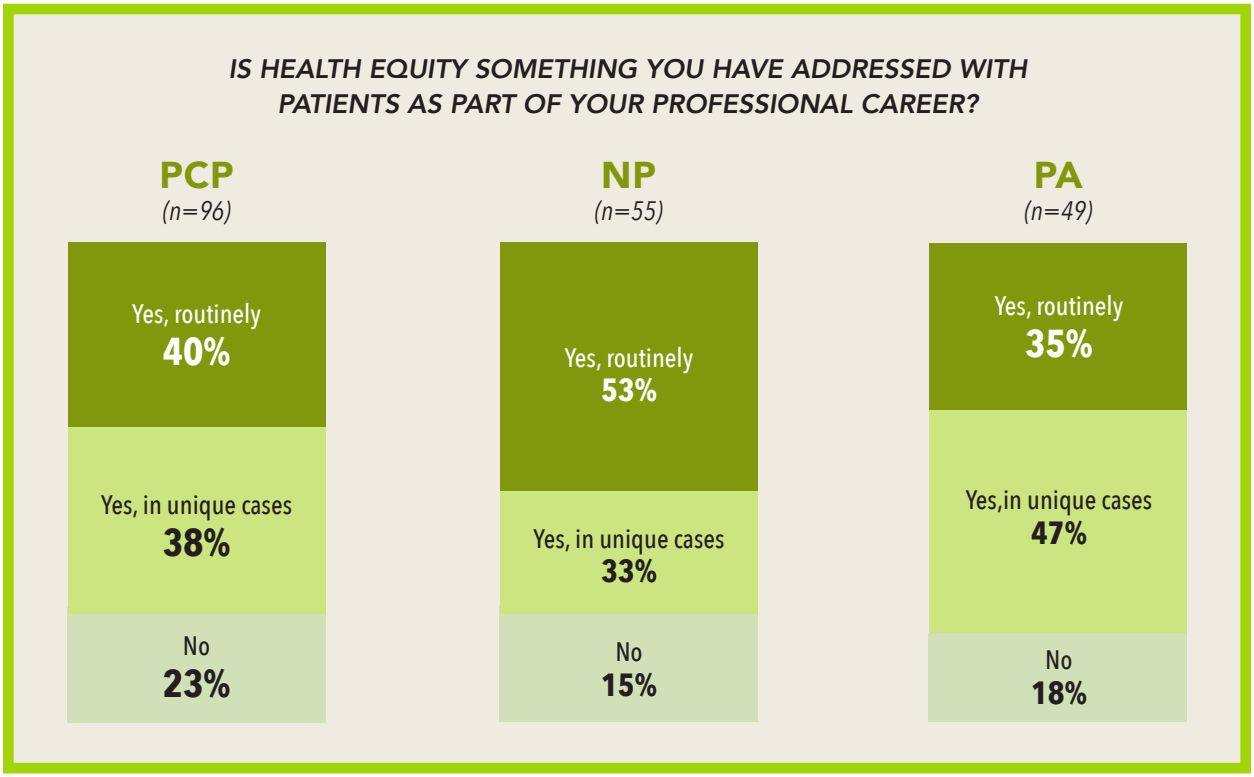
PLEASE SELECT HOW MUCH YOU AGREE OR DISAGREE WITH EACH OF THESE STATEMENTS

1.0	1.5	2.0	2.5	3.0	3.5	4.0
Nonclinical social or economic factors impact health outcomes.	There needs to be more focus on educating health care providers on their role in addressing health disparities and how to most effectively integrate that role in their current practice. As part of the social contract between society and health care professionals, attempting to understand the nonclinical factors influencing health should be part of a primary care provider's role.	Right now, the concept of addressing Health Equity is too nebulously defined to be within the scope of primary care providers.	Today's primary care providers do not have the competencies to be held accountable for addressing health disparities.	Social factors influencing health are too complex and multi-faceted to be within the scope of care offered by primary care providers.	Social factors influence health outcomes only in extreme cases of poverty.	Research has *NOT* shown a strong correlation between social disparities and health outcomes.

SCALE OF 1-4 WHERE 4 IS STRONGLY AGREE AND 1 IS STRONGLY DISAGREE

KEY FINDINGS

Non-clinical factors impact health outcomes— more education needed. All primary care providers are likely to agree that nonclinical factors impact health outcomes. They also tend to agree that there needs to be greater focus on educating health care providers on their role in addressing health disparities and how to most effectively integrate that role in their current practice.



More than half of those responding to the survey believe that 50 percent or more of their patients experience non-clinical social and economic hardships. Nurse practitioners and physician assistants indicated the highest level of belief (64 percent and 63 percent respectively), with primary care physicians having the lowest level of belief (46 percent).

HAVING THE CONVERSATION

Nurse practitioners were the most likely to ask questions during an office visit to determine if non-clinical social or economic hardships exist; physician assistants were the least likely to ask these questions. Primary care physicians were the most likely to base their determination on observations during the office visits (rather than direct questioning). Of the practice models, providers in health care systems were more likely to ask questions regarding non-clinical social or economic hardships; providers in private practice or self-employed tend to be less likely to ask these questions.

Forty-two percent of providers routinely discuss health equity with patients, with nurse practitioners being the most likely to routinely discuss these issues and physician assistants being the least likely. Twenty percent of providers said they do not discuss health equity at all. That stated, 93 percent of providers either strongly or slightly agree that patients should be asked questions related to non-clinical factors that may be impacting their health. Seventy-three percent strongly or slightly agree that health equity screenings should be required; nurse practitioners are more committed to this belief. Forty-five percent of providers felt that it would be intrusive to ask questions about non-clinical economic and social factors related to health equity; with physician assistants being the most likely to consider it to be intrusive and nurse practitioners the least likely to feel it is intrusive.

BARRIERS AND MOTIVATION TO ADDRESSING HEALTH EQUITY AND SOCIAL DETERMINANTS IN THE OFFICE PRACTICE

Limited time and resources, and lack of integration between clinical and community resources were key challenges to primary care providers engaging in health equity discussions with patients. Access to clear clinical pathways with the electronic health record to ensure patients receive appropriate support to address health inequities, additional resources for administrative follow-up, and national payment reform are all key motivators for providers in addressing issues related to health equity.

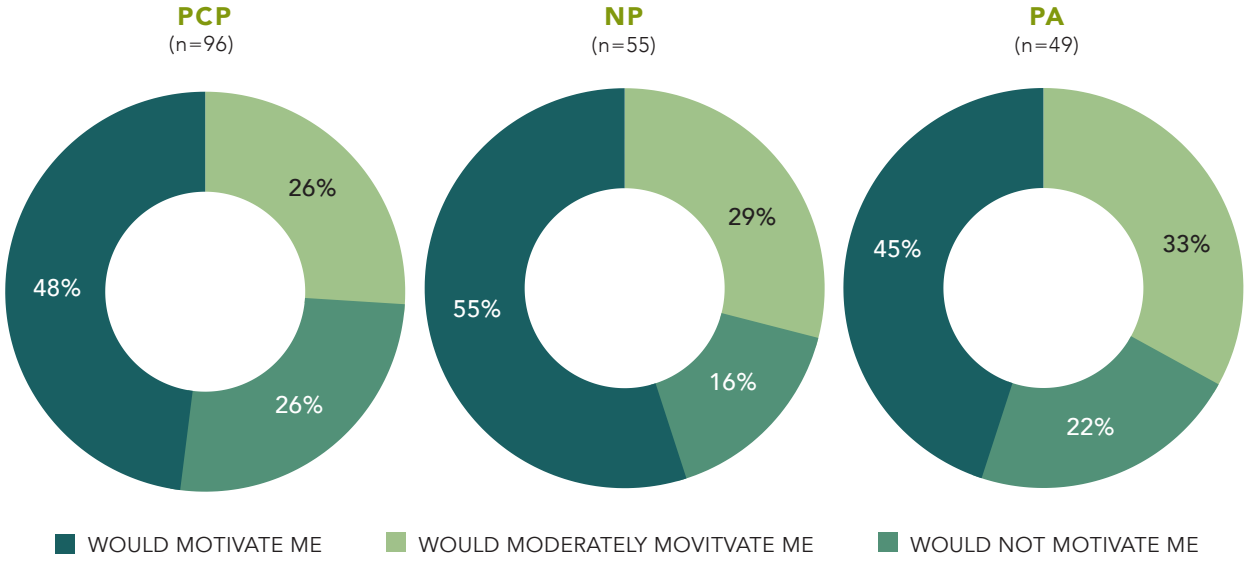
ARE ANY OF THE FOLLOWING FACTORS BARRIERS TO YOUR WANTING TO BE MORE INVOLVED IN ADDRESSING NONCLINICAL SOCIAL AND ECONOMIC FACTORS INFLUENCING HEALTH OUTCOMES?

PCP (n=96)	NP (n=55)	PA (n=49)	
71%	69%	76%	Not enough time during an office visit
63%	69%	65%	Limited resources to provide help effectively
69% ✓	58%	51% ✓	Community resources are not integrated with clinical resources to provide help effectively
43% ✓	24% ✓	27%	No financial incentive exists to engage in this effort
33%	31%	22%	I don't have the appropriate training or competencies to ask or respond to answers correctly
33% ✓	31%	22%	I need to focus on my clinical practice
21% ✓	4% ✓	18% ✓	It's not my job; patients see me for clinical purposes
12% ✓	2% ✓	6%	No proof exists that my involvement will make a difference
4%	6%	4%	None of the above

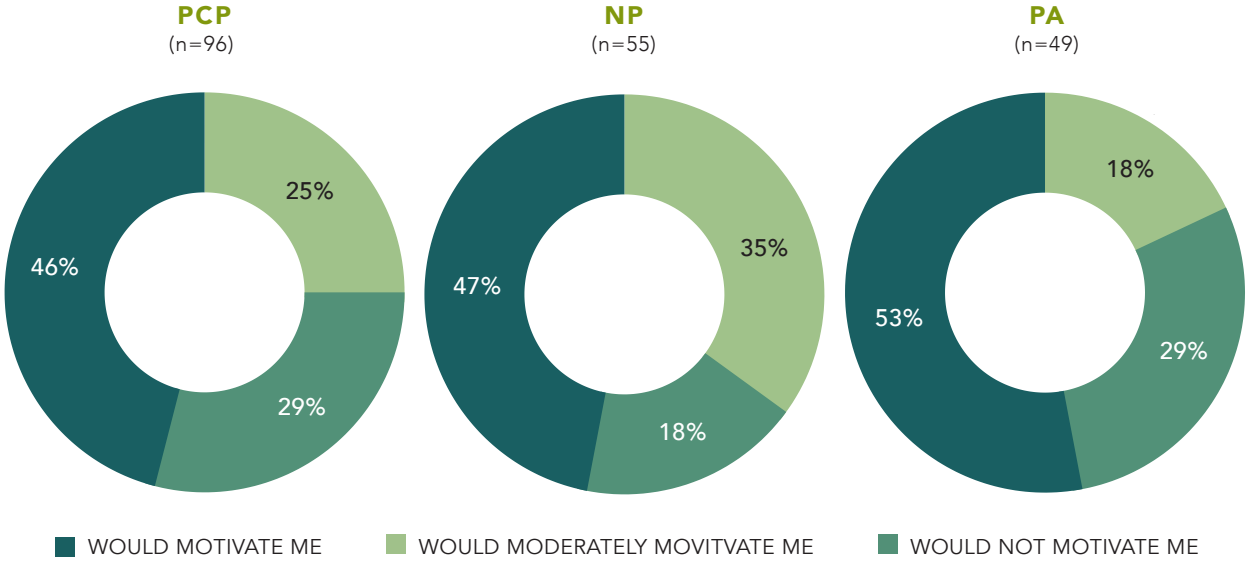
Private Practice (n=52)	Physician-Owned Medical Group (n=48)	Health Care System (n=46)	Hospital (n=25)	Self-Employed (n=25)	
62% ✓	73%	80% ✓	68%	72%	Not enough time during an office visit
62%	73%	67%	60%	52%	Limited resources to provide help effectively
54% ✓	63%	78% ✓	36%	64%	Community resources are not integrated with clinical resources to provide help effectively
29%	33%	37%	32%	40%	No financial incentive exists to engage in this effort
29%	33%	24%	28%	32%	I don't have the appropriate training or competencies to ask or respond to answers correctly
27%	17%	26%	24%	36%	I need to focus on my clinical practice
15%	13%	13%	16%	28%	It's not my job; patients see me for clinical purposes
4%	4%	11%	4%	20%	No proof exists that my involvement will make a difference
8%	6%	2%	4%	0%	None of the above

✓ Statistical differences between health care professionals at the 95% confidence level

HOW STRONGLY WOULD THE FOLLOWING MOTIVATE YOU TO ASK (OR CONTINUE ASKING) QUESTIONS ABOUT HEALTH INEQUITIES.
ACCESS TO CLEAR CLINICAL PATHWAYS WITH THE ELECTRONIC HEALTH RECORD TO FOLLOW TO ENSURE PATIENTS RECEIVE APPROPRIATE HELP.

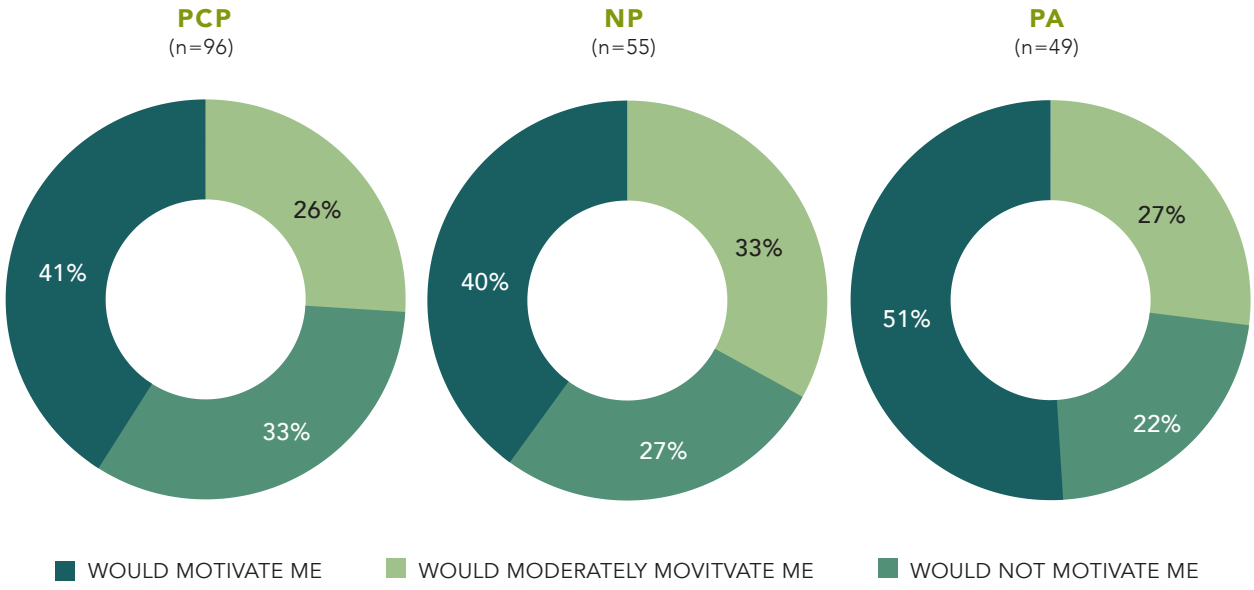


HOW STRONGLY WOULD THE FOLLOWING MOTIVATE YOU TO ASK (OR CONTINUE ASKING) QUESTIONS ABOUT HEALTH INEQUITIES.
ACCESS TO ADDITIONAL RESOURCES THAT WOULD BE REQUIRED FOR APPROPRIATE ADMINISTRATIVE FOLLOW-UP.



HOW STRONGLY WOULD THE FOLLOWING MOTIVATE YOU TO ASK (OR CONTINUE ASKING) QUESTIONS ABOUT HEALTH INEQUITIES.

NATIONAL PAYMENT REFORM RELATED TO CAR PROVIDED IN ASSOCIATION WITH HEALTH EQUITY.



DID YOU RECEIVE TRAINING IN HOW TO ADDRESS HEALTH EQUITY DURING YOUR FORMAL MEDICAL/CLINICAL EDUCATION?

HEALTH CARE PROFESSIONALS				YEARS OF PRACTICING			
PCP (n=96)	**NP** (n=55)	**PA** (n=49)		**<10** (n=41)	**11-15** (n=40)	**16-20** (n=53)	**20+** (n=65)
15%	6%	14%	YES	24% ✓	5% ✓	9%	11%
20% ✓	38% ✓	14% ✓	YES, BUT WE DIDN'T CALL IT HEALTH EQUITY	26%	28%	15%	26%
25%	33%	33%	YES, BUT VERY MINIMAL TRAINING	26%	38%	26% ✓	28%
41% ✓	24% ✓	39%	NO	24% ✓	30%	49% ✓	49%

✓ Statistical differences between health care professionals at the 95% confidence level

TRAINING

Training in social determinants was also assessed. Nurse practitioners were more likely to have received training in how to address health equity and social determinants of health, although those terms may not have been used for the training; primary care physicians and physician assistants were the least likely to have received training. Younger practitioners were more likely to have received some level of training.

WHO IS RESPONSIBLE?

When asked which organizations were responsible for health equity in the community, in a multiple response question, 50 percent of primary care providers say they believe it is the responsibility of public health departments; 46 percent policy makers; 34 percent community-based organizations and health insurers; 24 percent hospitals and health systems and primary care providers; 31 percent felt it is the responsibility of all of the above.

WHICH ORGANIZATIONS DO YOU FEEL SHOULD BE RESPONSIBLE FOR HEALTH EQUITY IN YOUR COMMUNITY?

HEALTH CARE PROFESSIONALS				EMPLOYMENT				
PCP (n=96)	**NP** (n=55)	**PA** (n=49)		Private Practice (n=52)	Physician-Owned Medical Group (n=48)	Health Care System (n=46)	Hospital (n=25)	Self-Employed (n=25)
53%	44%	53%	PUBLIC HEALTH DEPT.	52%	58%	54%	36%	44%
49%	47%	41%	LOCAL, STATE, FEDERAL POLICY MAKERS	46%	60%	37%	44%	44%
38%	40%	25%	DIRECT SERVICE COMMUNITY-BASED ORGS.	25%	52%	35%	32%	28%
37%	31%	35%	HEALTH INSURERS	37%	42%	28%	16%	48%
23%	36% ✓	14% ✓	HOSPITAL/ HEALTH CARE SYSTEMS	25%	25%	33%	20%	16%
24%	29%	18%	PRIMARY CARE PROVIDERS	23%	29%	28%	16%	20%
24%	36%	33%	ALL OF THE ABOVE	29%	27%	33%	36%	16%
1%	0%	0%	NONE OF THE ABOVE	0%	0%	2%	0%	0%

✓ Statistical differences between health care professionals at the 95% confidence level

IMPLICATIONS AND CONCLUSIONS

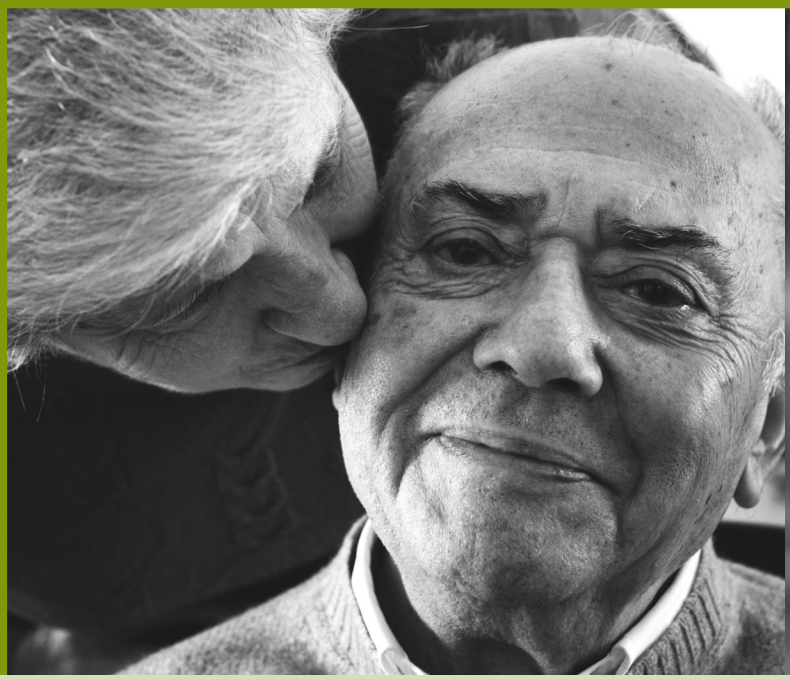
Primary care providers agree that there is a need to address health disparities, but they feel it will require increased access to resources and more effective integration of clinical and community resources for the primary care provider to feel their involvement will be productive. Access to clinical pathways in the electronic health record was an important motivator.

There must be increased effort in educating and training providers about health equity and the role health care providers play in addressing these issues— and how to effectively integrate that role into their current practice. This is particularly true of primary care physicians and physician assistants.

Primary care providers are more divided on who/which organizations should take ownership of health equity in their community. They are more likely to think it is the responsibility of institutions/organizations traditionally responsible for health disparities (e.g., public health departments, government, social services), and less likely to think it is the responsibility of health care professionals (e.g., health care providers, hospitals, health systems).

COMMENTS ABOUT IMPLICATIONS/CONCLUSIONS CONSISTENT WITH ORAL INTERVIEWS CONDUCTED FOR THIS STATUS OF HEALTH EQUITY REPORT

Independent of this online survey, the above implications and conclusions were validated by members of The Root Cause Coalition who were interviewed for this Status of Health Equity Report, particularly: the need to enhance resources and create effective integration between clinical and non-clinical community services in order to enhance health outcomes and to help ensure payment for services provided; and the need to enhance the curriculum for primary care physicians, nurse practitioners and physicians assistants in helping them understand their role in addressing health equity through the social determinants of health and how to implement interventions to enhance health outcomes. In addition, a need was identified to help all health care providers in increasing cultural competency in addressing health disparities.



CHAPTER 2

ACTIONABLE STRATEGY #1

ACTIONABLE STRATEGY #1

Scale innovative solutions to drive a new and sustainable model of care that improves health outcomes as it ensures health equity.

Based on the provider survey conducted by The Root Cause Coalition and in interviews with its member organizations, there are common critical areas of concern related to our current health care system in addressing health equity through the social determinants of health.

- The U.S. healthcare system is an overly complex, fragmented system of care without clear and consistent pathways for clinical and non-clinical providers to connect in meaningful and sustainable ways.

- The most fundamental fissures in the American health care system are rooted in health inequities driven by socioeconomic factors that have tremendous and deep-seated influence on individual and community health outcomes.

- To truly make an impact in addressing these social factors that influence health and well-being, we must create a local, regional and national infrastructure that is more effective in connecting clinical and non-clinical services.

- In addition, the infrastructure must include processes for non-clinical services to demonstrate value for services provided to ensure payment by payors for services rendered.

- Metrics and measurements addressing health inequities through the social determinants of health must continue to evolve to more effectively track and evaluate outcomes addressing health equity and social determinants of health across sectors.

The first actionable strategy identified in this Status of Health Equity report focuses on ways members of The Root Cause Coalition are scaling innovative solutions to drive a new and sustainable model of care that improves health outcomes as it ensures health equity.

Members of The Root Cause Coalition are working on a national level to address these issues with policy makers. For example, the Coalition's partners **ProMedica**, **OSF Healthcare** and **Methodist Health Care**, along with other prominent health systems across the country, are working with congressional leadership and have proposed the establishment of a National Commission to create a new health care delivery model. The commission would be comprised of a broad cross-section of professionals from health care, business, social services, and federal government to help establish a national model that will improve health care outcomes, reduce spending growth and improve spending efficiency. Among numerous priorities, the new delivery model would address health inequities through the social determinants of health such as housing, nutrition, social isolation, and transportation, as well as create new incentives for value across the entire healthcare continuum.

In addition, as part of the discussion about the first actionable strategy, this section examines how members of the Coalition are transforming, and creating transformational change in their communities, creating greater and more efficient connections between clinical and non-clinical services, embedding social determinants into organizational process to ensure reimbursement for non-clinical services, scaling innovative programs from local to national environments, and working to create uniform metrics in evaluating effective solutions in addressing health disparities created by the social determinants of health.

ACHIEVING ACTIONABLE STRATEGY #1 THROUGH:

CONNECTING CLINICAL AND COMMUNITY NON-CLINICAL SERVICES THROUGH TECHNOLOGY TO ADDRESS HEALTH OUTCOMES RELATED TO SOCIETAL FACTORS INFLUENCING HEALTH AND WELL-BEING.

The provider survey conducted by The Root Cause Coalition (see previous section) clearly pointed out that while there is a clear need to address health disparities through the socioeconomic factors that influence health and well-being, the infrastructure does not exist across the country to effectively connect resources and integrate clinical with non-clinical services. Members of the Coalition validated these survey results, and a number of organizations across the country are working diligently to create those connections.

As the largest private employer in New Mexico, **Presbyterian Healthcare Services** has a deep commitment to ensuring that everyone in the state has the opportunity to be healthy and live in a thriving community. That means focusing on health equity and the social determinants of health.

"At Presbyterian Healthcare Services, we view things from an equity lens— who is receiving the benefit and who is experiencing the burden," says Leigh Caswell, Vice President for Community Health at Presbyterian Healthcare Services.

With that in mind, Presbyterian reviewed data and facilitated community conversations across the state. As a result of these community discussions, Presbyterian prioritized key determinants of health and specific interventions that could impact health outcomes.

"We are working to build a closed-loop referral process so that community health workers and community resource providers will be connected throughout the care process."

–Leigh Caswell, PRESBYTERIAN HEALTHCARE SERVICES

In alignment with these community priorities, Presbyterian applied for and received Centers for Medicare & Medicaid Innovation (CMMI) funding in May of 2017 for an Accountable Health Communities (AHC) program, an initiative through which health care providers screen for health-related social needs and connect patients to resources. The AHC is being implemented more than 10 sites as of September 2019. As part of the effort, Presbyterian and partners have hired community health workers that focus on assessing patients' unmet social needs and linking them to appropriate resources. Says Caswell, "We are focusing on areas including food, housing, transportation, utility assistance, and personal safety. There will be access to data on key social determinants across all sites. By doing this, we can support patients and invest in resources, backed by data."

Presbyterian has contracted with NowPow to implement this project. NowPow's platform supports the referral process by building and managing community resource networks. Research indicates that these types of platforms demonstrate a significant increase in providers' ability to meet patients' unmet social needs; a reduction in Medicare inpatient stays; a reduction in Medicare unplanned readmissions; and a decrease in Medicaid emergency department (ED) visits.

"We are working to build a closed-loop referral process so that community health workers and community resource providers will be connected throughout the care process," says Caswell. "We are looking to achieve a true clinical community partnership."

Caswell believes that as a country, we are on a great trajectory relative to health equity and social determinants but that we also have a long way to go. "People are making space to have the conversation now," she says. "Addressing health equity and social determinants are critical to our mission of improving the health of our community. We are working to ensure addressing these issues are more integrated throughout our system and how we do health care, and continue to be stronger in our rural communities."

As hospitals, health care systems and payors increasingly address social determinants of health with health care delivery, one of the most significant challenges has been to connect patients and insurers to the programs that address the social barriers and prevent chronic disease – and to create a platform for reimbursement to occur for services provided.

Solera Health is working to make this a reality. Arizona-based Solera Health is an integrated service network that connects patients, payors and physicians with community organizations and digital providers. Solera helps consolidate highly fragmented programs and services into one integrated network, enabling health plans and medical providers to increase consumer participation while lowering associated costs. The company currently has more than 60 million lives under contract.

Solera's technology platform enables community-based organizations, which traditionally rely largely on grants to fund their services, to be paid through medical claims, like any other provider of healthcare services. That is a game changer for these organizations and for addressing the social determinants of health, according to Brenda Schmidt, Chief Executive Officer and founder of Solera Health.

Solera is a tech program supported by a curated network that then acts like a clearinghouse to connect people to services that are then reimbursable. Understanding the needs of providers, hospitals, health systems and payors was critical to making connections that made sense.

Says Schmidt, "There are some things we know about providers. They tend to be hyperlocal and need multi-local services that can help people. Also, in the past, providers were perhaps reluctant to refer people to the ecosystem of services because of a perceived lack of connections—and they didn't see a mechanism for payment for the referral. We heard from physicians that we need to work the connections into their workflow. Essentially, to develop an e-prescription for collecting service referrals."

"What we needed was to align a structure with a payment system where a visit was recorded and was verifiable (certified) for a claim. Health plans can't pay for services that aren't appropriately credentialed. Through Solera that credentialing and auditing service is provided."

Solera is helping redefine how payors are thinking about payment for these services. Solera can bridge the gap to get these services into the ecosystem. It is a wholistic approach – not capitated or affiliated with a singular condition. Solera provides a suite of nonclinical conditions compliant with health, and is creating an infrastructure and aligning payment around structures.

"We are only paid for successfully enrolling people and achieving impact – so we have considerable accountability on our side," says Schmidt.

"What we needed was to align a structure with a payment system where a visit was recorded and was verifiable (certified) for a claim. Health plans can't pay for services that aren't appropriately credentialed."

–Brenda Schmidt, SOLERA HEALTH

Concerns about gaps in the ability of health care providers to efficiently share information, including the social determinants of health, resulted in the **John Muir Community Health Fund (CHF)** awarding a grant to the Contra Costa & Solano Community Clinic Consortium in California to enhance data sharing capacity among local community health centers and hospitals. The community health centers and hospitals are part of Contra Costa CARES – a partnership with Contra Costa County to provide primary care medical home services to low-income, uninsured and undocumented adults.

"We are also supporting The Consortium and La Clínica de La Raza, a federally qualified health center, to integrate PRAPARE (Protocol for Responding to and Assessing Patients' Assets) – a standardized patient risk assessment tool for addressing the social determinants of health – into its electronic health system," says Lillian Roselin, Executive Director at John Muir Community Health Fund. "Housing is the biggest issue, followed by food insecurity and workforce development. Using this screening tool enables community health centers to more effectively refer patients to community resources."

The screening tool empowers all of La Clínica's Contra Costa clinics to collect and analyze data, with the pilot covering a subset of 500 patients. Consortium staff members conduct data analyses and report back to La Clínica with recommendations aimed at helping identify needed outside support services and informing intervention strategies and partnerships that will address patients' non-clinical needs and help them achieve and maintain good health. The Consortium convenes a quarterly learning collaborative to identify gaps and unmet needs, as well as opportunities for collaboration between community health centers and non-clinical service providers.

"Housing is the biggest issue, followed by food insecurity and workforce development. Using this screening tool enables community health centers to more effectively refer patients to community resources."

–Lillian Roselin, JOHN MUIR COMMUNITY HEALTH FUND

Using applied medical research, the **Gary and Mary West Health Institute** is advancing innovation and lowering costs in senior health. One such initiative is an interdisciplinary project in collaboration with the University of California, Irvine. "It's a community-based social needs study that's connected to a clinical team," says Brenda Schmitthenner, Senior Director of Successful Aging at the West Health Institute. "They screen for social determinants, and if appropriate, older adults are connected with a care navigator who refers patients to the appropriate community and social services."

As part of this project, some community-based organizations are connected to a single platform with health care providers who are able to track the referral and reference the same plan of care. It's a multidirectional community platform managed by a care navigator.

"Oftentimes, health care providers think their job is done once the referral is made. That is not so," says Schmitthenner. "The key is to create a platform that establishes connections between the practice, the patient, and the community resources."

West Health is also collaborating with Meals on Wheels America in utilizing a technology-based care coordination protocol to enhance home-delivered meal services and improve the health, safety and well-being of homebound meal delivery clients.

In March 2018, the West Health Institute, Meals on Wheels America and a research group in the Brown University Center for Gerontology and Healthcare Research completed a two-year research program to evaluate the use of a technology-supported change of condition monitoring tool to enhance meal delivery practices, as well as a care coordination protocol to improve the health, safety and well-being of vulnerable, homebound Meals on Wheels clients.

This protocol was initially tested with two regional Meals on Wheels programs, where it demonstrated the ability to engage staff and volunteer drivers in using an application on a mobile device to report concerns relating to any changes of condition they identified in senior clients during a meal delivery, at which point care navigation support was provided by designated care coordinators.

"By researching how we can coordinate and extend the ability of the drivers to monitor the health and well-being of clients, we hope to identify new ways to improve the lives of seniors through the people that may be one of their only connections to the outside world," says Schmitthenner.

Based on the initial study, a second research study was initiated in June 2018 to further test, improve and scale the client change of condition monitoring application and care coordination protocol across a wider group of Meals on Wheels programs nationwide.*

ACHIEVING ACTIONABLE STRATEGY #1 THROUGH:

EMBEDDING SOCIAL DETERMINANTS OF HEALTH INTO ORGANIZATIONAL PROCESSES TO ENSURE REIMBURSEMENT FOR NON-CLINICAL SERVICES.

One key imperative members of The Root Cause Coalition focus on to address social determinants of health is that the payment model must shift, including ensuring reimbursement for non-clinical services. Health plans are working to embed social determinants of health in their programming, and other members are working to develop evidence-based programs that demonstrate value and ensure reimbursement for services provided. For **Blue Cross and Blue Shield of Kansas City (Blue KC)**, the organizational journey to addressing the social determinants of health had its beginning in 2009, when the health insurer began to implement its value-based care strategy in primary care.

"The value-based conversation must consider the root causes of poor health, being the social determinants of health, which drive 80 percent of health outcomes," says Qiana Thomason, Vice President of Community Health at Blue Cross and Blue Shield of Kansas City. "Blue KC has a deep commitment to value-based care and the health of our community. Accordingly, over the last couple of years our conversation has evolved. Last year, the organization decided to embed the social determinants and health equity in our corporate strategy. That decision was made to enable the organization to offer new value to members and our community."

There are five main areas the social determinants are being integrated into corporate business planning: benefits and programs, care integration, data and insights, advocacy, and corporate philanthropy.

"2019 has been a foundational year as we begin to apply a social determinants of health lens to our strategy. With this comes the cultivation of new partnerships in the community and having new conversations internally within those strategic areas."

Blue KC is in the early stages of integrating social determinants into core business. Says Thomason, "We are evaluating care integration opportunities with our value-based primary care partners and positioning our incentive models and technology to help physicians and care teams address social needs at the point of care. Many of our clinical partners are already screening for social needs, however they lack the tools and resources to connect patients to get these needs addressed. We've partnered with Healthify, a services and technology company that offers a non-clinical care coordination platform for providers, to connect patients to social services in the community."

"The value-based conversation must consider the root causes of poor health, being the social determinants of health, which drive 80 percent of health outcomes."

–Qiana Thomason, BLUE CROSS BLUE SHIELD OF KANSAS CITY

"Once our platform is implemented, we will have better insights to inform our strategy and investments. The goal is to see long-term total cost of care reductions and improved health. All the evidence suggests there's a return on investment in addressing socioeconomic and environmental issues and we want to demonstrate that in Kansas City."

SOURCE: WESTHEALTH.ORG/PRESS-RELEASE/MEALS-ON-WHEELS-DRIVERS-EFFECTIVE-AS-EARLY-WARNING-SYSTEM-FOR-HEALTH-AND-SAFETY-ISSUES-OF-HOMEBOUND-SENIORS

According to Thomason, health providers and payors cannot truly address health inequities and social determinants of health long-term unless there is a shift in payment models and alignment among public and private payors.

"Many payors are accelerating value-based care, that allows us to focus on social determinants," says Thomason. "But downstream payment models must change to support social needs to get the outcomes we need nationally."

This shift is also necessary in our paradigms, not just payment. That means community-based organizations (CBOs) need to be a part of the health care ecosystem. Says Thomason, "Currently, many CBOs are paid by city and county funds, grants and philanthropy. However, they offer services that are valuable and can be monetized. What we need to understand is how do we collectively demonstrate value so that we might reimburse for their services."

Ceres Community Project is a community-based organization which provides 100 percent organic medically-tailored meals for no charge primarily to people living at or below 200 percent of the Federal Poverty Level and who are struggling with cancer, heart disease and other chronic diseases.

Ceres has prepared and delivered nearly 800,000 meals to more than 4,000 households since 2007. Each weekly delivery of ready-to-eat meals includes four entrees— poultry, fish and vegetarian— per person along with side dishes and pints of soup, salad and dessert. All of the ingredients are organic and 70 percent of it is produced locally.

All meals are made by teens as part of a commitment to community food system education and leadership development. The Ceres Community Project is now being implemented in more than a dozen communities across the United States and Denmark.

Young adults volunteer as chefs and gardeners at the organization's three commercial kitchen sites and two production food gardens (1/3 acre and 3/4 acre). During the process, they learn to grow food and cook healthy meals from scratch, as well as skills for success at work and in life. More than 450 young adults are engaged each year along with another 600 adult volunteers.

As the Ceres Community Project has expanded, the need for engagement into policy and advocacy became clear. With that in mind, Ceres, along with five other organizations in California, was successful in having the state legislature commit $6 million over three years in a pilot to evaluate the benefits of a nutrition intervention of Medi-Cal patients (about one-third of California's population) with congestive heart failure. At least 1,000 patients will receive 21 medically-tailored meals a week for 12 weeks along with three to four visits with a registered dietitian nutritionist. The analysis in the Medi-Cal claims database will compare outcomes and health care utilizations for patients served compared 4,000 patients who don't get the same intervention.

"Through this pilot we hope to study the impact the food and nutrition education intervention has on the health and health care utilization for people with congestive heart failure," shared Cathryn Couch, Chief Executive Officer and Founder of the Ceres Community Project. "By demonstrating the impact and potential cost savings, we are building an evidence-based process that can lead to policy change."

In conversations with legislators and other decision-makers, Ceres and their partners in the California Food is Medicine Coalition framed this program in terms of the potential to reduce the cost of care and save the state money. "This allowed us to make the case for a high quality intervention that included case management support and an educational component. Based on existing research data, we showed the potential cost savings of the intervention if we could reduce the annual cost of care for these patients by about 20 percent - an amount that is supported by other research studies."

The estimate – based on serving a range of patient populations, showed that the state could save nearly $12 million against an investment of $6 million as a result of reduced trips to hospital emergency rooms, shorter hospital stays and fewer hospital readmissions, among other factors.

"Our hope is that this state-wide medical nutrition pilot will help drive policy change so that this intervention becomes a standard reimbursable benefit in California," says Couch.

In addition to the Medi-Cal research project, Ceres Community Project is completing a separate, smaller research project with Kaiser Permanente in Santa Rosa providing a similar intervention to members with congestive heart failure at discharge.

"Through this pilot we hope to study the impact the food and nutrition education intervention has on the health and health care utilization for people with congestive heart failure by demonstrating the impact and potential cost savings, we are building an evidence-based process that can lead to policy change."

–Cathryn Couch, CERES COMMUNITY PROJECT

ACHIEVING ACTIONABLE STRATEGY #1 THROUGH:

SCALING INNOVATIVE PROGRAMS FROM LOCAL TO NATIONAL ENVIRONMENTS.

Many organizations are working to achieve better health outcomes by addressing the social determinants of health. A number of the organizations we talked to are extending their efforts state-wide, regionally and nationally.

As the **Solera Health** platform has shown success locally and regionally in connecting highly fragmented programs and services into one integrated network, allowing health plans and medical providers to increase consumer participation while lowering associated costs, the next step has been to scale the platform to a national audience.

In May, 2019, Solera Health received a new round of funding for $42 million from Blue Cross and Blue Shield plans and the venture capital arm of Health Care Services Corporation (HCSC) to continue to expand its platform across the country. The Blue Cross and Blue Shield plans represented in this deal cover about 30 million people in New Jersey, Alabama, Kansas City, South Carolina and California; HCSC represents more than 16 million members in Illinois, Montana, New Mexico, Oklahoma and Texas.

Solera now has the capacity to scale beyond its model for chronic disease prevention and management to address behavioral health and the social determinants of health including food insecurity, medically tailored meals, transportation, fall prevention and social isolation.

To further expand the reach and impact of its network, the company recently entered into a strategic partnership with Blue Cross Blue Shield Institute to launch a nationwide program to tackle social determinants of health at the community level.

"Solera and the BCBS Institute expect an impact for all Americans by creating the ability for health plans to pay for healthcare-related social services delivered by community benefit organizations as an important part of value-based care," says Brenda Schmidt, Chief Executive Officer of Solera Health.

Research has demonstrated how effective 'food is medicine' interventions can be in improving health outcomes as well as reducing health costs. According to research published in *JAMA-Internal Medicine* and *Health Affairs*, patients receiving home-delivered, medically-tailored meals had a 16 percent reduction in monthly health care expenditures.

With this in mind, the **Center for Health Law and Policy Innovation of Harvard Law School** in partnership with **Community Servings** worked with 35 organizations state-wide to launch the Massachusetts Food is Medicine State Plan. The goal of the initiative is to assess the need for— and access to— food is medicine interventions across Massachusetts. Based on the assessment, concrete strategies have been developed and implemented to increase the availability of food is medicine interventions in the state.

A key component in developing the Massachusetts Food is Medicine plan was active stakeholder engagement in the data-gathering process, which included broad dissemination of surveys, listening sessions across the entire state, and in-depth community member interviews with representation from health care payors, providers and clinicians, community-clinic collaborative programs, and community-based organizations (CBOs).

"We wanted to understand how patients are connected to services, what range of services are provided, how are they funded, and where programming specifically occurs," says Sarah Downer, Associate Director of Whole Person Care at the Center for Health Law and Policy Innovation of Harvard Law School.

"We worked with CBOs, food pantries, health care payors and providers, case managers, behavioral health professionals, the government, researchers and funders to establish a Food is Medicine coalition, and made a series of policy recommendations," says Jean Terranova, Director of Food and Health Policy at Community Servings.

"We wanted to understand how patients are connected to services, what range of services are provided, how are they funded, and where programming specifically occurs."

–Sarah Downer, CENTER FOR HEALTH LAW AND POLICY INNOVATION OF HARVARD LAW SCHOOL

SOME KEY THEMES FROM THE LISTENING SESSIONS INCLUDED:

- Health care providers: want and need more information about nutrition and health to best serve patients; want to connect patients to resources, but have time constraints; do not know what resources are available; and identified that food insecurity screening is not widespread, standardized or tracked.
- Community-based organizations and health care providers/payors: want to work together, but it can be difficult to align priorities; and identified a need for bidirectional, secure referral platforms.
- Community-based organizations: feel that at current funding levels, they will be hard-pressed to change their practices or serve many more clients; and felt there is a need for capacity building.

After evaluating the data, policy recommendations and a written plan were submitted to state legislators at an event at the Massachusetts State House in June 2019, which launched the plan's implementation. Part of the plan will require engagement by health care professionals as well as statewide screening for patients adding resources to scale.

The implementation of the plan will leverage and build on the expertise of individuals and organizations involved in three newly-established task forces, focusing on:

- Provider nutrition education and referral to high quality community-based nutrition resources.
- Standard-setting and capacity building alignment among Food is Medicine Community-Based Organizations.
- Research on the need for and efficacy of food is medicine interventions.

"The data has led us to work on operationalizing food is medicine interventions, so they are equally available to all individuals in the Commonwealth, regardless of where they reside," says Terranova.

ACHIEVING ACTIONABLE STRATEGY #1 THROUGH:

EVOLVING AND EXPANDING THE ROLE AND IMPACT OF FUNDING ORGANIZATIONS.

Funding organizations are the life blood for many non-profit organizations and researchers working to address health disparities and the social factors influencing individual and community health. Many members of The Root Cause Coalition are all continually evolving, some narrowing the projects they invest in, some growing their funding organization and others providing seed money for greater funding opportunities down the road, but all with the same goal – having greater impact in the communities in which they invest and serve.

The **Humana Foundation**, the philanthropic arm of Humana, Inc. recently made a fundamental change in how it invested in community projects: transitioning from issuing multiple grants to focusing on fewer, larger grants.

"We wanted to look at how the Humana Foundation operates in a larger, broader context of health equity, with a goal to impact people's lives in multiple communities nationally," says Brandy Kelly Pryor, PhD, Senior Director of Programs at the Humana Foundation and leading the newly formed department of social impact and community investment practice. "We wanted to focus on major, often overlapping, issues including food security, asset security, post-secondary education, and social connectedness to advance health equity. We are trying to get to the root of the issue that impacts people's healthy outcomes— the social determinants of health equity."

As a result of this new approach, in 2018 the foundation went from awarding 67 grants to nine grants with a specific focus on eight of Humana's Bold Goal communities, including two grants each in Louisville and two in San Antonio. These projects are integrated in Humana's Bold Goal to make the communities it serves 20 percent healthier by 2020.

Projects were awarded a minimum of $500,000 per year with the possibility of up to three years of funding. Previously, the foundation's largest grant had been for $200,000. To be eligible for a grant, the project had to focus on the social determinants of health.

In addition to the grant money, Humana provided an additional $25,000 as a learning bucket for community members and staff to come to Louisville to co-create with Humana staff and identify synergies. Says Kelly Pryor, "We wanted to be intentional about providing financial support, specifically for learning and connecting. It was important to dismantle any power structure to see how we could come together to make the impact more sustainable."

Programs funded by the Humana Foundation include:

- A $560,000 grant to expanding existing programs to assess and address barriers including social isolation, food insecurity and lack of post-secondary educational attainment.
- A $770,000 grant to expand its financial literacy program, improving financial independence and providing families and residents experiencing economic distress with financial literacy coaching.
- A $1.02 million grant to address social isolation and increase social connections by engaging seniors through free access to internet-connected technology.
- A $833,000 grant to impact food insecurity and social isolation through senior wellness intervention program, assisting seniors who screen positive for food insecurity with comprehensive services that stabilize their household and address prevalent health issues.
- A $1.02 million grant to address social determinants of health and health equity barriers to improve the health and quality of life of uninsured and underserved people by providing affordable access to healthy food.
- A $620,000 grant to a cross-sector collaboration designed to transform affordable access to healthy food.
- An $820,000 grant to promote social connection and food security among minority, underserved and low-income seniors, as well as asset security and post-secondary success resources for their families.

"Major foundations have been thinking about the root causes of health for a while," says Kelly Pryor. "The focus increasingly is on providing tools so communities can lead in addressing the social determinants in their communities. It takes a multitude of things and partnerships to move the needle."

In some instances, major foundations work together to make a difference. In Baton Rouge, for example, the Humana Foundation awarded $720,000 and worked with Blue Cross Blue Shield of Louisiana Foundation to address food deserts by saturating areas with the highest rates of food insecurity and health disparities with numerous access points for purchasing fresh food at an affordable price.

"Major foundations have been thinking about the root causes of health for a while. The focus increasingly is on providing tools so communities can lead in addressing the social determinants in their communities. It takes a multitude of things and partnerships to move the needle."

–Brandy Kelly Pryor, HUMANA FOUNDATION

AARP Foundation's vision is a country free of poverty where no older person feels vulnerable. The organization began a new three-year strategic plan in 2018, with a focus on helping older adults increase their economic opportunity and social connectedness, regardless of geographic or demographic factors. In its own programs and services, the Foundation focuses on innovative, evidence-based solutions. It also explores ideas from the broader world, seeking opportunities to bring those ideas to scale. All its efforts take a whole-person approach to the improvement of health and well-being.

"There's often a misperception that older adults in America have what they need— that Social Security and Medicare will cover all of their expenses. But the truth is that more than 37 million people who are 50 or older are either already in poverty or just one life event away from slipping into it," says Emily Allen, Senior Vice President of Programs at AARP Foundation. "So we must look at broader issues that include income security, housing security, food security and social connectedness."

"We have evolved a lot as an organization," says Allen. "We continue to evaluate what reducing senior poverty looks like. What is the collective impact/cross issue approach? We are continuing to bring the issues together to have greater impact in the lives of people."

One in five Americans 65 and older are socially isolated. Lack of accessible, affordable transportation, medical conditions and other challenges can limit social interactions, as well as the ability to get medical care or healthy food. Although there isn't a direct correlation between lower incomes and being at higher risk for social isolation, an AARP Foundation study by the University of Chicago found that income is a significant factor in whether older adults are socially connected, and in their overall happiness.

Being connected to other humans is critical to long-term health and well-being. "Human connection is a basic need. Without it, so many fundamental ingredients of a healthy life, like having access to nutritious food or the nurturing support of others, can be out of reach," says Allen.

According to Lisa Marsh Ryerson, President of AARP Foundation, as people age, the world moves from huge and broad to the size of a pinpoint. She says, "There's a growing problem facing older adults today regardless of their background, gender or economic circumstances, and this public health concern is only going to get worse in the years and decades ahead. The problem is the increase of loneliness and social isolation."

Loneliness and isolation are related but different things. Says Ryerson, "Loneliness is something we feel. It's subjective. Social isolation is related to more objective criteria, like the size of your social network. So social isolation is a major area of focus for the AARP Foundation. That focus enables us to create more direct impact and develop solutions that will also ultimately address loneliness."

According to a study published in *Perspectives on Psychological Science*, the health effects of prolonged isolation are equivalent to smoking 15 cigarettes a day. An earlier report found that subjective feelings of loneliness can increase the risk of death by anywhere from 26 percent to 45 percent.

HEALTH RISKS OF ISOLATION FOR SENIORS

SOURCE: CONNECT2AFFECT WEBSITE

AARP Foundation recognized that a first step was to raise awareness about the issue of isolation. With that in mind, the organization launched the *Connect2Affect* website. The site is part communications vehicle and part resource; it includes an easy self-assessment test that asks yes or no questions relating to relationships, mobility and major life changes to help evaluate someone's isolation risk.

AARP Foundation is also funding innovative technology to help people connect. Says Allen, "We are using voice-enabled technology with low-income seniors to help them find out what is happening in the community and connect them to resources."

In the area of income security, AARP Foundation is evaluating how it can help low-income seniors achieve greater short-term savings and how technology may help facilitate that process. Says Allen, "To do that, you have to peel away the real problem and identify the solution."

When working with partners in cross-sector relationships, a key to success is finding shared value. Says Allen, "We can't just look at partnerships from a philanthropic perspective. All parties must benefit, so that we all do well by doing good."

One of the biggest challenges among those who would offer assistance to senior populations is that older adults are not used to asking for help. "As we look at increasing enrollment in SNAP, for example," notes Allen, "we recognize that some older adults feel that getting food assistance might indicate some kind of personal failing, or they worry that they might be depriving others, such as families with young children. We work hard to dispel these misconceptions."

Getting good, quality data and measurements is an ongoing challenge but critically important to AARP Foundation. The organization invests key resources in continuing to develop measurement standards and improve data collection quality."

According to Ryerson, we all need to have a mind-shift in how we think about caring for seniors. She says, "If we only use the medical model to intervene on behalf of older seniors, we will see them as a problem to be solved rather than an asset to bolster communities. With the aging of the boomer generation, we must envision a new element in all models of care, and that element is connection. Just as we focus on preventive medicine, we need to focus on preventive connection. Connection is the catalyst to re-energize purpose-driven lives."

Since 1979, the **Local Initiatives Support Corporation (LISC)** has served as a community development intermediary bridging the gap between residents and local institutions who understand their community needs and the government, foundations and corporations which have the capital. LISC has 35 offices nationally and a rural program that reaches 44 states. It works with more than 2,000 non-profit organizations and other partners to deploy capital investments and support programs that address social determinants of health.

"The focus of LISC is on health equity achieved through investments in housing and commercial real estate, workforce development pathways, safety, social cohesion and other efforts that create opportunities for families and communities to thrive," says Julia Ryan, Vice President of Health at LISC. "In our investments we are looking to spur greater economic opportunity for people and places which is inextricably linked to health and wellness."

LISC takes various approaches to advance health through investment, according to Ryan. "The philosophy is to finance real estate projects or small businesses in ways that improve health and well-being," she says. "We are being more strategic about the financing and ways we work with borrowers – typically real estate developers and small businesses. We're asking if they might make different choices to improve health and considering how we can make that easy and beneficial for them."

One area for increased opportunities for partnerships and investment for LISC has been to work with health systems which are addressing health inequity in their communities.

"More health care organizations are looking at impact investing to achieve both social and financial returns," says Ryan. "It is powerful, but it helps to have partners in the community to guide strategy and structure. What you do depends on the community. Interventions in Toledo, Ohio, are different than interventions in Flint, Michigan."

A few of the healthcare organizations LISC works with include:

- **Dignity Health**, which joined with Morgan Stanley Foundation and Kresge Foundation to capitalize the $200 million Healthy Futures Fund managed by LISC. The Fund finances the development of Federally Qualified Health Centers in underserved areas, co-located with affordable housing grocery stores and other spaces that address social determinants of health for low-income residents.
- **ProMedica**, headquartered in Toledo, Ohio, to create a $25 million Health Impact Fund, a loan pool for development and small business projects in the northwest Ohio and southeast Michigan region to increase economic opportunity, address social determinants of health and improve the overall quality of life in these communities. The loan pool is part of a broader alliance between the two organizations to scale economic opportunities and improve health outcomes.
- Atrium Health, based in Charlotte, North Carolina, to produce more quality affordable and mixed-income housing for Charlotte families, with complementary services to support health and economic stability. The partnership between LISC and Atrium Health secured a Fannie Mae Sustainable Communities Innovation Challenge Award in May 2019.

As the largest locally-based health insurance provider in the Kansas City area, **Blue Cross and Blue Shield of Kansas City (Blue KC)** recognizes the need to address health inequities. In the Kansas City region, more than 360,000 people are food insecure, including one in six children. In Wyandotte County, the average life expectancy is 73.35 years compared to the national average of 78.80 years.

To help understand and address issues related to health outcomes in food and nutritionally insecure families, Blue KC recently announced its Transforming KC Health Research Grant, in partnership with the regional life sciences research organization, BioNexus KC.

"In the proposal, we required community-based organizations and clinical partners to collaborate, so that hospitals and universities are partnering to move the needle on social determinants of health," says Qiana Thomason, Vice President of Community Health at Blue Cross and Blue Shield of Kansas City. "We received very strong, diverse proposals with different approaches to families, neighborhoods, patients and hospitals, participants and clients, as well as expansions of existing programs."

A major change to the grant this year was to have only one larger award. This year, the award will be a two-year, $400,000 grant, where previously, the organization had given out more awards but with a maximum of $50,000. Thomason says, "We are trying to be more impactful in our investment, and really feed dollars around what communities need, health improvement and affordable healthcare."

Understanding that food is a foundation to good health, Blue KC implemented the Well Stocked program in 2018. The goal of the program is to partner with local organizations to address hunger disparity and increase access to nutritious food in underserved areas of Kansas City. For example, to increase access to nutritious food in underserved areas of Kansas City, Blue KC partnered with Cultivate KC, a local nonprofit working to provide food, farms and community in support of a sustainable and healthy local food system for all, to offer reduced-cost Lyft rides to local farmers markets.

"With programs like Well Stocked, we wanted to be more deliberate and impactful in addressing core social issues that are impacting our community," says Thomason. "With this program, we are partnering from a funding perspective and manpower perspective along with conveners in the nutritional access space, food space and distributions channels, among others. We are also focusing on food policy, working toward cross sector policy on procurement to help feed more Kansas Citians."

In 2018, the **John Muir Community Health Fund** leadership noticed that they were, unintentionally, steadily increasing grant making related to social determinants of health. At a board retreat that year, the health fund put structure around grant program guidelines to intentionally address social determinants of health.

That opened doors to funding programs related to workforce development, food insecurity and helping establish clinical community connections through the establishment of screening programming that includes social determinants of health.

"We are a strategic grant maker," says Lillian Roselin, Executive Director at the Community Health Fund. "We currently have 10 to 12 multi-year grants out. We help organizations with the planning, program launch and measurement, and help the organizations to ensure the program is sustainable."

Since its inception in 1997, the Community Health Fund has funded more than $29 million in grants for health initiatives supporting programs that improve the health of medically uninsured and underserved populations in central and east Contra Costa County.

As part of its commitment related to addressing food insecurity, the Community Health Fund focused on the affect food insecurity had on college students. A national research survey recently found that 36 percent of students at surveyed colleges and universities do not get enough to eat. In the Community Health Fund region, they found that 54 percent of Los Medanos Community College and Diablo Valley College students who participated in the national survey indicated that they had experienced some degree of food insecurity in the 30 days prior to the survey.

"This program really started as a grassroots effort at the colleges, and the administration of the schools were aware of the issue, and were helping support as they could, but there was no formal plan," says Roselin. "So we worked with our long-time food partner to discuss the issue, and made introductions between leadership at the schools to begin what could be done to help the students."

The first step was to use discretionary funds from the Community Health Fund to bring the colleges together with a business consulting group to develop a business plan to expand and sustain the existing food pantry programs.

Since that time, refrigerators have been purchased, and the physical space of the on-campus food pantries have been expanded. Meat, eggs, baby formula, and toiletries are among new products being offered. The two colleges have expanded their physical space, additional staff has been hired and the food pantries have extended their hours and outreach efforts to raise awareness of the availability of the pantries.

"We started with two colleges and are now up to six including some outside of our funding area," says Roselin. "Based on the business plan, the colleges have formed a collaborative that serves as an umbrella organization. They recently added a position of college food pantry coordinator. In addition, they established an ordering and delivery system so that all colleges can have food delivered to their respective campuses."

The food program is prepared to be sustainable, according to Roselin. "As part of the formal business, they are now working to receive grants from other funders."

The **Connecticut Mental Health Center (CHMC)** is the local community health center for the New Haven area, partnering with the state of Connecticut and Yale University. The Center provides comprehensive behavioral health services to approximately 4,000 low-income individuals annually.

The CMHC Foundation raises $100,000-200,000 a year which are directed to small investments. Says Kyle Pedersen, Director of the CMHC Foundation, "The small infusion of money can lead to other programs that are in need. Charitable philanthropic money, paired with state resources, can drive change and enable long-term commitment to health and well-being."

The connection between mental health and physical activity has been well established. With this in mind, the CMHC Foundation made an initial investment to give bikes, along with new helmets and locks to individuals in need. This initial investment was then operationalized by the center's outpatient rehabilitation department. Says Pedersen, "Over a four-month period we had given away 40 bikes. In addition, we established an on-site bike repair clinic where people could bring their bikes. We are also now working with a bicycle co-op in the area that refurbishes bikes and gives them to us to provide to people."

In addition to giving away and rehabilitating bicycles, CMHC is a strong advocate for healthy activity, working with a New Haven coalition for active transportation, and a local cycling advancement program.

Based on these efforts, CMHC has been recognized by the League of American Bicyclists as a Gold Level Bicycle Friendly Business. Says Pedersen, "This is significant because the league provides a road map on how to address social determinants of health issues via bicycling, including structure improvements and advocacy efforts necessary to be recognized."

The bike program has had benefits both clinically and operationally. Says Pedersen, "With the bike project we worked with the Yale School of Management team. We wanted to find the best way to let people know about group rides, repair clinic availability, and other activities. We learned our clients are interested in text messaging communication. We hope to continue to work with our school of management to explore the feasibility of implementing options and opportunities."

Pedersen has been working with Yale colleague Annie Harper, Ph.D., on another social determinant of health, financial health. Harper, who has a background in micro-finance and cultural anthropology, is conducting action-oriented research on poverty and mental illness.

"We don't know enough about what it means to be poor and being healthy," says Pederson, "The research has been looking at microeconomic decisions and how that impacts health. For example, how do people use check cashing and other non-bank services. We can help with counseling, but also talk to banks about what services they are offering, and how that might be changed to help those in need."

"Poverty is multi-faceted, and finances and money are part of that. Having mental illness only exacerbates the issues," says Harper. "Our research addresses two overlapping buckets. One relates generally to financial access and poverty. The second relates specifically to people who have serious mental illness, and who also tend to be poor, helping them, as far as possible, retain control over their finances, relinquishing control, if necessary, to a third-party safely and with dignity, and how to use money most effectively."

As a result of the research, Harper and her colleagues recommended three different services the banking industry could provide to help people with mental illness manage their money and finances more effectively: customizable mobile banking (text alerts); self-imposed spending limits on debit cards to limit how, when and where money can be spent; and view-only account access for a third-party to have access to an account but not have the ability to modify it.

THE CYCLE OF MONEY AND MENTAL HEALTH ISSUES

SOURCE: MOONEY AND MENTAL HEALTH POLICY INSTITUTE

"Our work also recognizes that debt is more confusing and harder to define than you might think," says Harper. "When you talk to people in poverty about debt, they are in debt in so many ways, they don't really understand what is happening. Debt is the most stressing part of poverty. Layer onto that mental illness, and the stressors increase exponentially. If you can relieve some of these stressors through these banking services, you can enhance health and well-being."

After initial funding for this project was provided by the CMHC Foundation, the project was awarded funding through the National Institute of Mental Health (NIMH), and the Steven H. Sandell Grant Program for Junior Scholars in Retirement Research.

"The initial funding on this project from the Connecticut Mental Health Center Foundation was critical," says Harper. "It was seed money that led to greater funding on an important topic where there hasn't been a lot of research previously."

In June 2019, the **Children's Hospital of Michigan Foundation, rebranded itself as the Children's Foundation** to position the foundation for future growth throughout Michigan. Previously, the foundation had been mainly focused on work in Detroit, Michigan, and surrounding areas.

"Now the foundation's resources for issues like mental health, abuse and neglect, and injury prevention will have a state-wide reach," says Larry Burns, President and Chief Executive Officer of the Children's Foundation. "By expanding our charitable efforts into Western Michigan and all across the state, we have the ability to assist and impact more children, young adults and families, and expand our vision as a children's health and well-being organization in Michigan."

Southeastern Michigan organizations, including The Children's Hospital of Michigan will remain a significant focus of continued funding. But in its latest round of funding includes the first grants it has made on the state's west side including the Western Michigan University Homer Stryker M.D. School of Medicine and the Brain Injury Association of Michigan's programs.

Since 2011, the Foundation has awarded more than $52 million to more than 65 community partners.

It will also provide an opportunity for the organization to focus on issues related to the social determinants of health and health equity. Says Burns, "Funding organizations in health care are increasingly realizing that keeping people healthy has greater impact, and so health care needs to go beyond clinical.

"Leaders in health systems are becoming more interested in the social determinants of health and we are adjusting how we fund programs as a result," says Burns. "Organizational and community leaders are beginning to understand and appreciate health equity issues and the importance of addressing these to achieve health and well-being."

For example, the foundation supports *Brilliant Detroit*, a community revitalization project dedicated to helping families with children ages from birth to eight years have a more stable neighborhood environment in high-need areas.

Neighborhoods are selected based on data indicating need and density, then meetings are held with neighbors to determine if the community desires a Brilliant Detroit home, which serves as a community center.

"Once that determination is made, a home in disrepair is purchased, and then renovated to create a community center." Says Burns, "We are helping to fund one house in support of that program."

ACHIEVING ACTIONABLE STRATEGY #1 THROUGH:

CONTINUING TO EVOLVE METRICS AND MEASUREMENT IN ORDER TO MORE EFFECTIVELY TRACK AND EVALUATE OUTCOMES ADDRESSING HEALTH EQUITY AND SOCIAL DETERMINANTS OF HEALTH ACROSS SECTORS.

Almost all members of The Root Cause Coalition interviewed for this report stressed the importance of measuring health outcomes and having uniform metrics in evaluating health equity interventions in order to demonstrate the effectiveness of those programs in order to receive payment for service provided. And while they virtually all have established methods to measure success, metrics are focused more on outputs rather than outcomes. They all recognized the challenge of measuring health outcomes because of the nuanced nature of addressing social determinants of health, and the longitudinal nature of measuring success. That stated, members are advancing the ability to effectively measure the success of addressing health equity through socioeconomic factors.

The **Hospital Quality Institute (HQI)** in California was established in 2013 to improve patient safety and quality care for Californians and to accelerate that rate of improvement. As part of its mission, HQI helps hospitals address health care disparities.

"Hospitals have a unique and critical opportunity to address these issues," says Boris Kalanj, MSW, Director of Cultural Care and Experience at Hospital Quality Institute (HQI) in California. "They very much want to contribute to greater equity in health care and health. Our primary recommendation to hospitals has been to start with the basics: get valid, reliable data on your patients' race, ethnicity, language, education and other demographics. We need to improve the collection and accuracy of the data so we can stratify quality and safety metrics."

With that in mind, HQI has partnered with hospitals and other organizations in the state to standardize the collection of patient race, ethnicity and language (REAL) data, which is essential for identifying and addressing disparities in quality of care.

HQI partnered with the Disparities Solutions Center at Massachusetts General Hospital (MGH) to produce a gap analysis of REAL data collected in California hospitals. This was done as part of the Health Services Advisory Group's Hospital Innovation Improvement Network (HSAG HIIN). Data comparison reports for the 10 hospitals in the sample revealed that the majority of hospitals reported a greater proportion of White patients, a lesser proportion of Hispanic/Latino patients, and a greater proportion of English-speaking patients compared with the census data for their core market areas. The findings suggest that hospitals may be under-capturing the proportion of patients who are not White, those who are Hispanic/Latino, and those who have limited English proficiency. This has clear implications on the hospitals' ability to conduct equity of care analyses.

Based on these gaps and the accumulated wisdom in the field, recommendations to help improve REAL data included: strengthening leadership and organizational commitment to addressing disparities; ensuring that systems support complete and accurate race, ethnicity, and language data collection; providing routine training for staff collecting the data; providing patient education on the importance of REAL data collection and proactively addressing their potential concerns; and educating staff, providers, and patients on the importance of using professional interpreters.

The Centers for Medicare and Medicaid Services' (CMS) HIIN program, in which HQI participated, has developed and promoted specific hospital-based actions related to improving health care equity. As part of this collaboration new health equity metrics were incorporated into a template for organizational self-assessment, allowing hospitals to develop nuanced understanding of their strengths and development needs in addressing disparities.

"We know that quality and patient safety, and particularly equity of care as their key ingredient, are all intricately linked to greater societal factors," says Kalanj. "The socioeconomic environments in which patients live heavily impact how patients use and receive care in our health care system. Improving the collection of REAL data and utilizing the Health Equity Organizational Assessment can give hospitals a head start in measuring and addressing health inequities."

For **Local Initiatives Support Corporation (LISC)** it is critical to understand how community development investments to produce quality housing, jobs and thriving neighborhoods impact health for people in a given community.

Julia Ryan, Vice President of Health at LISC says, "We are developing systems to assess the potential health impact of projects and programs and then assess that over time. Our team is also continually working to use evidence about social determinants of health to help partners understand how community development can produce good health." Health impacts from housing and social cohesion interventions are well understood and documented. More work is needed around economic opportunity.

Another key is to carefully manage expectations regarding a timeline for results. Ryan says, "This is hard work that takes time. Organizations need to be in this for the long-term. Community development is an involved, nuanced process. Measurement is tough. You need to be clear on how you measure equitable engagement and get to results."

How the **Mid-Ohio Foodbank** evaluates the success of its programs is evolving. Says Matt Habash, President and Chief Executive Officer of the Mid-Ohio Foodbank. "We have begun a process over the years to evolve from measuring success in how many pounds of food we deliver to who is better off because of the food that is distributed."

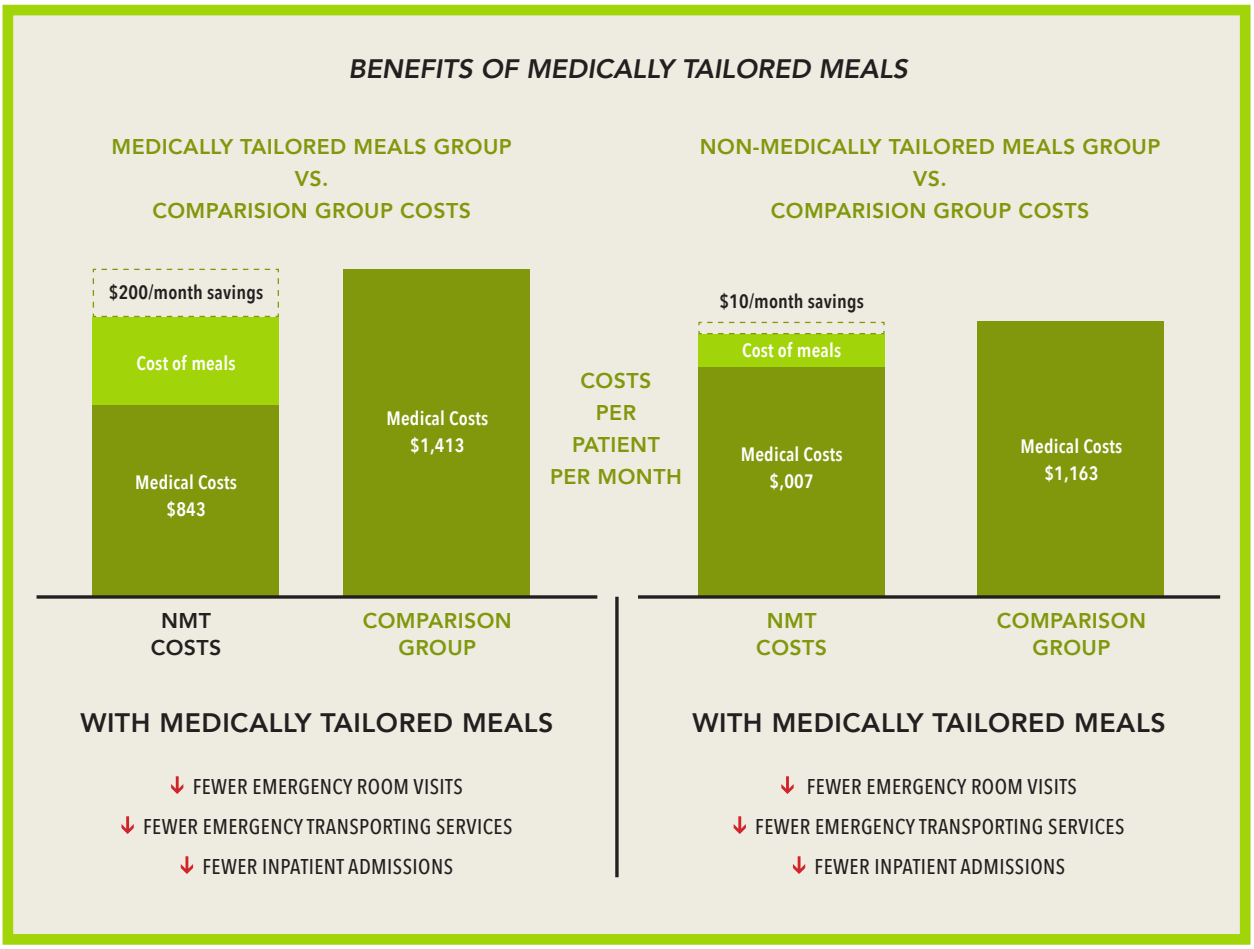
One example of that is the Produce Connect program which links patients to the healthy foods needed to manage and improve health. Partnering with a community FQHC, the Mid-Ohio Foodbank is tracking 12,000 clients. Through the Produce Connect program, the Mid-Ohio Foodbank and the FQHC are able to track different items related to health and well-being such as diabetics for A1C improvement, surplus food availability, and getting food to those who are food insecure.

"We want to look at how we connect our data, and aggregate the data, and to make it simple for the health care providers to connect with patients around food," says Habash.

In addition to tracking clients through Produce Connect, Mid-Ohio also is participating in a three-year study with Squibb, along with three other foodbanks and FHQCs, related to access to food, and from that group hope to help develop a strategy for emergency food distribution.

To help evaluate the benefits of medically-tailored meals, **Community Servings** participated in a study—"Meal Delivery Programs Associated with Improved Healthcare Utilization in Dually Eligible Medicare-Medicaid Beneficiaries," published in *Health Affairs* in April 2018, funded by **AARP Foundation** and undertaken in partnership with Massachusetts General Hospital. The study examined the impact of home-delivered meals reimbursed by a health plan.

Also participating in the study was Commonwealth Care Alliance (CCA), a community-based organization that offers health plans to manage and deliver care for adults over the age of 21 who are dually eligible for Medicaid and Medicare with complex medical, behavioral health and social needs.



The study examined two meal programs: A medically-tailored meal (MTM) program provided by Community Servings, and a non-tailored meal (NTM) program provided by a Meals on Wheels vendor. Individuals who were enrolled in CCA with similar demographic profiles as the intervention groups served as the controls.

"What the study showed is that patients receiving medically-tailored meals experienced a $220 per month savings compared to the comparison group, and the non-medically-tailored meals group saved $10 per month," says Jean Terranova, Director of Food and Health Policy at Community Servings. "Savings for those receiving medically-tailored meals resulted in fewer emergency room visits, fewer emergency transport services required, and fewer inpatient admissions."

Share Our Strength's Cooking Matters Campaign helps families maximize their food budget for their health and wallet by teaching parents and caregivers with limited resources to shop for and cook healthy meals. To ensure effectiveness, Cooking Matters is continually evaluating impact to help validate that programming is having the intended effect.

"We are committed to continual learning and work with our clients and stakeholders to identify the most meaningful measures of impact and program design," says Leigh Ann Hall, MPH, RDN, Managing Director for Cooking Matters.

Among their efforts, Share Our Strength worked with Altarum Institute to understand the long-term impact of participation in their six-week hands-on *Cooking Matters for Adults* shopping and nutrition course. This study* included 1,600+ subjects inclusive of adults taking a Cooking Matters course and a comparison group of families who did not take the course. Subjects were surveyed at baseline, and again three and six months after the course was completed.

The study found that after a Cooking Matters course, participants saw:

- A 10 percent increase in the confidence families had in their cooking abilities.
- An 11 percent decrease in barriers to making healthy, affordable meals.
- An increase in the frequency of meal preparation.
- An increase in vegetable consumption, including green salad and non-fried options.
- A 17 percent increase in confidence in stretching their food dollars.
- A sustained impact after six months with participants continuing to prepare healthier meals.

Members of The Root Cause Coalition are proactively working to create a new and sustainable model of care that improves health outcomes as it ensures health equity by: connecting clinical and community non-clinical services to address health outcomes related to socioeconomic factors influencing health and well-being; creating processes to ensure reimbursement for these non-clinical services; and scaling innovative programs from the local to national level. Funding organizations are also evolving to have greater impact in communities in addressing social determinants of health. And across all sectors, organizations continue to evolve in how they are tracking and evaluating outcomes related to health equity and social determinants of health.

*SOURCE: COOKINGMATTERS.ORG/SITES/DEFAULT/FILES/CM_LONGTERMSTUDY_SINGLEPAGES.PDF

CHAPTER 3

ACTIONABLE STRATEGY #2

ACTIONABLE STRATEGY #2

Align communities and advance authentic collaboration to address the root causes of health inequities

Health systems, payors, funders, and community-based organizations (CBOs) interviewed for this report were all striving to find ways to have authentic and sustained collaboration in order to align communities and clinical services in providing meaningful interventions in addressing health disparities driven by socioeconomic factors. A number of organizations focus on aligning communities through place-based and community revitalization programs that address health inequities as a result of geography; others focus on economic stability through workforce development programs; food banks are expanding their strategic plans beyond food access and distribution to address broader issues related to social determinants of health; and other members are focusing on ways to help stressed CBOs have more sustained success.

ACHIEVING ACTIONABLE STRATEGY #2 THROUGH:

IMPLEMENTING PLACE-BASED AND COMMUNITY REVITALIZATION STRATEGIES THAT ADDRESS GEOGRAPHICAL HEALTH INEQUITIES.

Organizations increasingly have a clear understanding of the connection between geography and health and well-being, in which an individual's ZIP code can be a better indicator of health than their DNA. Member organizations of The Root Cause Coalition are committed to working with neighborhood partners to focus on the incredibly nuanced process of community revitalization. They also realize that each community has different needs and must be approached differently, including rural and urban areas. In addition, organizations are focusing on programs which provide immediate housing, on-site medical supervision, and case management and supportive social services for patients experiencing homelessness who are transitioning out of an acute-care hospital.

"The connection between place and health and well-being is well documented, but less evident is the specific impact of community revitalization on health outcomes and cost. Community development is incredibly nuanced and complex. We work closely with community partners and non-profit organizations including our local arts commission, housing authority, social service agencies, and government partners to engage the community, to listen and learn what the real needs and priorities are in the community."

–Kate Sommerfeld, PROMEDICA

Over the last 10 years, **ProMedica**, a health system headquartered in Toledo, Ohio, has become increasingly invested in addressing health inequities through the social determinants. Initially, the organization focused on food insecurity with a food clinic, and expanding to screen all patients in their system for 10 socioeconomic factors that influence health and well-being. The organization looked at macro factors including kindergarten readiness, infant mortality and obesity. The board and leadership of the organization recognized the myriad of challenges that impact communities due to the social determinants and committed to take action.

"The real questions are how do we totally remodel our broken health system while still ensuring appropriate access to care?" says Randy Oostra, President and CEO of ProMedica. "Simply changing how we pay for services and creating catchy names for programs does not generate the dialogue needed to fashion a model for future generations. We must disrupt and then reconstruct, health care in this country, while maintaining and protecting components that are solid."

As a result, ProMedica has "Taken a comprehensive approach to addressing health inequity and social determinants of health, using data analytics, and focusing on specific populations," says Kate Sommerfeld, President of Social Determinants of Health at ProMedica.

Based on research, ProMedica began implementation of a place-based strategy that included the establishment of the Ebeid Center for Population Health in a previously vacant building in the UpTown neighborhood located next to the downtown business district in Toledo. The Ebeid Center now includes a full-scale grocery store in an area that had previously been designated a food desert, a financial opportunity center supported by a 1:1 financial coaching model to help residents and employees improve their credit scores, a food education and teaching kitchen, a community space for neighborhood meetings, and a privately owned and operated call center that employees 60 residents from the neighborhood. Additionally, ProMedica established the ProMedica Ebeid Neighborhood Promise (ENP), a 10-year community revitalization initiative committed to addressing social determinants of health and community development priorities in the UpTown neighborhood.

"Simply changing how we pay for services and creating catchy names for programs does not generate the dialogue needed to fashion a model for future generations. We must disrupt and then reconstruct, health care in this country, while maintaining and protecting components that are solid."

–Randy Oostra, PROMEDICA

"The connection between place and health and well-being is well documented, but less evident is the specific impact of community revitalization on health outcomes and cost. Community development is incredibly nuanced and complex," says Sommerfeld. "We work closely with community partners and non-profit organizations including our local arts commission, housing authority, social service agencies, and government partners to engage the community, to listen and learn what the real needs and priorities are in the community."

"Through Ebeid Neighborhood Promise, we are really looking to implement a health-centered community development strategy that incorporates solutions that consider the intersections of health, housing, workforce development, education, economic development, the arts, leadership, and capacity building," says Kendra Smith, Director of Social Determinants of Health at ProMedica.

One goal of this neighborhood revitalization initiative is to create and implement a viable infrastructure that will support long-term neighborhood health and growth. With this in mind, ProMedica is collaborating with New York City-based LISC (Local Initiatives Support Corporation) to develop the model to be replicated in other communities throughout ProMedica's service area.

"We work closely with LISC on developing an overall comprehensive community development plan, particularly related to workforce development, financial stability and housing," says Smith.

LISC and ProMedica have also partnered to create the ProMedica LISC Health Impact Fund, a $25 million loan pool for development projects in the Toledo region that increases economic opportunity, addresses social determinants of health, and improves overall quality of life. The pool is part of broader alliance between LISC and ProMedica to mobilize resources for underinvested communities to scale up economic opportunity and improve health outcomes in Toledo and the surrounding region over the next decade.

Projects that build or rehab quality housing, boost small businesses, develop green space, etc. may qualify for a loan from the Health Impact Fund. Loan amounts range from $30,000 to $6 million, and include pre-development, acquisition, construction, mini-perm, bridge, and small business loans.
Current projects include:

- A $424,595 loan to support the redevelopment of the former Wonder Bread factory in the Vistula neighborhood (Toledo, Ohio), part of a $6.2 million adaptive mixed-use redevelopment of the three-story 56,608-square-foot industrial building that will result in commercial space on the first floor and approximately 30 one- and two-bedroom residential units that will be affordable for renters between 80 percent and 120 percent of area median income.

- A $261,000 loan to support the redevelopment of a vacant building in UpTown, Toledo, which is part of a $2.3 million redevelopment of the three-story 14,655-square-foot building to include retail and office space.

"As a whole, the goal is to focus on the community and how to address issues of place and people," says Smith. "And as part of that you want people that are in the community to be at the table leading the conversation around a long-term vision and plan of action."

When New Mexico-based **Presbyterian Healthcare Services** conducted state-wide assessments of its communities, food insecurity, food quality and healthy eating were identified as some of the most significant health issues, including in rural areas. That is a significant finding since most of New Mexico is rural.

According to Leigh Caswell, Vice President for Community Health at Presbyterian, that requires flexibility in how it implements its food initiatives. She says, "In some rural areas it might be distance, but it also might be quality. There might be ability to access food, but the food might be coming from a gas station which is very limited or expensive. In rural areas, people might be driving 50 miles to get to the nearest grocery store. Understanding that interventions cannot be one-size-fits-all is a core competency for any type of food insecurity model."

With that in mind, Presbyterian implemented a multi-disciplinary approach to addressing food and hunger issues statewide, including:

- Launching a Food Farmacy that provides fresh produce and nutritious shelf-stable items to select Presbyterian patients in need.
- Partnering with the United States Department of Agriculture Food and Nutrition Service (USDA) and the New Mexico Children, Youth and Families Department (CYFD) to provide free nutritious meals and snacks to children visiting several Presbyterian hospitals.
- Establishing a "farmers' market on wheels" mobile Farmer's Market program which provides neighborhoods designated as food deserts with access to fresh and local fruits and vegetables.
- Supporting local programs working to address food insecurity. This includes funding a demonstration kitchen at Road Runner Food Bank's Healthy Foods Center and subsidizing produce through the La Cosecha Community-Supported Agriculture project, which allows low-income families to receive low-cost weekly boxes of locally grown, organic produce.
- Integrating healthy food into the system by contracting with group purchasing organizations, distributors, and food service providers that support healthy food; creating community gardens to grow fresh produce.
- Working with more than 30 elementary schools in the Albuquerque Public School district and other school systems in the state, to encourage kids to support school gardens, nutrition education, and to make nutrition and physical activity healthly habits for life.
- Implementing a "Fresh Rx" program that provides overweight or obese patients with counseling about maintaining a healthy weight. Patients also receive a prescription for fresh fruits and vegetables that can be used at local farmers' markets and through a Community Supported Agriculture program.

"We are on a great trajectory relative to health equity and social determinants, but we have more work to do," says Caswell. "People are making space to have the conversation now. Addressing health inequities and social determinants are critical to our mission of improving the health of our community. We are working to ensure addressing these issues are more integrated throughout our system and how we provide health care, and continue to strengthen our relationships and programs in our rural communities."

As part of **Share Our Strength**'s work to end childhood hunger in the United States and abroad, the **Cooking Matters Campaign** teaches participants to shop smarter, and to use nutrition information to make healthier choices and cook delicious, affordable meals. Through its network of nationwide partners and thousands of

in-person programming instructors, Cooking Matters has helped more than 700,000 low-income families in communities across the country learn how to eat better for less.

The Cooking Matters Campaign operates a unique model of collaboration with local program partners. Share Our Strength provides field tested and up-to-date program materials, training, evaluation, and the support of a national leader in cooking and food skills education. Local program partners provide program coordination in the field, procure local-level resources to support implementation costs and capacity, and can choose from the Cooking Matters suite of program resources to meet the specific needs of low-income adult audiences in communities they serve. Share Our Strength actively seeks regular feedback from program participants and partners to inform program design that best meets the needs of those being served and to more seamlessly scale models that can be integrated within other programs and services.

"For example, we've recently completed a series of listening sessions, surveys and co-creation with more than 200 partners and program participants to inform a new, more flexible in-person programming format that can more easily be integrated within healthcare or WIC settings," says Leigh Ann Hall, MPH, RDN, Managing Director for Cooking Matters. "At the same time, we are deepening our understanding of potential technology supports for people in more geographically spread communities and those who may not have access to in-person programming."

Julia Ryan, Vice President of **Local Initiatives Support Corporation (LISC)**, notes how the extraordinary disparities in life expectancy between communities – sometimes just miles apart – serves as a continual reminder of how important it is to focus LISC's place-based investments on addressing social determinants. Sometimes those place-based investments are spearheaded by unexpected leaders. She tells a story of how a multi-partner effort to reduce crime in Alameda County, initiated by a local law enforcement agency, evolved from a safety effort into a far more comprehensive initiative to sustainably revitalize a community with significant challenges related to poverty and health.

The Alameda County Sherriff's Office sought to reduce crime, increase community engagement and build community capital through a creative placemaking approach including the establishment of a pop-up festival and marketplace called Eden Night Live. The location for the festival was an underused space in the community. In all the activities planned, the arts played a role in drawing people to the event and providing opportunities for local entrepreneurs.

The Sherriff's Office and its partners came to recognize that what they had viewed as "crime drivers" – things like blight, financial insecurity of families, and lack of recreational opportunities for youth – were also social determinants of health. Embracing a health frame for their work helped draw new partners and resources to the work.

Successes of Eden Night Live included:

- Providing opportunities for local commerce.
- Providing opportunities for socioemotional growth.
- Building a creative community space.
- Fostering community expression of art.
- Providing opportunities for greater community cohesion and tolerance.
- Establishing an avenue for positive interaction with the police.
- Embodying a public display of community investment.*

According to Ryan, improving health equity is now a major strategic priority of LISC. She says, "We've committed to investing $10 billion over the next 10 years to improve health and wellness in our communities around the country. We're honored to be partnering with so many health care institutions and extraordinary community organizations to achieve that goal."

*C OKEKE. BUILDING BEYOND POLICING: A CASE STUDY OF EDEN NIGHT LIVE IN ALAMEDA COUNTY, CALIFORNIA URBAN INSTITUTE. URBAN.ORG/SITES/DEFAULT/FILES/PUBLICATION/99038/ALAMEDA_COUNTY_POLICE-COMMUNITY_RELATIONS.PDF

In Los Angeles County, there is no lack for motivation in addressing homelessness. The county has the nation's second-highest number of people experiencing homelessness and the greatest number of unsheltered homeless individuals.

To help address this issue, **National Health Foundation (NHF)** focuses on recuperative care programs, which provide immediate housing, on-site medical oversight, case management and supportive social services for individuals experiencing homelessness who are typically transitioning out of an acute-care hospital. According to Los Angeles County records, about 50 percent of people who spend time in a recuperative care facility go on to secure permanent housing.

Guests of National Health Foundation's recuperative care program stay anywhere from 10 days to several weeks. All people in the program are experiencing homelessness. Says Danielle Cameron, Chief Strategy Officer at National Health Foundation. "At the completion of the program we provide comprehensive information to the guest about his or her medical home and social service referrals so that person is better able to manage their own health and has more direct connections to the community."

National Health Foundation is rapidly expanding its recuperative care program. It just recently opened a new building dedicated to housing services, the 62-bed Pico Union Recuperative Care Center. National Health Foundation also operates recuperative care centers in its Mid-City Los Angeles and Ventura locations, with a total capacity of 98 beds. Last year, NHF served 1,063 individuals and placed approximately 65 percent into housing.

The Pico Union Recuperative Care Center is located in a renovated 100-year-old sanitarium just outside downtown Los Angeles. Says Cameron, "We could have gone elsewhere, but we felt it was important to be in this building. It was symbolic to recuperate the facility as we help people recuperate."

The project was a partnership between National Health Foundation, HomeAid Los Angeles and etco HOMES. HomeAid provided free and reduced-cost construction supervision, labor and materials, which significantly reduced the overall cost of the project, and etco HOMES served as the project's build captain. The Los Angeles County Homeless Initiative's Measure H also provided capital funding. In addition, Woodbury University architecture students were enlisted to design the interior wardrobe space and outside dining area. Neighborhood volunteers helped install windows, paint, assemble furniture and sew curtains, among other activities.

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–Danielle Cameron, NATIONAL HEALTH FOUNDATION

A key to making the decision was engaging the neighborhood in a conversation about the establishment of the recuperative care facility in their neighborhood. They held community forums and addressed issues from safety concerns to a potential loss of parking spaces. Neighborhood volunteers helped to plan the grand opening of the center and continue to be engaged in the program.

L.A. Care Health Plan, which serves more than two million members in Los Angeles County, signed a contract with National Health Foundation in January, 2019, to lease 16 beds at the new Pico-Union Recuperative Care facility. The hope is to illustrate the positive impact on health outcomes of recuperative care centers, with a goal that the state will consider funding these types of beds in the future. This new pilot is a continuation of a partnership between L.A. Care and NHF. Earlier this year, L.A. Care awarded NHF a $150,000 grant to help develop the Pico-Union facility.

NHF also recently signed a similar contract to lease beds with Dignity Health. Cameron says, "The focus is providing people a safe place to recuperate and help them along on their path to housing."

ACHIEVING ACTIONABLE STRATEGY #2 THROUGH:

HELPING ENSURE FINANCIAL STABILITY THROUGH WORKFORCE DEVELOPMENT.

In conducting interviews of community constituents to identify top needs, oftentimes the most immediate need identified was the need to find a job. As a result, a number of members focus on workforce development programs, which have a number of key outcomes: increasing financial security for community members and enhancing their quality of life, but also creating a workforce pool for member organizations, as well as reducing health care costs and enhancing utilization.

In 2013, **CareSource**, a health plan headquartered in Dayton, Ohio with more than two million members across five states, was seeing significant growth in Medicaid recipients with Medicaid expansion. Today, CareSource is one of the nation's largest non-profit Medicaid managed care plans.

The company conducted focus groups to get a better understanding of how CareSource could best help its members. They said: help me find a job. With that in mind, in 2015 CareSource implemented a pilot program, called Life Services, which couples the largest low-income subsidy safety net, Medicaid, with a holistic approach to addressing economic well-being and social connectedness.

"We started the program in Ohio and have scaled to cover all 88 counties in Ohio. In 2017, we replicated the program for our members in Indiana and Georgia," says Karin VanZant, Vice President, Integrated Community Partnership at CareSource.

A key component of Life Services is JobConnect, an initiative that helps members to increase skills and attain connections to long-term employment.

Members opting-in to the program are assigned a Life Coach who helps individuals identify resource strengths and prioritize areas that need reinforcing—for example, emotional support, food stability, child care, or physical health. Life Coaches then connect members with community services such as food banks and transportation vouchers. Additionally, coaches may assist members eligible for public assistance with managing state and federal resources such as Temporary Assistance for Needy Families (TANF) or the Supplemental Nutrition Assistance Program (SNAP).

Once immediate needs have been met, members are connected with education programs and employment opportunities to help them increase skills and attain connections to long-term economic stability. CareSource then works with members for up to 24 months to help them navigate the work world, prepare for their loss of government subsidies (i.e. "Subsidy Cliff"), increase their financial literacy, and strategize future career steps.

JobConnect also provides positive support to Medicaid members with recent criminal justice involvement or behavioral health problems such as serious mental illness (e.g., bipolar disorder, major depression, or schizophrenia) or substance use disorder. Once stabilized, *JobConnect* links them with education or employment opportunities. Importantly, employer partners express an increasing willingness to accept applicants with past substance use or a criminal background who actively participate in the *JobConnect* program.

In evaluating the *JobConnect* program, three outcomes were assessed using data from several sources: ongoing metrics on program enrollment and employment success; healthcare utilization compared administrative claims during the six months before opting in to *JobConnect* with the six months following opt-in among a sample of 392 participants with consistent CareSource Medicaid enrollment.

Initial results of the evaluation have been positive particularly related to opportunities for employment and economic stability, healthcare utilization and barriers to daily life.

"From a business perspective we are measuring utilization," says VanZant. "We saw a significant decrease in emergency department visits, but interestingly, as our utilization numbers went down we saw an increase in pharmacy costs. What we found is that even with a diagnosis, people were not taking medications. As they participated in Life Services, they had a better realization that the medications helped with jobs and job security. Their overall disease management was improving, leading to lower health care costs."

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–Karin VanZant, CARESOURCE

OTHER POSITIVE RESULTS INCLUDED:

- *Increased Opportunities for Employment and Economic Stability*. Across the nine Ohio counties where *JobConnect* was initially implemented, on average, members who completed the opt-in phase received three referrals to community resources, such as connections to food banks and housing assistance. Also, nearly 90 percent of members who were employed at any time while in *JobConnect* have retained their job.
- *Decreases in Self-Reported Barriers to Daily Life*. Members who responded to at least three assessments reported significantly lower severity of barriers at the third assessment compared to the first, with the greatest decrease evident for primary needs (e.g., food, shelter and physical health).

JOBCONNECT CONSUMER IMPACTS

475
Employer Partners

12,673
Total Community Referrals

3,630
Members who have opted into Life Services

85
Percentage of Members who have retained employment at 90 days

386
Members who have completed education

1,537
Employed Members

16,000+ Members who have interacted with Life Services

*SOURCE: CARESOURCE LIFE SERVICES PPT, DECEMBER 2018. UPDATED AUGUST 2019.

Skilled nursing facilities in Central and East Contra Costa County in California – which often serve the area's most vulnerable, low-income older adults, many of them on Medi-Cal – do not have enough trained staff. At the same time, those areas of Contra Costa have a large number of unskilled, low-income residents seeking jobs. The **John Muir Community Health Fund (CHF)** saw this as an opportunity to address a significant health disparity, while also providing a career pathway for low-income individuals who are looking for work.

To achieve that goal, the CHF provided a series of grants to create a partnership that includes Ombudsman Services of Contra Costa & Solano, Opportunity Junction (OJ), Mt. Diablo Adult Education (MDAE) and NorCal Care Centers.

Phase one of the three-year initiative involved the creation and implementation of an 11-week, certified nursing assistant (CNA) training program at MDAE's Career & Technical Education Center. In addition to MDAE training students with the skills for certification, OJ offers students "wraparound" social support services that include hot meals during class time and food deliveries to tide them over through the weekend.

The first cohort of CNAs, who ranged in age from 18 to 63-years-old, graduated in May 2019. "All but two qualified for financial assistance, and all 16 in the initial cohort passed their clinical certification exams, with starting salaries from just under $16 to more than $18 per hour," says Lillian Roselin, Executive Director at the CHF. "Many also receive full health benefits with their new salaries." The second cohort began in August 2019.

Now the initiative enters phase 2, which will include identifying additional health care professional educational and training needs, determining ongoing educational opportunities for participants, and expanding further into Eastern Contra Costa County.

Credit Adjustments, Inc. (CAI) headquartered in Defiance, Ohio, is a leader in receivables management with a focus in health care and higher education. As part of its commitment to the community, 10 percent of the organization's earnings go to charitable causes.

CAI has grown rapidly as the organization was awarded a contract with the US Department of Education to provide support in collecting defaulted student loans. To meet the needs of the contract, CAI was in immediate need of trained call center representatives. Leadership at the organization saw this expansion as a way to meet a community need as well as a company need.

Working with community partners, CAI established a second chance hiring, rehabilitation and addiction program. The company partnered with Cherry Street Mission Ministries' Life Revitalization Center in Toledo, Ohio, along with a local community college to create and implement a 10-week certification course to train individuals as call center representatives. Graduates from this program then have the opportunity to become employees at the company.

There were initially five cohorts with approximately 45 people enrolled, many of whom had been residents at the Cherry Street Mission, which provides housing for the homeless.

"About 50 percent of the people in the first training cohort completed their certificate and got jobs with CAI at the Toledo office," says Hayley Studer, Chief Mission Officer at CAI.

There were a number of positive outcomes from this pilot program. Ninety percent of the people had improved housing, and four people purchased cars just seven weeks after completing the program. CAI has continued to expand, adding 200 jobs at a second location in the Toledo UpTown neighborhood, a community identified as being in need of economic revitalization. The organization outgrew its first Toledo-based call center, which was located on the third floor of ProMedica's Ebeid Center for Population Health.

This process has also given CAI the opportunity to provide additional wrap-around services once individuals are employed. Leadership of CAI hope the model they are working to create can become an example for other businesses to follow.

Loma Linda University Health, with a primary service area including California's San Bernardino, Riverside, and Ontario metropolitan areas, is known world-wide for its education, clinical service and research. In addition, Loma Linda has always had a strong culture of interest in its community, but lacked an enabling institutional infrastructure. With this in mind, Loma Linda University created the Institute for Community Partnerships which connects the community to the university and four hospitals.

"Sometimes, organizations are so eager to fix problems that we don't listen, and try to fix things we don't understand," says Juan Carlos Belliard, PhD, MPH, and Director of Loma Linda University Health's Institute for Community Partnerships. "In some areas, the university doesn't have the experience. We need those who have been there."

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–Juan Carlos Belliard, LOMA LONDA UNIVERSITY HEALTH'S INSTITUTE FOR COMMUNITY PARTNERSHIPS

The first step was to have discussions with the community. The Institute for Community Partnerships established a community-wide network in San Bernardino including the school superintendent, members from the faith-based community, the health department, and other community leaders and created a collective impact model, not talking about issues in isolation. It also was a grassroots network including parents and neighbors.

From those discussions, workforce development was identified as a key area of interest to address the region's greatest challenge, poverty.

Once the goal of workforce development was identified, Loma Linda University Health established the Promotores Academy, with a mission to train individuals from the community. Says Belliard, "Integrating individuals in the community for better health outcomes is a unique upstream approach to improving health and health care as well as addressing workforce needs."

Students receive training in individual and community capacity building, health promotion and disease prevention, cultural mediation, advocacy, home visitation skills, and more. The Academy provides ongoing support and mentorship to build professional and workforce capacity.

One of Loma Linda University's key programs in workforce development is the San Manuel Gateway College, a non-profit college helping people not attending a tradtional four-year college so they can enhance wages as medical assistants, surgical techs, pharmacy techs, and community health workers.

"The college is a pipeline for graduates to go on to a four-year school," says Belliard. "Half of graduates go back to school."

The San Manuel Gateway College integrates training programs in health careers with clinical experience, allowing students to benefit from hands-on training and mentoring by Loma Linda University Health faculty and students. The Certified Medical Assistant Program educates multi-skilled professionals specifically to work in ambulatory settings performing administrative and clinical duties. Pathways include certified nursing assistant, pharmacy technician, community health worker training and surgical technician. More pathways are being added. These are six to 18-month programs that provide entry-level skills for employment opportunities that provide a living wage.

"One person who is now working as a medical assistant had previously dropped out of school," says Belliard. "He had mental health issues, had a fire in his house and his family life became destabilized. Thanks to the support from their employer and the stability of their job, they were able to put their life back together.

"Another student who had participated in our high school pipeline program became one of our medical students and is now a faculty member in our school of Medicine. He mentors other students who are following his footsteps. Truly, a life transformed that is now transforming other's lives."

ACHIEVING ACTIONABLE STRATEGY #2 THROUGH:

Expanding beyond traditional (or current) food access and food distribution strategies to address broader issues related to social determinants of health and equity.

In addressing a key social determinant of health— hunger— food banks have traditionally been focused on food access and food distribution. However, as these organizations have continued to evolve, particularly in major metropolitan areas, food banks are evolving to implement strategic plans that address broader issues related to health inequities creating more meaningful relationships with the communities they serve. These areas include public advocacy and community engagement, and include a focus on how to use technology to enhance operations as well as track and evaluate nutrition programs in health outcomes longitudinally.

Hunger stifles potential. And the **Greater Chicago Food Depository** continues to address a high level of need in its community. The Food Depository serves more than 812,000 people each year. One in six children in Cook County, Illinois is at risk of hunger.

For Kate Maehr, Executive Director and Chief Executive Oofficer at the Greater Chicago Food Depository, participating in the Feeding America national hunger study in 2014 was a turning point for the food bank.

"We saw real data about the reality of how food impacts health," says Maehr. "It wasn't just diet-related issues that were impacting clinical issues such as heart disease, obesity and diabetes. We saw how diet-related issues were impacted by the social determinants of health."

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–Kate Maehr, GREATER CHICAGO FOOD DEPOSITORY

Based on that research, the leadership at the Food Depository launched a new strategic plan identifying three goals over the next four years: expand access to nutritious food; partner with and strengthen community-based responses to hunger and its root causes; and inspire and engage community members to lift its collective voice to end hunger.

"As a food bank, traditionally, we had been in the business of food distribution and food access. After 2014, we began to focus increasingly on nutrition education, community engagement and advocacy," says Maehr.

As part of this, the Greater Chicago Food Depository continued to evaluate its food supply and what it was distributing. The organization made a commitment to produce and expand access to fruits and vegetables. According to Maehr, at times this changed the conversation around food donations. She says, "Because there was an increased emphasis on quality, there were times when we actually say 'no thank you' to certain types of food."

Cross-sector partnerships are critical to achieving the goals of the Food Depository's strategic plan. That approach includes working with multiple health partners such as Federally Qualified Health Centers (FQHCs) and hospitals in Cook County to support the implementation of food insecurity screenings and connecting patients to resources such as the emergency food network and benefits outreach to help connect patients with federal nutrition programs and Medicaid. The Food Depository has also worked with an FQHC on a prepared meal project to address food insecurity in a cohort of high-risk patients.

"We started the prepared meal pilot program in January, 2018," says Maehr. "We are seeing that patient readmissions are being reduced due to these efforts. Now we really need to unlock the data and demonstrate efficacy."

Like the Greater Chicago Food Depository, the **Mid-Ohio Foodbank** in Columbus, Ohio, is evolving as an organization.

Mid-Ohio Foodbank provides food to a half-million people each year by partnering with more than 650 community partners across 20 central and eastern Ohio counties. Since 1980, the Mid-Ohio Foodbank has joined with food pantries, soup kitchens, shelters, produce markets, senior centers, and after-school programs to make nutritious food accessible for those who are hungry. In the past year, the food bank distributed more than 70 million pounds of food enabling its partner charities to provide more than 155,000 meals every day.

"What we know is that the ability for people at 200 percent of the poverty level to buy food goes way down - and sick care goes up," says Matt Habash, President and Chief Executive Officer of the Mid-Ohio Foodbank. "We began to think beyond the Mid-Ohio Foodbank as an organization focused on food distribution and access to food. We learned we could have a more influential, meaningful relationship with the community we served."

With this approach in mind, the foodbank began to look at how to access fresh food inexpensively. What they began to identify was a low-cost/high-quality access strategy that would meet basic needs.

"We began to move from the concept of food for today to food for health, which started us down the path to focus more on perishable foods," says Habash. "Now more than 60 percent of the food we distribute is fresh food."

In addition, Mid-Ohio Foodbank established the Produce Connect program which links patients to the healthy foods needed to manage and improve health. Clients can go online and sign-up for the service, which provides weekly access to free, fresh produce at participating locations across central Ohio.

"We partnered with a community FQHC, and are currently tracking 12,000 clients, each of whom receive a Produce RX card to receive free healthy produce weekly," says Habash. "It has been a success and we are working to expand the database to 12 additional sites."

One area of focus of the program was the ability to track clients more effectively. With Produce Connect, Mid-Ohio Foodbank and the FQHC are able to track different items related to health and well-being such as diabetics for A1C improvement, surplus food availability and getting food to those who are food insecure.

"We want to look at how we connect our data, and aggregate the data, and to make it simple for the health care providers to connect with patients around food," says Habash.

According to Habash, in the past, food has often been disconnected from health care. Now, health care organizations are beginning to make referrals to food pantries and food banks.

That's a good thing, says Habash. "What we need to focus on is how payment for that referral is achieved. We want to have increased referrals, but we have to see some payment reform so appropriate payment takes place for that referral."

Since opening its doors in 1975, the **St. Louis Area Foodbank** has provided the community it serves with more than 500 million pounds of food, serving nearly 400,000 people annually. The Foodbank, which is part of the **Feeding America Network**, services 26 counties, 12 in Illinois and 14 in Missouri, and has more than 500 community partners.

The foodbank is in the first three years of a seven-year plan, implementing strategies designed to help the organization lead the bi-state region's hunger relief efforts. Strategies include: the collection and use of real-time data; the infusion of technology to optimize operations; a focus on placing the needs of partners and clients at the center of any decisions; and a disciplined approach to food acquisition with a focus on healthy foods.

"We all know hunger is a bad thing," says Ashley Rube, Outreach Coordinator for the St. Louis Area Foodbank. "But what we find with those in need is that there are often more things going on that impact decisions about food. The body gives us a signal not about starvation and potentially death but about struggling to meet the things that life demands. So while we need to tackle immediate food issues, we need to understand the other multiple, nuanced issues that people factor in to whether or not to buy food."

According to Rube, the St. Louis Area Foodbank is striving to address hunger in a broader context as it continues to evolve and sharpen its focus on nutrition and health-based outcomes.

"We will always be focused on food security, and we would like to take on a leadership role within our region's anti-hunger efforts," she says.

According to Rube, if the foodbank can continue to make serious headway toward "shortening the line" and reducing hunger in the region, it can start investing resources and energy into addressing issues that exacerbate and connect to hunger.

"We will continue to work closely with experts in other fields to make our collective work more effective," she says. "Ideally, through efforts to build a more food-secure region, we will also be convening and collaborating with a wide array of partners and participating in systemic change that offers people more stability and better quality of life."

"We are hopeful about where the direction our work will take us and becoming increasingly intentional about listening to the people and organizations we serve — fighting hunger in its local context."

The process of engaging communities and individuals in need can be very nuanced. Says Rube, "With people who do not have a voice, it is not so much about storytelling, but that they become part of the storytelling process. We need to be in their shoes. What does it mean to create a story about how this can impact people's lives. We need to humanize the hunger issue, deal with the stigma and back up the story by raw facts."

Feeding America has been in existence for more than 35 years, addressing hunger through a nationwide network of food banks. The organizational model was focused on food distribution for those in need.

As the charitable food sector and research has evolved, as well as broader awareness on the root causes and intersectionalities of social determinants of health, Feeding America has expanded its focus. It not only works to address food insecurity today, but also aims to solve for food insecurity tomorrow. This includes working towards outcomes for, and with people facing food insecurity to have reliable access to enough nutritious food, support in making healthy choices and experience improvements in financial security.

"In 2010, we began to take a new direction," says Jessica Hager, Director of Healthcare Partnerships and Nutrition at Feeding America. "We made the decision to address food insecurity not just from a distribution model. We felt we had a responsibility to do more."

The organization developed a 2025 goal stating that, in collaboration with their network and partners, they will ensure access to enough nutritious food for people struggling with hunger, and make meaningful progress toward ending hunger. This goal focuses on four areas – the three outcomes noted above, as well as engaging the general public and utilizing policy and advocacy to improve food security.

There were a number of key principles the organization applied as it began implementing these areas of focus.

"We were really applying a socioecological model to our approach – on the individual level, family level, community level, and system level," says Hager. "It is the model that helped to inform the health and nutrition work specifically."

It is important to meet people where they are and work in collaboration with communities and people with lived experience —in any inequity issue, according to Hager. She says, "For example, some food pantries offer health screenings where they know neighborhoods have high rates of diagnosed, and often undiagnosed, diet-related diseases. Working with different community partners, food pantries are able to address food insecurity and chronic disease in a more comprehensive, and often more effective way. Research we've conducted in partnership with food banks and health care partners further supports the value in addressing food insecurity with a more comprehensive approach that includes but goes beyond caloric intake."

Meeting people where they are at also means putting the individual at the center of what the organization is trying to accomplish. Says Hager, "We engage people with lived experience of food insecurity to better understand and develop interventions, and know people are the true and most authentic voice of their community."

ACHIEVING ACTIONABLE STRATEGY #2 THROUGH:

SUPPORTING COMMUNITY-BASED ORGANIZATIONS.

The significance of community-based organizations (CBOs) in addressing health inequity and socioeconomic factors influencing health and well-being was highlighted in a national report commissioned by the **Alliance for Strong Families and Communities** and the American Public Health Services Association, produced by Oliver Wyman and Sea Change Capital Partners - *A National Imperative: Joining Forces to Strengthen Human Services in America.*

As part of the report, tax returns for nearly 45,000 human services CBOs were analyzed, and more than 200 executives from CBOs and public sector agencies were surveyed about their main challenges, risks and opportunities. Those include:

- Approximately one in five Americans utilize services provided by CBOs including housing, counseling, nutritional support, and employment training, making it possible for people to live more productive, healthier lives.
- The value created by CBOs extends beyond those who receive services. More than three million Americans work at CBOs. This benefits not only the local but national economy. CBOs generate in excess of $200 billion in direct economic value to the economy.
- Investment in "upstream" human services has the potential to transform our healthcare system and our judiciary/corrections system.

CBOs are critical in helping communities and individuals achieve health and well-being, including:

- Ensuring children and youth are protected and live in safe homes and neighborhoods so they succeed in school and have strong, nurturing and economically secure families.
- Helping older adults maintain a high quality of life.
- Supporting people with disabilities so they can live their lives fully.
- Providing workforce supports that help people obtain and retain employment at livable wages.
- Ensuring quality affordable housing.
- Promoting improved health outcomes and reduced health care costs.
- Providing crucial effective mental health and substance abuse services, especially given the current opioid epidemic.

But many CBOs are severely stressed. Nearly half of CBOs participating in the report had a negative operating margin over three years; 30 percent have reserves covering less than one month of expenses; one in eight human services CBOs are technically insolvent. The study found that the CBOs facing the greatest

financial stress included organizations focusing on housing and shelter, mental health and general human services; the CBOs tending to face less financial stress include organizations delivering services including public safety, food and nutrition and youth development.

The Alliance for Strong Families and Communities helps community-based organizations in a number of ways. One way is to help these organizations with administrative needs, so they can be more effective in providing service to their communities. Partner organizations with limited capacity and resources can outsource various financial and administrative duties to the Alliance. The Alliance also provides benefit packages as well as comprehensive employee assistance programs and work-life services at a reasonable cost. Additionally, the Alliance offers an unemployment tax program that enables better management of cash flow and claim tracking.

Collaborative Consulting works with foundations, health systems, community-based organizations (CBOs) , and national associations, to help build the capacities and leadership needed to design, implement, and sustain cross-sector partnerships.

"All of our projects are anchored in cross-sector collaborations," says Lori Peterson, Chief Executive Officer and Founder of Collaborative Consulting. "But in considering cross-sector partnerships, you really need to start off with the question – 'Is a cross-sector partnership the right strategy?' You need to do your due diligence, determine what you are trying to achieve, and then grapple with the decision if partnership is the right strategy to achieve your goals."

Having a sound framework is critical for health and social care providers in translating new models of care and reimbursement structures into viable opportunities for growth and sustained viability. That means doing the hard work to ensure design and implemention strategies to achieve organizational readiness are in place. Collaborative Consulting has helped facilitate that process with CBOs and healthcare organizations across the country, including:

- Partnering with a foundation to design and deliver a four-year business acumen-building initiative for a network of CBOs providing services to older adults and persons with disabilities. The initiative included an assessment of market conditions, organizational assessments, and guidance on business plan development and capacity building. To help facilitate partnership readiness, Collaborative Consulting facilitated bringing together subject matter experts, healthcare speakers, and CBO peers to accelerate learning.
- Developing a partnership readiness framework and a complementary suite of more than 20 CBO tools designed to help accelerate cross-sector partnerships. These include an assessment tool currently available through the National Association of Area Agencies on Aging - Aging and Disability Business Institute (ADBI) and four supplemental tools (market assessment, competitor assessment, building the business case, and prioritizing opportunities) co-designed with CBOs participating in an ADBI Learning Collaborative.
- Working with multiple entities leading Medicaid transformation initiatives (e.g., the New York DSRIP Performing Provider Systems, Accountable Health Community) to assess the readiness of CBOs, to design capacity building initiatives based on the assessment results, and to deliver components of the capacity building programs.
- Working with numerous types and sizes of CBOs such as Centers for Independent Living, Aging and Disability Resource Centers, Area Agencies on Aging, Aging Service Providers, and Meals on Wheels Providers to assess their markets, their organizations, and to determine a strategic position within the system of health that leverages their strengths and capitalizes on market opportunities.

"To partner successfully, CBOs and health care organizations must be willing to adopt new mindsets and approaches," says Peterson. "They need to expand business acumen to build capacity and achieve successful cross-sector partnerships, including adopting new perspectives about our health care system, and accepting that the process of partnering does not come with a standard playbook."

"But in considering cross-sector partnerships, you really need to start off with the question – 'Is a cross-sector partnership the right strategy?' You need to do your due diligence, determine what you are trying to achieve, and then grapple with the decision if partnership is the right strategy to achieve your goals."

–Lori Peterson, COLLABORATIVE CONSULTING

Through research, advocacy and philanthropy, **West Health** is working to help seniors receive better care across all settings, including the home, so they can age in place for as long as possible with access to high quality care and supportive services. Lowering health care costs to enable successful aging is the singular mission across all West Health entities, which also include the **Gary and Mary West Foundation and West Health Policy Center**.

Senior dental care is one of the largest under-funded areas of care, according to Brenda Schmitthenner, Senior Director of Successful Aging at the West Health Institute. She says, "These are often low-income, high-need individuals. They are stressed about not being able to chew food, yet they don't seek dental care because they're embarrassed about not being able to pay for it. Through the Gary and Mary West Senior Dental Center, we started providing affordable dental care at a downtown senior center, and it has had an incredible impact on people's lives."

The Senior Dental Center links high-quality and affordable oral healthcare with a suite of nutrition, case management and wellness services offered through Serving Seniors' Gary and Mary West Senior Wellness Center, creating a one-of-a-kind, integrated community-based system of care for older adults.

The West Health Institute team has multiple research projects in progress and has published a number of articles on the critical role of community-based organizations in addressing malnutrition in community-dwelling older adults. One article published in the *(American Society on Aging Managed Care Field Guide)* recommends that community-based organizations can aid in preventing and treating malnutrition in seniors by integrating screenings for malnutrition and other social risk factors into their programs, as well as using the data to help demonstrate value to healthcare partners.

Health systems, payors, funders, and community-based organizations are in the process of aligning community and clinical services to address health disparities created by socioeconomic factors through place-based and community revitalization programs and through workforce development programs. Foodbanks continue to evolve to implement strategic plans that move beyond food distribution and access to address broader issues related to social determinants of health. Members of The Root Cause Coalition are also focused on finding ways to help stressed community-based organizations have more sustained success.

CHAPTER 4

ACTIONABLE STRATEGY #3

ACTIONABLE STRATEGY #3

Engage and learn from communities most affected by inequities and health and social conditions

For organizations looking to achieve sustained change and improve health outcomes in a community, it is critical to build context and change the narrative. The culture and the language in any given community can be loaded. Change is very much a process and organizations must be willing to invest time and resources both inside their organizations and outside in the communities they serve. Equally important is the need to engage and learn from communities early on, so that change becomes organic rather than something that feels pushed upon the community by the organizations.

Members of The Root Cause Coalition understand that to impact social conditions and health inequities, they must engage and learn from communities first. Member organizations interviewed accomplished that by establishing and expanding programming to enhance cultural sensitivity and cultural competency in an organizational and community context, and focusing on communications programming that adds context to the community narrative.

"Some people don't feel that addressing social determinants is in our lane. That we take care of people who are sick and that should be our focus. At the same time, from a different perspective, the community looks at our hospital system and thinks of it as a big corporation that makes a lot of money and that we should be doing more in the community. So we are working to educate these various key stakeholders and help find balance and move the conversation forward."

–Danielle Price, UNIVERSITY HOSPITALS

The infant mortality issue in Lucas County, Ohio, the entire state of Ohio and the nation, particularly for African Americans, is significant. In 2016, the infant mortality rate for African American babies in Lucas County was nearly three times as high as the infant mortality rate for white Lucas County babies, according to Ohio Department of Health statistics. Lucas County is among nine urban counties and metropolitan areas that account for close to two-thirds of all infant deaths, and 90 percent of black infant deaths in Ohio in 2017.

In response to this, a number of organizations collaborated and received a grant from the Ohio Department of Health to establish a Getting Healthy Zone as part of the Healthy Lucas County Community Health Improvement Coalition. This grant is funding community engagement utilizing the evidence-based Best Babies Zone approach to improve infant vitality in seven urban Toledo census tracts located within five ZIP codes. The project, coordinated by Hospital Council of Northwest Ohio, mobilizes residents and organizational partners to address the social, structural and economic determinants of health and promote health equity. These efforts are led by **ProMedica**, Neighborhood Health Association, Mercy Health, Toledo-Lucas County Health Department, their home-visiting programs and the Northwest Ohio Pathways HUB community-wide care coordination system.

ProMedica has a specific focus on two census tracks which contribute up to 20 percent of infant deaths and 16 percent of pre-term and low-birth-weight deliveries in the area. More than half of the 11,372 residents in the identified ZIP codes are African American, and 78 percent of female residents are living below 200 percent of the Federal Poverty Level, according to the U.S. Census Bureau.

To help reverse infant deaths, ProMedica has implemented a "boots on the ground" strategy. Rather than waiting for high-risk moms to come to ProMedica clinical sites, the organization has a dedicated team going where women in need are, canvassing the neighborhood to identify high-risk moms, and then connecting them to resources – including food, housing, transportation, a medical home, and other items – in order to help increase the odds of the mom having a healthy baby.

"As we canvassed the community, we were surprised that more than half the people we talked to knew someone who had lost a baby," says Teanya Norwood, Social Determinants of Health Outcomes Manager for ProMedica.

The program is beginning to show promise. Says Norwood, "Through this process, we have connected more than 300 moms with community resources and have made approximately 75 referrals to the home visitation program within our census tracks."

ACHIEVING ACTIONABLE STRATEGY #3 THROUGH:

ESTABLISHING AND EXPANDING PROGRAMMING TO ENHANCE CULTURAL SENSITIVITY AND CULTURAL COMPETENCY IN AN ORGANIZATIONAL AND COMMUNITY CONTEXT

One of the most significant challenges in addressing social determinants of health and health equity is to create cultural competency internally and in the community. Achieving greater cultural competency is critical to building meaningful relationships at all levels in a community to achieve impact.

With a median household income of $80,088, New Jersey is the second wealthiest state in the nation, yet more than 38 percent of households in the state struggle to afford basic needs including food, heat, child care, transportation, health care and technology. More than 915,000 New Jersey residents go to bed hungry and more than 8,800 are homeless or housing insecure.

As the second largest employer in New Jersey , and a major economic force in communities state-wide, **RWJBarnabas Health (RWJBH)** recognizes its responsibility as an anchor institution to improve the health of communities across the state. With that in mind, RWJBH committed to a buy, hire, and invest local strategy.

"The RWJBarnabas Health Social Impact and Community Investment Practice is policy led through an equity lens. With this as a basis, we develop policies that create more inclusive employment and procurement practices to foster local talent and stimulate local economies," says Michellene Davis, Esq., Executive Vice President and Chief Corporate Affairs Officer at RWJBarnabas Health. "We continually seek to focus institutional attention on this issue, as well as work with our partners to ensure that they adopt similar practices. This is how we ensure the growth of our communities."

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–Michellene Davis, RWJBARNABAS HEALTH

The RWJBarnabas Health anchor mission seeks to provide increased opportunities for minority-owned, women-owned, and veteran-owned businesses across the state.

"As part of that process, we conducted contract reviews for construction, supply chain and made adjustment to be more inclusive, including taking proactive measures to adopt a prompt payment policy," says Davis. "By having clear language in our contracts relative to diversity and inclusiveness, we were able to help usher in change."

With hiring practices, RWJBH closely measures race, ethnicity, ZIP code, hourly wages, and other measurements. In addition, RWJBH ensures that the individuals hired from the community are not simply hired into entry-level positions, but they are provided training, certifications and professional development opportunities to ensure that they advance in their career. Davis adds, "Through active career ladders, we want our employees to be well-poised for the next position, we want to ensure that they are the best candidate for the promotion."

RWJBarnabas also recently announced that employees earning a minimum wage will soon see a pay increase to $15 an hour by the first quarter of 2020, which will impact 3,500 of its 35,000 employees. This commitment by the system is faster than the timeline for the recently-enacted state law that will require most businesses to increase their minimum wage to a $15 hourly wage by 2024.

In addition, to help RWJBH employees interact more thoughtfully with patients and the community, helping the system provide equitable care to all, the organization implemented *The Cost of Poverty Experience*. (COPE), a 2.5-hour simulation developed by Think Tank, Inc. Based on the real-life experiences of families affected by generational or situational poverty, COPE provides participants with a more robust understanding of the decisions, trade-offs, challenges, barriers, and inequities that so many within our community face every day. RWJBH supported Think Tank's development of a health care version of COPE, developed in partnership with The Root Cause Coalition, which differs from the community version in that it highlights the social determinants of health and the effects of health disparities in the community.

As part of the program implementation, the Social Impact and Community Investment (SICI) practice contracted with Think Tank, Inc. to train and certify 30 RWJBH employees as COPE facilitators, who will be able to independently host COPEs throughout the system and expand the understanding of the root causes of poverty.

As a payor, **Blue Cross Blue Shield of Minnesota (Blue Cross MN)** has opened the door to addressing social determinants. One key to moving the initiative forward is by changing the internal culture of the organization by integrating health equity into the business.

To facilitate this process, Janelle Waldock, Vice President of Community Health and Health Equity at Blue Cross MN, and her team work with departments within the organization to develop their own health equity plan. She says, "Some departments are seeing a natural link to their businesses. But there are other departments where the connection is not as immediate and we are continuing our dialogue to increase urgency around this."

"In working with departments, we look at what barriers exist to embedding social determinants in their business plan and help them bring a level of intentionality to what they do. When they do that, they see success, they own it, we get it over the hump. With this in mind, we have developed a health equity toolkit that helps teams bring a health equity lens in developing and implementing their plans."

–Janelle Waldock, BLUE CROSS BLUE SHIELD OF MINNESOTA

In helping different departments identify how they are going to measure success, Waldock and her team serve as subject matter experts and as a catalyst support role, almost like a consultancy, in helping company leaders create their health equity goals and build them into business plans.

Addressing the social determinants of health and health inequities tends to be a longer-term process, which can create an inherent tension between the long-term nature of the work and the more immediate or even day-to-day needs that must be addressed by business departments.

"In working with departments, we look at what barriers exist to embedding social determinants in their business plan and help them bring a level of intentionality to what they do," says Waldock. "When they do that, they see success, they own it, we get it over the hump. With this in mind, we have developed a health equity toolkit that helps teams bring a health equity lens in developing and implementing their plans."

In addition, Waldock has dedicated outreach specialists whose sole job is to bring a health equity perspective within the organization where planning is being done regarding business issues. Says Waldock, "These people have high cultural competencies skills and they bring a more expansive view regarding community issues, which can lead to the changes in business programming."

A key aspect of addressing health equity and social determinants is ongoing educating and increasing awareness. According to Danielle Price, Director of Community Health Engagement at **University Hospitals** in Cleveland Ohio, "Some people don't feel that addressing social determinants is in our lane. That we take care of people that are sick and that should be our focus. At the same time, from a different perspective, the community looks at our hospital system and thinks of it as a big corporation that makes a lot of money and that we should be doing more in the community. So we are working to educate these various key stakeholders and help find balance and move the conversation forward."

For Price, the social determinants of health are related to those societal factors influencing health where we live, learn, work, and play. Health equity is more about the fair distribution of resources, not just about disparities. She says, "It is about ideology, culture and how we implement strategies that improve "place." It is about equity, diversity and inclusion.

One critical audience that Danielle is seeking to engage in health equity are middle managers at University Hospitals. To that end, the organization completed a two-day workshop to build the team's capacity regarding equity, diversity and inclusion.

"We spend time managing from the middle, because these are the people who will be implementing," says Price.

"We talked about how we must own community impact and use it as a platform for community health improvement," she adds. "This requires raising awareness with department heads in our hospitals as well as engaging people in the community."

"Through educational opportunities such as the two-day workshop, we are trying to achieve perspective transformation, which is the first step in changing behavior."

ACHIEVING ACTIONABLE STRATEGY #3 THROUGH:

CREATING COMMUNICATIONS PROGRAMMING THAT ADDS CONTEXT TO THE COMMUNITY NARRATIVE

Nearly all of the members interviewed for this health equity report stressed the importance of listening to the community, being in their space and starting the communications process early on when beginning to focus addressing social determinants of health in any given community. They also stressed the importance of establishing communications programming that adds context to a community's already established narrative.

The **RWJBarnabas Health** Social Impact and Community Investment Practice in New Jersey relies on the community and its partners to co-design its initiatives. An example of this was to increase awareness about social determinants. RWJBarnabas Health partnered with youth journalists, Newark Beth Israel Medical Center, and the Greater Newark Community Advisory Board to create a 48-minute documentary that highlighted food insecurity in Newark, New Jersey. The partners then co-facilitated listening sessions throughout the City of Newark to meaningfully engage the community on the issue.

Says Michellene Davis, Esq., Executive Vice President and Chief Corporate Affairs Officer at RWJBarnabas Health, "We conducted sessions with more than 400 attendees from eight different neighborhoods that represented people ages seven to 80 years, and included community residents, clinicians, law enforcement, clergy and food advocacy groups."

The results from the listening sessions were striking. Seventy percent discussed issues of access to food resources such as SNAP; 90 percent discussed community aspects such as gardens, bodegas, and adopt-a- lot;

95 percent discussed the social determinants of health such as lack of jobs, education and transportation; and 100 percent discussed the need for advocacy and policy change. "We have had more than 2,000 Food for Thought documentary hits on YouTube, so it has helped get the word out as well as helped us identify priorities related to how we could help our communities," says Davis. Since the production of this video, in 2018, Newark Beth Israel Medical Center and RWJBarnabas Health have worked with diverse partners to establish or expand policies and programs that address food insecurity in Newark, including:

- The Beth Greenhouse is a sustainable, hydroponic greenhouse that produces more than 5,000 pounds of high-quality, nutritious, locally-grown lettuce, herbs and greens to the Newark area each year. The greenhouse was built to help increase food access in the community surrounding Newark Beth Israel Medical Center which lacks access to fresh and affordable produce. With the release of the documentary, the Beth Greenhouse began accepting SNAP (Supplemental Nutrition Assistance Program) making it the first hospital-based vendor in New Jersey to do so.
- The Beth Greenhouse Farmers Market is hosted weekly inside the main lobby of Newark Beth Israel Medical Center. The market features produce from The Beth Greenhouse. This extends the work of the greenhouse and increases access for individuals.
- The Wellness on Wheels (WOW) Van is a greenhouse and cooking school on wheels. It brings free demonstrations and nutrition education into local neighborhoods. WOW also delivers fresh fruits and vegetables grown from RWJBarnabas Health Greenhouses directly into the community.
- KidsFit is a pediatric weight management program which focuses on establishing healthier lifestyle habits for children via exercise, nutrition and behavioral changes that can foster and boost self-esteem. The goal is to prevent serious health complications later in life, instill education and promote healthier habits in children and the adults that help manage their lives. As a result of the convenings throughout the city, KidsFit has increased its reach and achieved positive behavior change in children.

In addition, RWJBarnabas Health recently advocated for a revision to a policy to enable smaller farms that accept SNAP benefits to also qualify as WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) vendors. Previously, WIC— which operates two key programs, the Farmers Market Nutrition Program and the Senior Farmers Market Nutrition Program— could only be used at farms that had five or more acres of land. This limited access for individuals who lived in areas that WIC certified farmers could not or did not transport goods, as well as limited the ability of small, urban farmers to provide affordable, healthy produce to community residents who qualified for WIC. This change will increase access to fresh fruits and vegetables, increase utilization rates, and stimulate local economies.

Though challenging, collaboration across sectors is critical to the mission of ending hunger, says Kate Maehr, Executive Director and Chief Executive Officer at the **Greater Chicago Food Depository**.

"It is not about us. It is about the people we serve. Health is easy for people to say yes to, but collaboration is hard work," Maehr says. "To collaborate for impact requires trust, financial support and time."

While cross-sector collaboration can be challenging, it can also be very rewarding. Maehr notes that recent work with Cook County Health and other health care systems has achieved some great accomplishments.

"We first started with an educational symposium, where we invited CEOs from business and health care and providers to attend," Maehr says. "Initially, they kind of scratched their heads and weren't quite sure why they were there. But they eventually are becoming advocates."

Listening to the providers was particularly meaningful. She says, "The providers said 'they don't teach us this stuff in med schools.' We had to learn that clinicians don't want to enter into this process without telling the patient about something they diagnosed. It was clear the infrastructure was not in place to enable them to help their patients, and to establish an efficient referral process for patients experiencing hunger. As a starting point, the providers now complete a two-question survey on hunger which is entered in the provider's electronic health record, allowing the provider and the Food Depository to more efficiently track patients."

After conducting an assessment on gaps in where professionals can gather information and resources for addressing food insecurity, **Feeding America** launched a new online resource, *HungerandHealth.org*. The public site aims to educate, connect and engage cross-sector professionals on the intersections of food insecurity, nutrition and health.

"With the development of this website, we wanted to take an intentional focus," says Jessica Hager, Director of Healthcare Partnerships and Nutrition at Feeding America. "We wanted to increase awareness about the reality of food insecurity, engage professionals across various sectors, and empower site users to utilize promising and proven tools and resources for addressing the intersections associated with food insecurity, nutrition and health."

The website, which was developed by a multi-disciplinary team including public health professionals, providers, and the academic community, helps connect dots to external publics more effectively. "Solving food insecurity is not simple and requires the work of diverse partners and communities," says Hager. "As new partners join this important work, we wanted to provide high-quality tools, resources and connection points through a user-friendly platform."

In addition to engaging the public, Feeding America recognized the importance of engaging health care partners in helping solve health inequities. Says Hager, "Providers have an interest and stake in addressing social determinants of health and related inequities. They want to know what they can do, and have come to the Feeding America network to advise, collaborate and partner. Beginning to address social determinants of health, such as food insecurity, in the health care setting is different and requires training and a new way of working."

With this in mind, Feeding America partnered with **Humana** to develop and post a toolkit, on *HungerandHealth.org*, that serves as a resource for health care providers in identifying patients who are food insecure and helping them make connections with community resources to improve their access to healthy foods and public benefits (i.e., SNAP, WIC).

"The toolkit, along with many other tools and resources, has helped to educate, engage and empower healthcare partners in addressing food insecurity. *The HungerandHealth.org* website helps us to reach partners and expand this important work."

Promoting cultural competency across the board within organizations and in the community at large is essential in addressing health equity. As part of that, it is critically important to build meaningful relationships at all levels of the community. Organizations must embrace the leadership and structure that already exists within communities and build on that structure to work with cross sector or other professional partners.

Being able to walk into a neighborhood or a community and really listen without bias or perceived understanding of what it is like to live in the areas of our work will go a long way to building trust, increasing knowledge and ultimately leveraging resources that can reverse and help end the systemic root causes of health inequities.

A CALL TO ACTION

The Actionable Strategies based on the interviews with members of The Root Cause Coalition and the primary care provider survey begin to create a compelling narrative for the need to disrupt and – simultaneously deconstruct and reconstruct our health care delivery model, focusing increasingly on addressing health disparities created through socioeconomic factors that influence health and well-being.

This report dramatically illustrates the hard work that is already in the process to address the social determinants of health from many organizations across the U.S. However, for all these tremendous efforts there is still significant work to be done. We must change and expand the definition of our nation's health care model to consistently include non-medical services and support for the social determinants of health and health disparities among health systems, payors, providers, policy makers, community leaders, and the general public.

To realize The Root Cause Coalition Mission and Vision to reverse and end the systemic root causes of health inequities for individuals and communities through cross-sector approaches, the following actions must be considered and implemented:

BY 2025

1. In payment reform, include methods and processes to ensure payment to care providers and non-clinical community-based organizations for demonstrated value related to addressing health inequity as a result of the social determinants of health. As part of this, develop a reimbursement model from Medicare and Medicaid for services provided by providers and community-based organizations that demonstrate value related to reducing costs, enhancing health outcomes and improving efficiencies while addressing the social determinants of health and health inequities.

2. Create a standardized integrated health benefit technology platform that connects patients, payors, providers and community organizations in order to consolidate fragmented programs and services into an integrated network.

3. Increase by 50 percent the number of commercial health plans and health systems nationally that embed social determinants of health and health inequities goals into their strategic plans, programs and services.

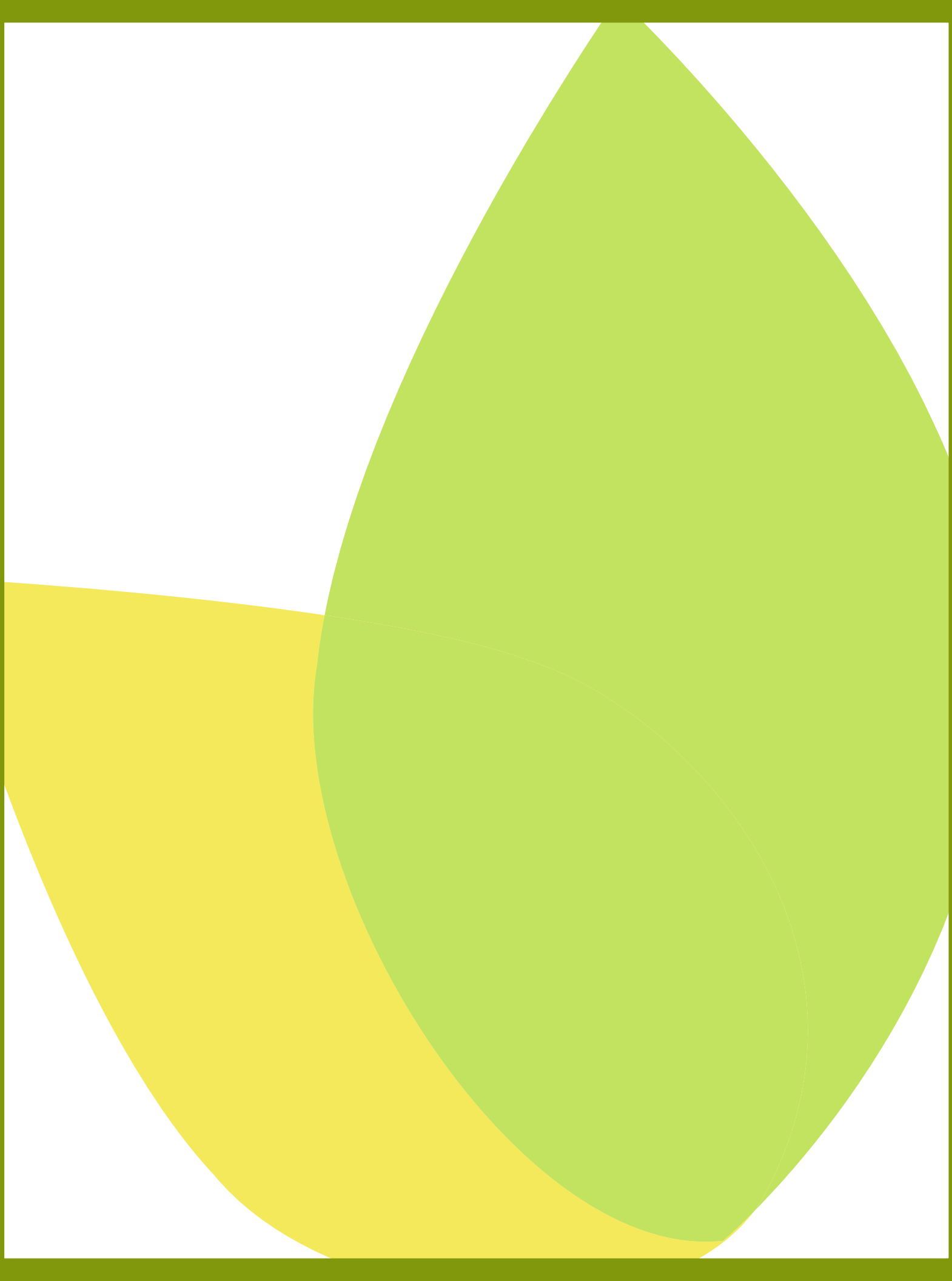
4. In all medical and clinical education programs nationwide, create a more robust system of educating and training providers about health equity and the role health care providers play in addressing these issues and how to effectively integrate that role into their current practice. In addition, ensure that cultural competency training is included in the curriculum.

5. Define a national target for healthcare expenditures (i.e., 15% of the GDP).

6. Develop a comprehensive plan to address our nation's deficits in infant mortality, mental health services and substance use disorders.

7. For health care organizations and corporations nationally, encourage the need to change ongoing education among board members, leaders and employees related to racial equity and cultural competency issues within the workplace.

8. Establish clearer, standardized metrics for measuring health outcomes related to racial disparities and the social determinants of health.



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Lisa Marsh Ryerson, President
Emily Allen, Senior Vice President of Programs

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Qiana Thomason, Vice President of Community Health

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CareSource
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Ceres Community Project
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Ashley Rube, Outreach Coordinator

Successful Aging at the Gary and Mary West Health Institute
Brenda Schmitthenner, Senior Director

University Hospitals
Danielle Price, Director of Community Health Engagement

GLOSSARY

Authentic collaboration: A profound, collective purpose to achieve a shared goal.

Community: A group or populace who live in a specific locality, share government and often have a common cultural and historical heritage.

Community-based organization: A public or private nonprofit organization that is representative of a community or a segment of the community and works to meet community needs.

Creative placemaking: Inspires people to collectively re-imagine and re-invent public spaces as the heart of every community.

Downstream interventions and strategies: Interventions and strategies focusing on ways to deliver equitable access to care and services in order to lessen negative impacts of disadvantage on health.

Evidence-based care: The conscientious use of current best evidence in making decisions about patient care.

Financial stability: The ability of an individual to facilitate and manage financial opportunities and risks, and to absorb financial shocks over time.

Health disparity: A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Health equity: The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Health equity versus health equality: Health equality and inequality relate to the sameness of health; Health equity and inequity relate to the fairness or unfairness/unjustness of health. Health equality refers to allocating resources equally among beneficiaries; Health equity refers to allocating resources on the basis of need.

Payor: A company or an agency that purchases health services, such as insurance companies, health maintenance organization, a care service contractor, or any legal entity responsible for handling claims for health care services.

Placed-based strategies in health: Based on a growing recognition of the relationship between neighborhoods and health, organizations are implementing strategies to improve health in neighborhoods or communities with poor health outcomes.

Providers: Health care providers are all types of health care professionals who directly administer medical aid and/or care to a patient. For example primary care physicians, nurse practitioners, nurses, and physician assistants.

Social Determinants of Health (SDOH): Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.

Upstream interventions and strategies: Strategies and interventions focusing on ways to advance deep-rooted social and economic structures that decrease barriers and improve support systems in order to help people achieve their full health potential.

Value-based health care: A delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes. Value-based care programs reward providers for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way.

For more information on the sources used to create this glossary, please visit RootCauseCoalition.org/SHER

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Second Harvest Heartland • Solera Health, Inc. • St. Louis Area Foodbank

AS OF JANUARY 2020

WHO WE ARE

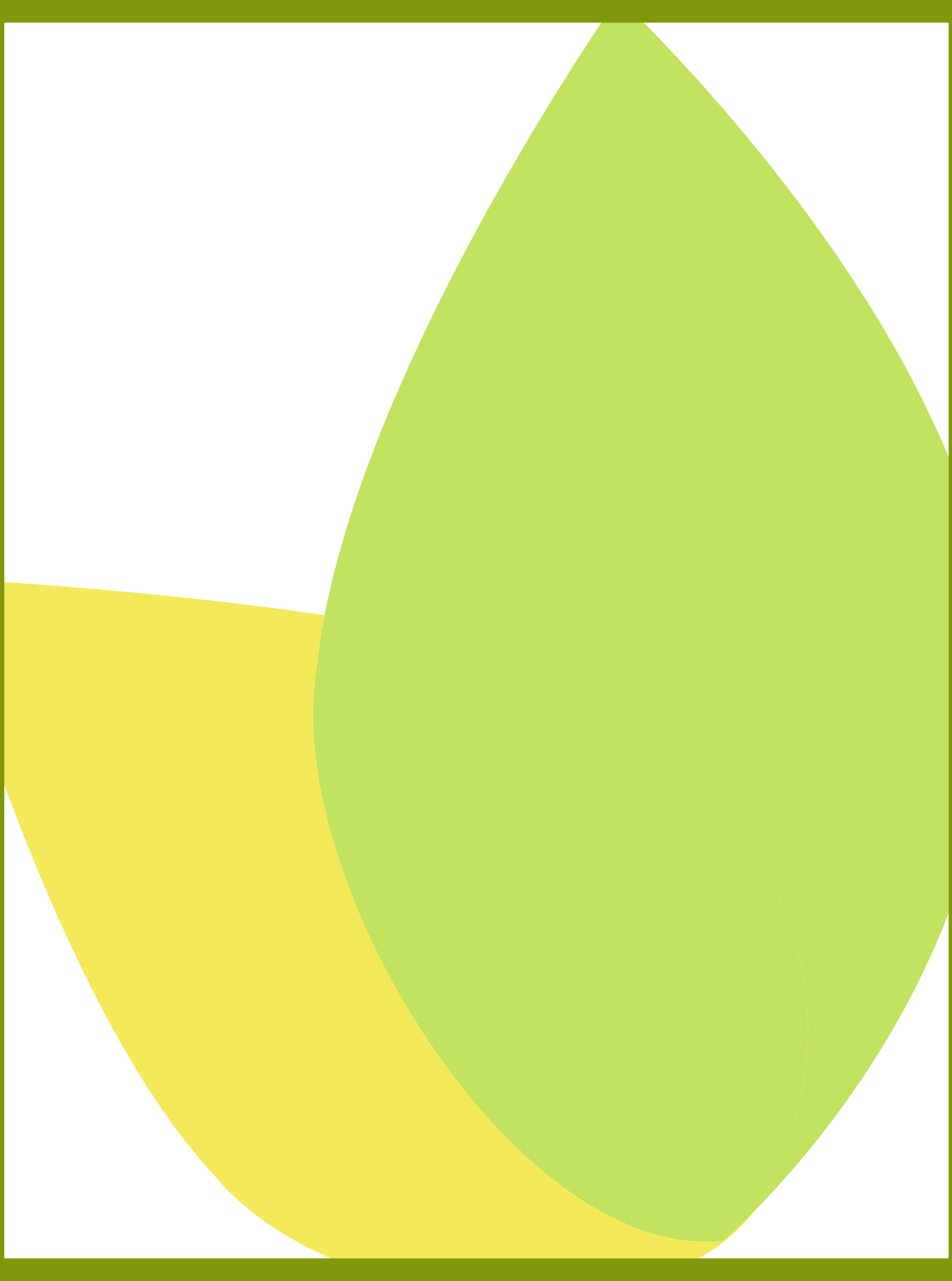
Established in 2015, The Root Cause Coalition is a non-profit, member-driven organization comprised of more than 75 leading health systems, hospital associations, foundations, businesses, national and community nonprofits, health insurers, academic institutions and policy centers. The Coalition works to achieve health equity through cross-sector collaboration in advocacy, education and research. In support of this mission, the Coalition seeks to uphold its four core values: *Focusing on Community Change, Advancing Authentic Collaboration, Scaling Innovative Solutions, and Engaging and Learning from Communities.*

OUR MISSION

We bring awareness and coordinated leadership to address the social determinants of health and their resulting barriers by articulating, demonstrating and advocating for bold and innovative solutions and policies that lead to improved health outcomes and economic stability.

OUR VISION

Reverse and end the systemic root causes of health inequities for individuals and communities through cross-sector approaches and partnerships.



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