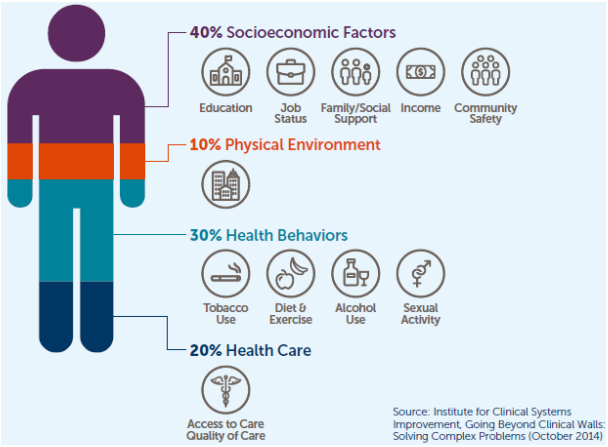
Expand & Enhance Access to Social Care | August 2024

Purpose: This plan outlines an approach for building capacity and reducing barriers across the Olympic region (Clallam, Jefferson, and Kitsap counties) for connecting regional community members to resources and services to address social needs. This plan will inform Olympic Community of Health (OCH) investments and activities in the three-county region. It is expected that this plan will change and evolve over time.

What problems are we trying to solve?

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

Factors that contribute to health



Over two decades of research demonstrates the negative impacts of adverse social conditions on health. Poverty, job insecurity, housing instability, housing quality, environmental pollutants, food insecurity, lack of educational support, social isolation, chronic stress have all been shown to impact health. Recently, research demonstrating the promise of social care to deliver better outcomes at lower cost has increased. Investments in housing, income support, nutrition, education, and coordination are proving to be effective strategies to improve health outcomes and/or reduce costs, thus creating **healthy people, thriving communities**.

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

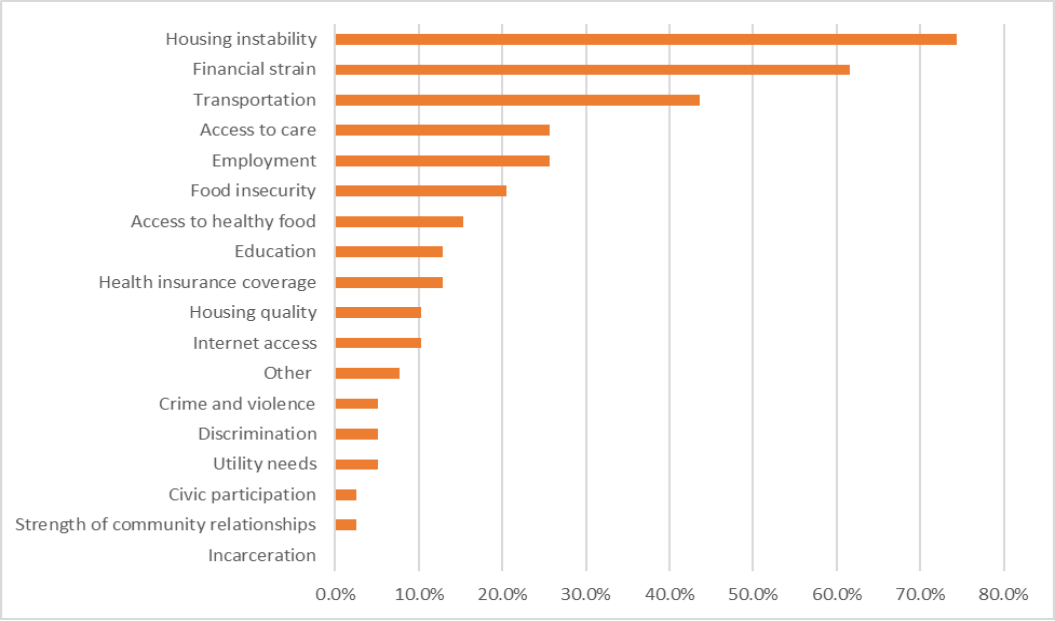
In addition to the challenges faced in working to address social needs, partners in the Olympic region have identified key barriers to supporting community members with social needs:

- Misaligned and unstable financing to address social needs.
- Not enough or nonexistent resources and services to meet community need.
- Gaps in services, fragmented services, services that are difficult to access, and inefficient services (geography, funding, eligibility, workforce, etc.).
- Multiple coordinators; service duplication.
- Lack of systemic county- and regional data to demonstrate full need and progress toward shared goals.
- "Social bed days" and inability to transition from higher levels of care due to social needs
- Infrastructure and capacity at organizations offering resources and supports is challenged (workforce, turnover, funding, trauma, etc.).
    - Systems are often designed to cater to the funder and the agency, not the community members they serve, placing the burden on individuals to navigate complex, cumbersome, and time-consuming systems.
- Lack of understanding of the process, stigma, and fear create barriers to access.
- Lack of knowledge of available resources and services by both community members and providers.

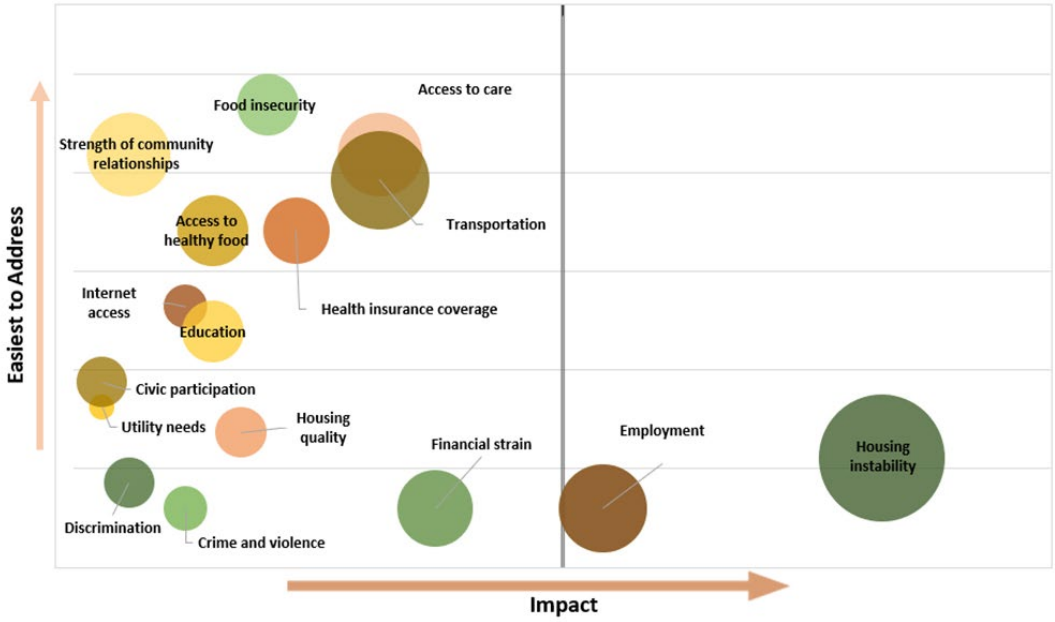
Top Social Needs in the Olympic Region (2020)

Olympic Community of Health worked with Collaborative Consulting in 2020 to dive deeper into the social conditions impacting community members across the Olympic region. A regional survey was conducted to understand the dominant social needs in communities.

Dominant social needs in Olympic region communities (2020)



Regional partners were also asked to rank social risk factors that would have the greatest impact (horizontal axis), that are easiest to address (vertical axis), and that would benefit most from a regional response (circle size).



Interventions to address social needs

Often, intervention efforts focus on reacting to immediate social needs such as providing temporary housing or food, without making their way further upstream to prevent the needs from occurring in the first place. While these activities are necessary and will benefit the individual, there are a multitude of opportunities to prevent social needs. These opportunities range from action focused on individuals to action focused on communities. Actions to address immediate needs can be implemented in concert with upstream actions to prevent the social need. The below table provides an example of levels of interventions to address unmet medical transportation needs.

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

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

Benefits of these opportunities include:

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

Specific areas for enhancement:

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

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

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

Specific areas for strategic action as identified by regional partners include:

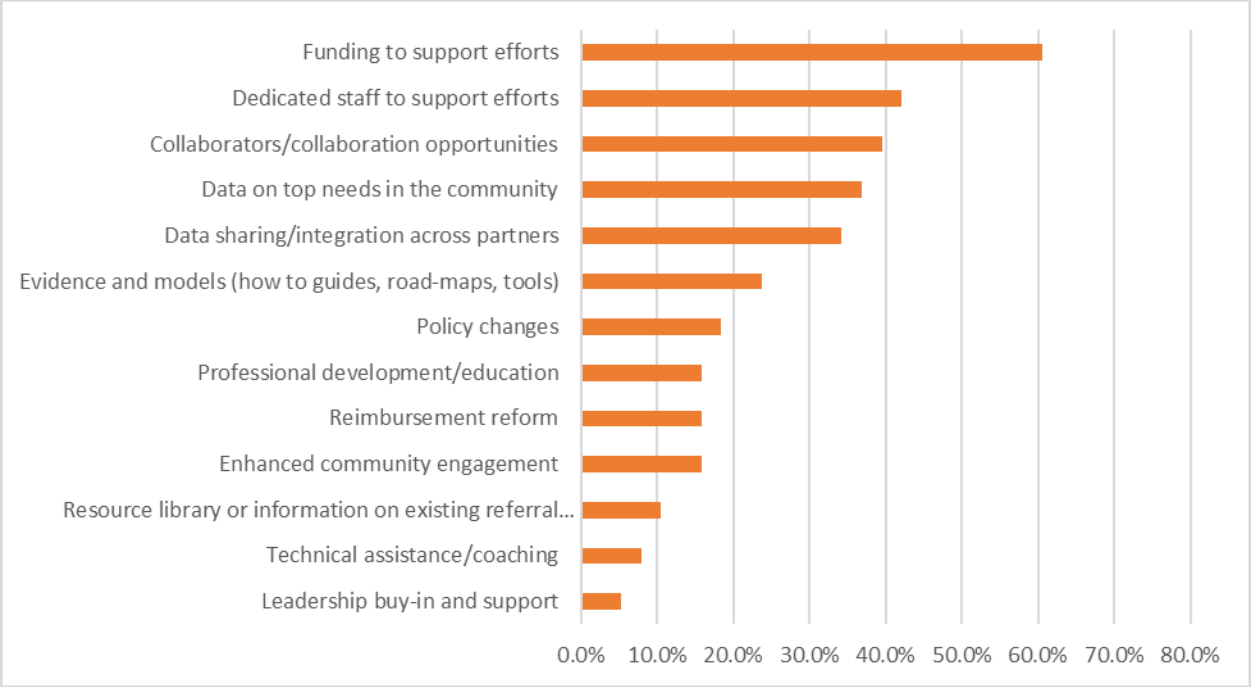
- Address the underlying conditions of employment, housing, and education as they influence each other and other social needs.
- Increase employment opportunities and establish employment programs including job creation, job training, and support to secure living wage jobs.
- Increase access to and availability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

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

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

- Pooled resources and increased leverage to advocate for funding changes.

Resources to increase a social needs focus as identified by partners in 2020:



Top social needs in the Olympic region (2024)

Since releasing the *Transforming & Advancing the Social Determinants of Health in the Olympic Region* report in 2020, OCH and its partners have taken many steps to build capacity and further address social needs and there are exciting opportunities ahead.

In collaboration with local, regional, and statewide partners, OCH and its sister organizations (Accountable Communities of Health or ACHs), are in process of building and launching Community Care Hubs throughout the state. Community Care Hubs are community-driven, regional networks helping community members connect to social and health services that match their unique needs. When community members get the right support — whether job training, food, mental health care, or childcare — their health, their family's health and the health of the whole community improves. With Community Care Hubs, people in every part of the state get what they need to achieve well-being and thrive.

State and federal funders are allocating funding to ACHs in part to build local capacity to better meet regional and community needs for social conditions. In preparation for this new body of work, in 2024 OCH revisited the work of 2020 and connected with partners to identify the top social needs in the Olympic region. Steps OCH took:

- Revisited the 2020 report,

- Reviewed local community health improvement processes and community health needs assessments conducted by regional partners,
- Reviewed inputs that led to the OCH 2022-2026 Strategic Plan,
- Heard from local partners participating in the Olympic region Community Care Hub Advisory Group at their April 2024 meeting and via a subsequent optional survey,
- Reviewed data from OCHs *Connecting to Data* tool (last updated in early 2023), and
- Reviewed notes from a variety of other meetings where regional social needs were discussed.

Based on these inputs, the current top social needs in the region are:

- **Access to the full spectrum of care** including primary care, dental, specialty care, substance use disorder treatment, and mental health treatment
- **Access to healthy, affordable food**
- **Financial strain**/employment/poverty/basic needs
- **Housing** including supportive, transitional, respite, workforce, and general high-quality, affordable housing for all
- **Transportation**

The Path Forward

As OCH and its partners work together to establish a Community Care Hub, a key component of success will be to ensure that community members can be connected to dignified, responsive, local, available, and effective resources and services to get their needs met. This is also a key area for ensuring long-term success and retention of the Community-Based Organizations and the Community-Based Workforce (CBW), those individuals working in a variety of organizations, Tribes, industries, and sectors dedicated to helping connect people to the care and support they need to be healthy and thriving (Community Health Workers, Navigators, Care Coordinators, etc.). This workforce feels satisfied with their work when they can actively connect community members to care and support as opposed to putting them on wait lists or informing them that a need cannot be met.

Starting in late 2024, OCH will take an intentional approach through funding, coordination, and convening, to sustainably build more capacity throughout the region to better address social needs.

Funding

OCH will release funding opportunities to identify regional partners who have expertise and capacity to take steps to:

- Expand eligibility and increase flexible funding for existing programs that are working for the current top social needs.
- Ensure that services and resources are available for all Olympic region community members with an identified need.
- Establish new services and resources as needed.

- Ensure that the region has a healthy balance of interventions that address immediate needs and upstream prevention strategies.
- Grow administrative capacity of community partner entities as needed to ensure long-term success and sustainability.

Coordination

OCH is a recognized bridge builder and problem solver in the region and partners appreciate the role OCH plays in catalyzing change for health transformation. Given the highly collaborative and rural nature of the region, it's imperative to maximize partner efforts through coordination and avoid duplication or overlap.

OCH will:

- Track partner efforts and maintain a regional resource directory to better understand available resources and programs.
- Identify areas that are interconnected and support partners in creating synergies both for partners and community members.
- Enhance referral systems and processes to better connect clients to existing community resources.
- Support data sharing through regional technology to stay on top of resource needs and gaps.
- Provide timely and accurate data and analytics to partners.

Convening

Time and time again, partners identify convening as the most important value add from OCH. Through convenings, partners stay connected, better understand one another's work, and creative and innovative ideas are spread. These issues are complex, and success will happen if partners are working together collectively to address them. The top social needs are not unique to one county or community; they cut across the region. When partners come together, we see increased infrastructure, resources, skills, and innovation.

OCH will:

- Foster dialogue and connections between and among community and clinical partners.
- Create space for sharing successes, challenges, and innovation.
- Identify areas where deeper collaboration could maximize cross-partner efforts and minimize duplication.
- Uplift and celebrate client and patient success stories.