

Health and Wealth

November 8, 2018

Financial Opportunity Center/Bridges to Career Opportunities National Meeting

Houston, TX

Daniela Lewy, MPH, EdLD

Senior Program Officer

LISC National

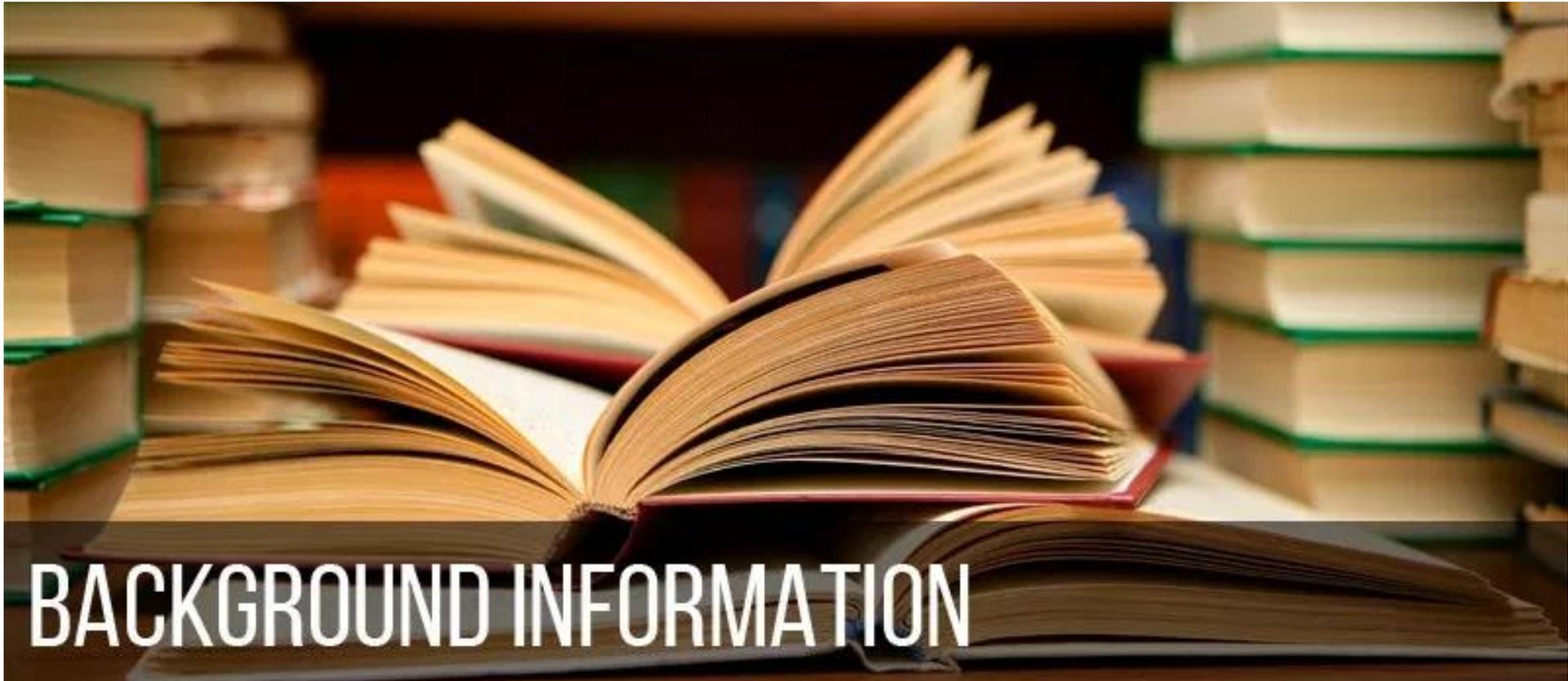
Hello
my name is

Objectives:

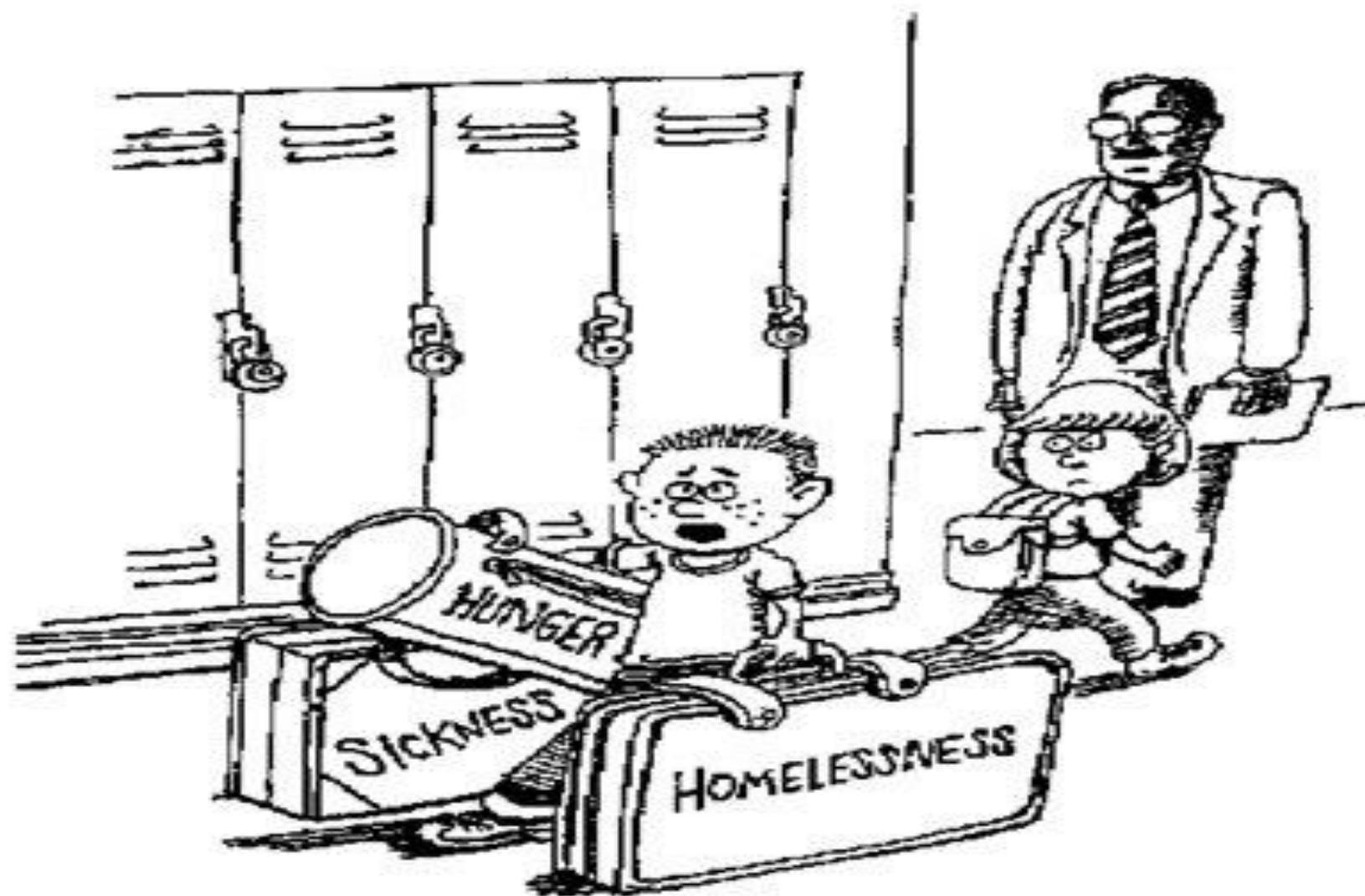
1. Define “Social Determinants of Health”
2. Share connections between health & wealth
3. Articulate the LISC vision for health partnerships
4. Provide examples of health/wealth opportunities



Social Determinants of Health

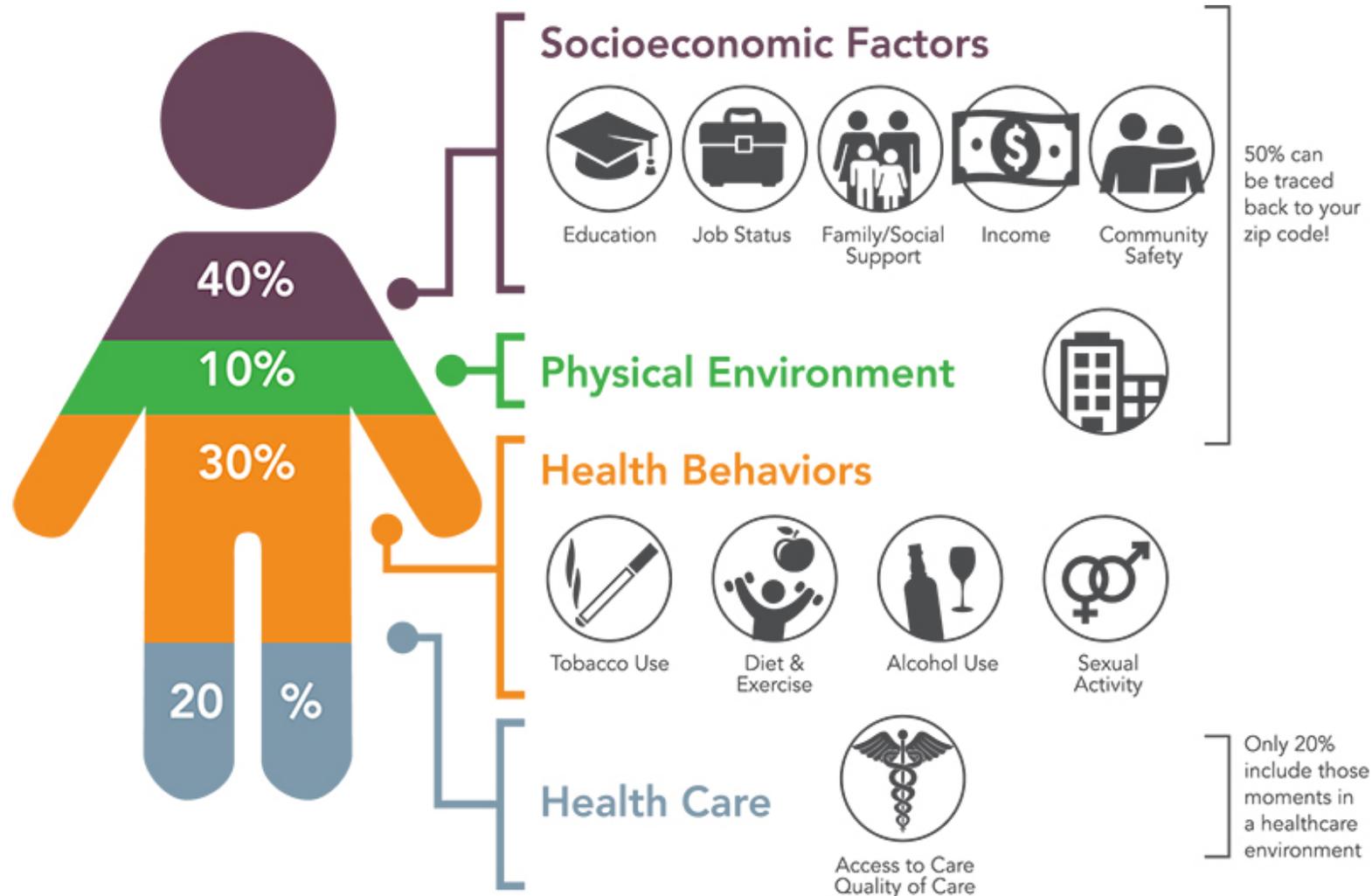


**“Could someone help me with these?
I’m late for math class.”**





Source: Ravi Narayan, SOCHARA, India



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Demography is Destiny



Pick almost any metropolitan area in our country, and you will find 10, 15 or 20 years' difference in life expectancies, depending on where people live.

A baby growing up in the middle-class neighborhood of Richmond, Virginia will likely live to be 83, while a baby growing up in Gilpin, five miles to the east, will likely live to be 63.

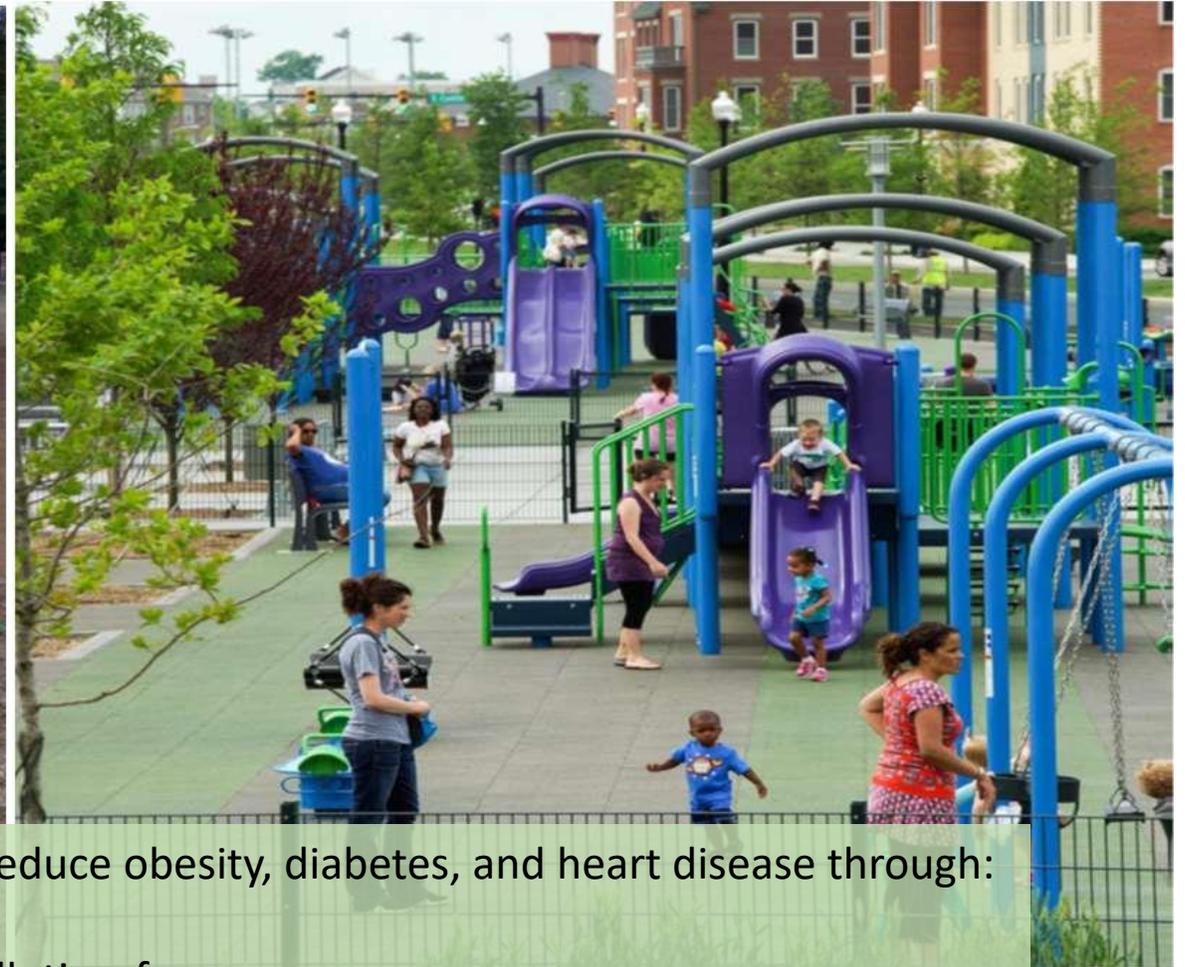
**Our work is complex,
but our philosophy is
simple:**

*We believe that all residents
deserve to shape and live in
thriving neighborhoods of
choice and opportunity.*

Comprehensive Community Development: A Prescription for Health and Health Equity



Place Matters to Health



- Neighborhoods promote mental health & reduce obesity, diabetes, and heart disease through:
 - Safe, crime free places to play
 - Opportunities for exercise in clean, pollution-free spaces
 - Access to fresh produce
 - Fewer liquor and fast food outlets

Food Access Matters to Health



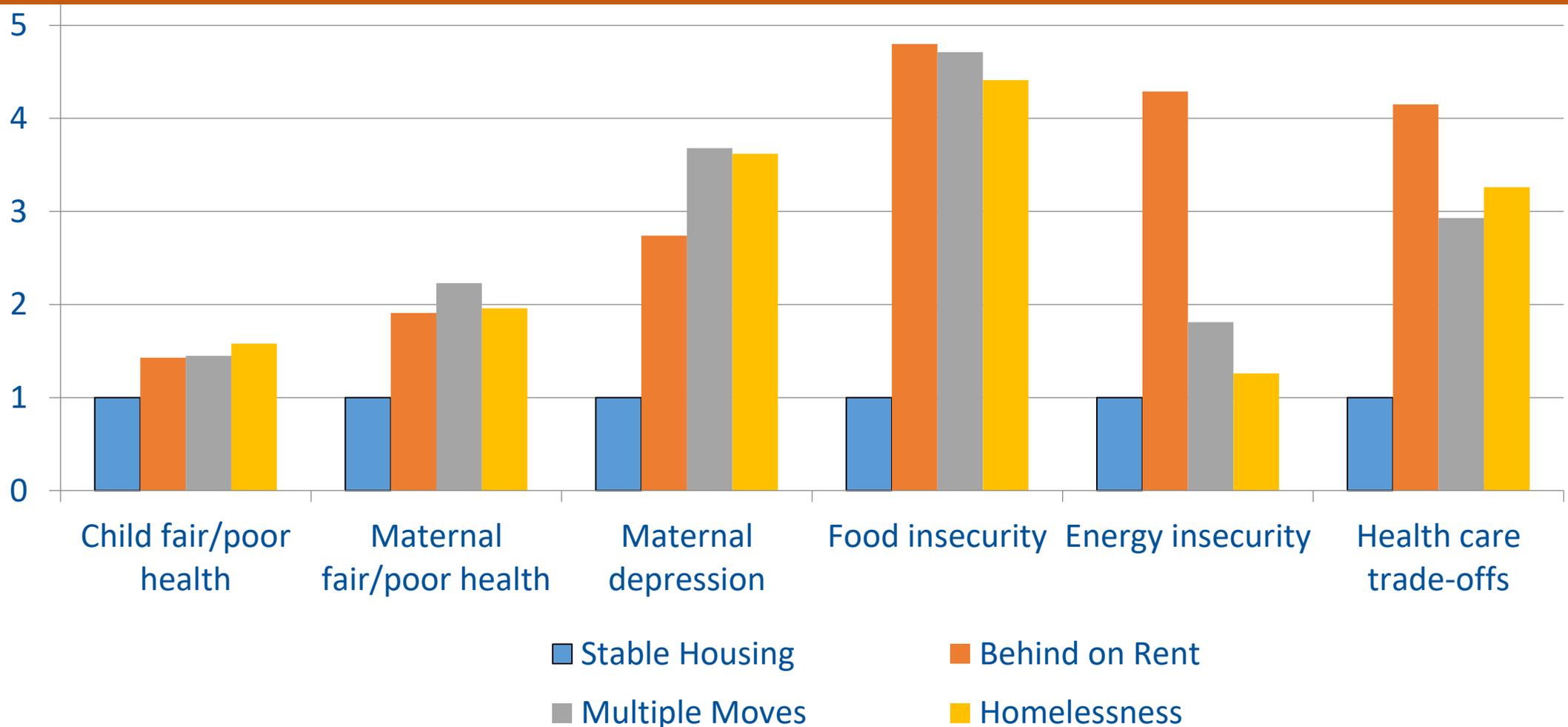
- Almost 39 million workdays are lost to obesity-related illnesses each year.
- Only 21% of adults consume recommended amount of fruits a day.
- Only 33% of American adults eat recommended amounts of vegetables a day.
- Every year, one out of six people get sick, 128,000 are hospitalized and 3,000 Americans die from foodborne illnesses.
- 80% of heart disease, stroke & Type 2 diabetes could be prevented if people ate healthier, were physically active and stopped using tobacco.

Housing Matters to Health



- Americans spend 90% of their time indoors, 2/3 of this time at home – especially vulnerable young children who are exposed to household hazards:
 - Lead – 310,000 children ages 1-5 have elevated blood levels
 - Asthma – 20 million Americans have asthma triggered by pests, poor ventilation, mold, Cancer – carcinogenic materials, smoking, etc.
- Residential crowding leads to infectious disease
- Rent burden can lead to frequent moves – a cause of stress and mental health issues
- Families often choose to pay their rent/mortgage over spending money to go to the doctor
- Poor housing strongest predictor of emotional/behavioral issues in low-income children

Outcomes of unstable housing with health and material hardship outcomes



Violence Reduction Matters to Health

- Homicide rates among 10-to-24-year old African American males (60.7 per 100,000) exceeds that of white males in the same age group (3.5 per 100,000).
- Homicide is the leading cause of death for African Americans, Asians and Pacific Islanders, and American Indians and Alaska Natives between the ages of 10 and 24
- Adults exposed to violence as children are more likely to suffer from chronic health conditions, compared to unexposed adults.
- Increased exposure to violence predicted a higher number of days with asthma-related symptoms in a study of seven cities across the U.S.
- Persons who described their neighborhood as not at all safe were nearly three times more likely to be physically inactive than those describing their neighborhood as extremely safe
- Young people exposed to violence as a victim or witness are at significantly higher risk for PTSD, major depressive episodes, and substance abuse and dependence.

Wealth matters to everything!



Maslow's Hierarchy of Needs



Jobs are needed to build wealth and health

Work and Wages Matters to Health

10 million low-wage workers (often called “working poor”):

- Have less access to health insurance
- Have less access to preventive care
- Are more likely to work in hazardous jobs

Lack of control over working conditions and non-standard hours increase illness, injury, and mortality.

Working poor parents can not afford quality child care, and lack paid leave to care for families & themselves.

Unemployed individuals are more likely to suffer from:

- Stress
- High blood pressure
- Heart disease
- Depression

In the U.S., racial and ethnic minorities, and those with less education, often already at-risk for poor health outcomes, are most likely to be unemployed.

Opportunity Gap, Income Gap, and Life Expectancy

- Structural barriers isolate some neighborhoods from economic opportunity and exacerbate opportunity gaps.
- Global commerce and new required skills mean that residents often struggle to benefit from renewed growth in regional economies.
- Differences in economic opportunity predict stark differences in life expectancy.





- County Health Rankings finds that vocational training for adults increases employment and earnings among participants, including young adults and unemployed individuals
- Increased earnings lead to better medical health benefits, resources for healthier housing, income for healthy foods, and opportunities to live in safer environments



LISC Partnerships with Health Care

Motivations, opportunities, and potential results

Equality

Opportunities for LISC to improve Health and Health Equity



Equity



Why do Healthcare Organizations want to partner with CDFIs?

1

Reduced expense of high cost patients & fewer readmissions

2

Stronger, more stable and plentiful workforce

3

Better and more authentic community relationships

4

Safer more vibrant neighborhoods in which to do business

For hospitals: it is a 2 in 1:

1. Mission Alignment
2. ROI



Opportunities for Community Development to improve Health Outcomes

Employment & Wealth Creation:

- Jobs
- Small business development
- Financial coaching
- Ladders of opportunity

Shelter:

- Affordable housing
- Healthy & green homes

Vibrant Neighborhoods:

- Sound community investment
- Facilities
- Infrastructure
- Amenities
- Safe neighborhoods

Social Cohesion:

- Vibrant arts and cultural development
- Engagement
- Organizing
- Connectedness
- Participation

Education:

- Educated youth
- Early childhood development
- Workforce development

How do we do it?

Policy

Support policy and system changes that create conducive environment for a healthy neighborhood

Investment

Invest in real estate and small businesses

Community Planning

Integrate health considerations into community planning and development

Program Design & Implement

Develop programs with local organizations; expand community partnerships and local capacity

Creation of Financial Products

Structure financial tools and products for investments in SDoH

Evaluation

Target and measure SDoH outcomes; build impact frameworks, analyze, design (and apply) program refinements



What are the funding sources from Healthcare Partnerships?



1.



2.



3.

Health Foundations

LISC Partnership Example

LISC-ProMedica Investments for Healthy Communities



\$25 million loan fund

- \$10 million from ProMedica and \$15 million from LISC over 10 years
- Financing for quality affordable housing, small businesses and community facilities
- Focus on Toledo and surrounding region
- Projects are screened and tracked for the health impact they produce for people and communities



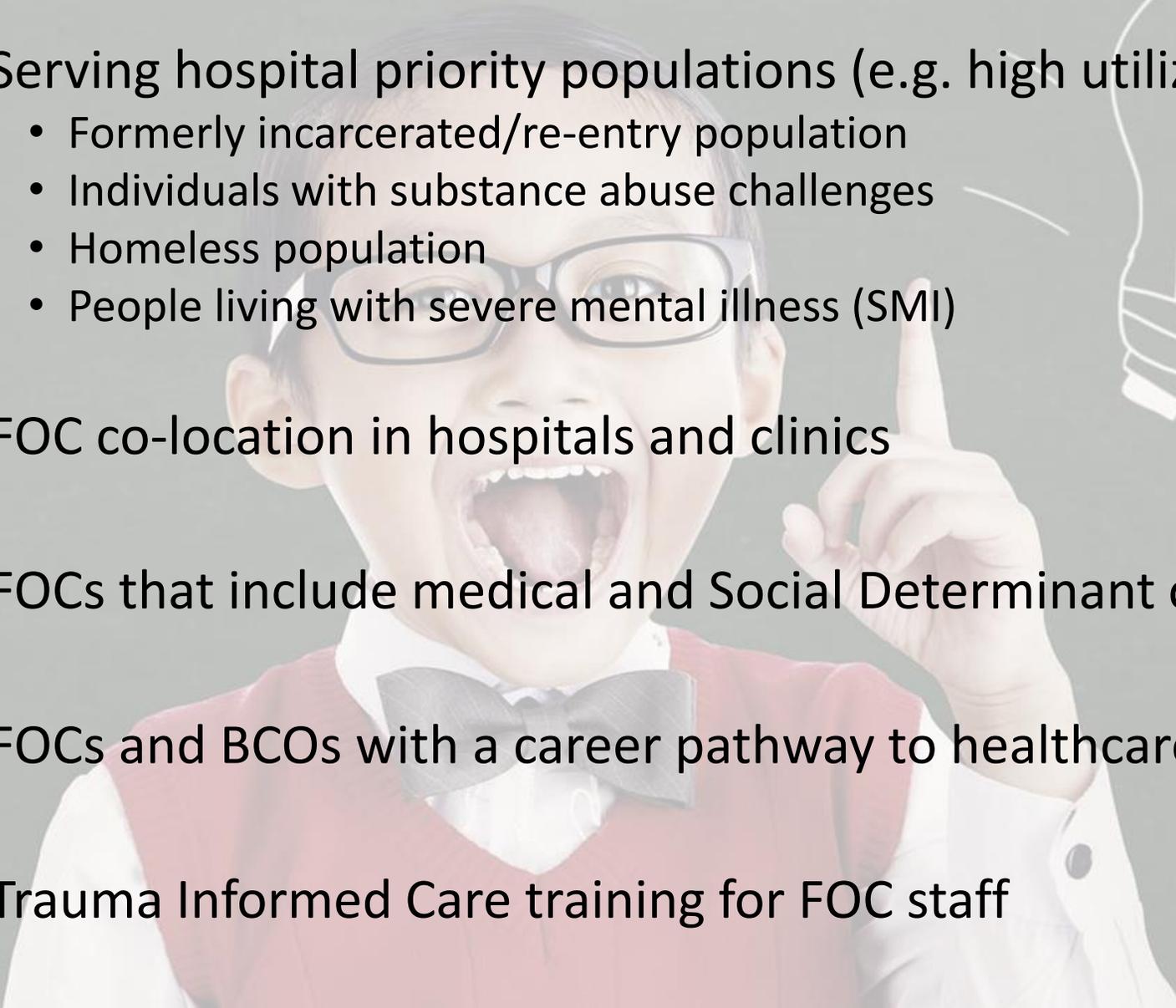
\$20 million grant pool

- \$10 million from ProMedica and \$10 million from LISC over 10 years
- Supports community programs and services that address safety, economic opportunity, healthy food access and other social determinants of health
- Shared commitment to advancing research and measurement at the intersection of health and community development



Examples of FOC/BCO opportunities with Healthcare Institutions

- Serving hospital priority populations (e.g. high utilizers):
 - Formerly incarcerated/re-entry population
 - Individuals with substance abuse challenges
 - Homeless population
 - People living with severe mental illness (SMI)
- FOC co-location in hospitals and clinics
- FOCs that include medical and Social Determinant of Health referrals
- FOCs and BCOs with a career pathway to healthcare positions
- Trauma Informed Care training for FOC staff





Any Questions?

HonorHealth Desert Mission



A Community Born from Service

Desert Mission began in 1927 and addressed the health and social needs of struggling families in North Phoenix.

We continue that legacy today by making health and social services accessible to the most vulnerable members of our community.

Strategic Planning Link

Mission: *To improve the health and well-being of those we serve.*

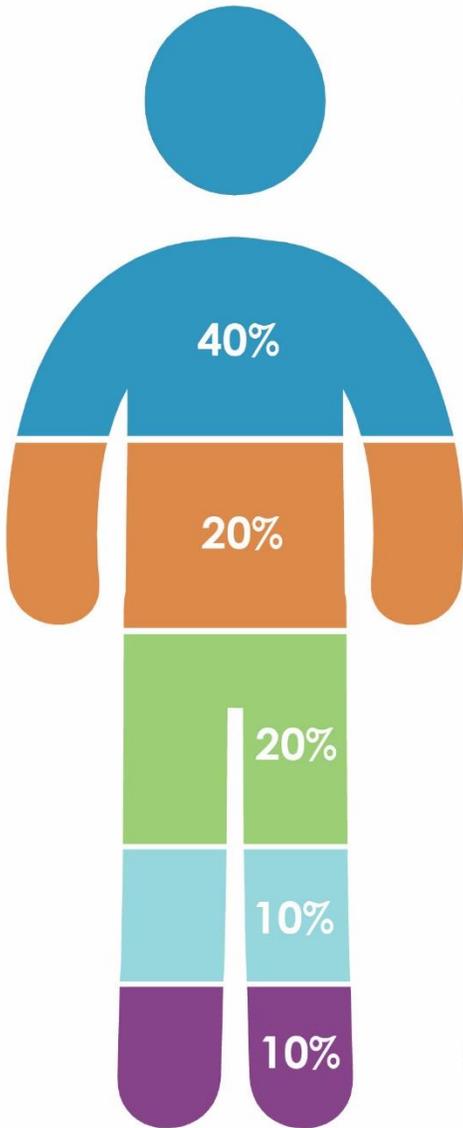


2015 HonorHealth Priority Needs

- Mental and Behavioral Health
- Substance Abuse
- Geriatric Health
- Chronic Disease Prevention and Management
- Social Determinants of Health

DETERMINANTS OF INDIVIDUAL HEALTH

20 percent
of health
and well being
is related to
access to care
and
quality of services



- SOCIOECONOMIC FACTORS**
 - Employment
 - Education
 - Family
 - Social group
 - Housing
 - Income
- MEDICAL CARE**
 - Access to care
 - Quality of care
 - Insurance
- HEALTH BEHAVIORS**
 - Nutrition
 - Physical activity
 - Tobacco & alcohol use
 - Chronic disease maintenance
- PHYSICAL ENVIRONMENT**
 - Home environment
 - Neighborhood walkability
 - Safe outdoor space
 - Pollutants & toxins
- BIOLOGY & GENETICS**
 - Predisposition to chronic issues, cancer etc.
 - Overall physiology

The Impact: Social Determinants

The World Health Organization defines social determinants of health as circumstances in which people are born, grow up, live, work and age, and the systems put into place to deal with illness.

These circumstances have tremendous affect on one's health. And, they can affect anyone, regardless of age, race, ethnicity.

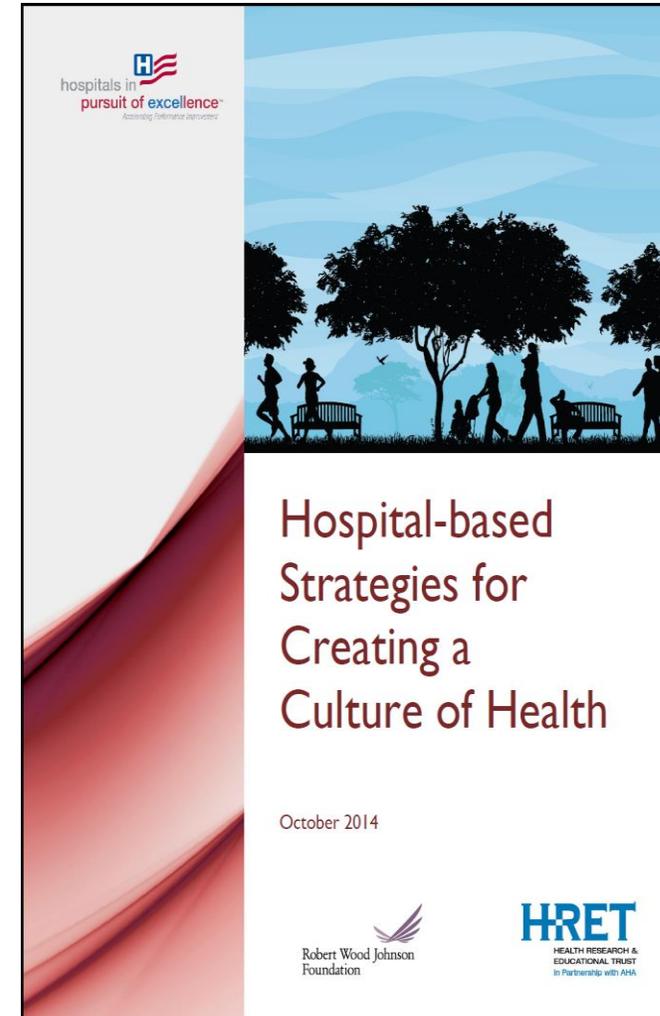
For example, in the U.S. each year,

- **1.48 million individuals are homeless**
- **3.6 million people cannot access medical care due to lack of transportation**
- **42 million people face hunger, and**
- **12.7 percent of households are food insecure**

Robert Wood Johnson Foundation: Culture of Health Best Practice

Robert Wood Johnson Foundation and their team of social, economic, health and national outcomes researchers, released their annual report in December of 2014 which stated:

“Your mortality and your health outcomes are determined MORE by your **ZIP CODE** than your genetic code or the quality of your health care”



Building the Elements of a Successful Service Delivery Model



“Food Insecurity...”

- USDA’s measure of lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods.
- Food-insecure households are not necessarily food insecure all the time. Food insecurity may reflect a household’s need to make trade-offs between important basic needs, such as housing or medical bills, and purchasing nutritionally adequate foods.

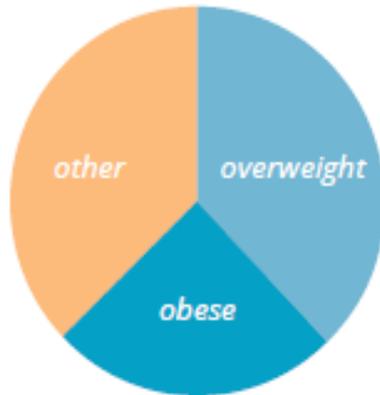
Primary Care: Food Insecurity Screening

American Academy of Pediatrics

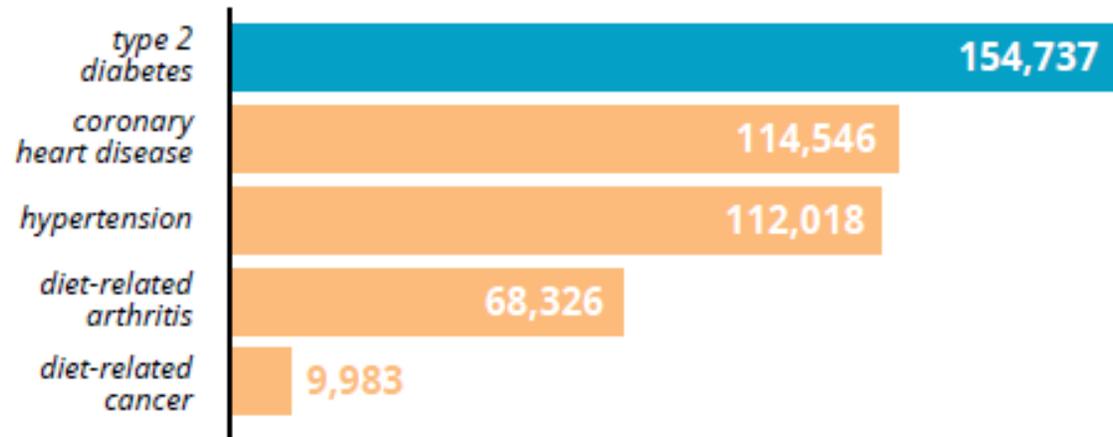
DEDICATED TO THE HEALTH OF ALL CHILDREN™



*Nearly 2 in 3 Arizonans are overweight or obese.*¹¹



Nearly 500,000 Arizonans will face diet-related illness by 2030
Type 2 Diabetes will be the most common diet-related illness.¹²



A Call For *Continued Innovation...*

- Food Insecurity Screening: EPIC
 - Discharge planning, Referral Resources
- Diabetes “Wellness” Boxes
 - Transition Specialist Program
- Financial Wellness and Opportunity Center
 - Job training, budgeting, case management

Screening for Food Insecurity

ferences Dictations Media Manager Preview A/S Print A/S Request Outside Records

Food Insecurity Questionnaire - Food Insecurity

Time taken: 1428 2/2/2017

Values By [Create Note](#)

During the last 12 months

Did you worry that your household would run out of food before you were able to get more?	<input checked="" type="radio"/> Often	<input type="radio"/> Sometimes	<input type="radio"/> Never	<input type="radio"/> Don't Know
Did your household run out of food before you were able to get more?	<input type="radio"/> Often	<input type="radio"/> Sometimes	<input type="radio"/> Never	<input type="radio"/> Don't Know
Would you like a referral to Desert Mission Food Bank?	<input type="radio"/> Yes	<input type="radio"/> No		

(K) Restore Close F9 Cancel

ACO Coach Note

Nutrition Call to Action...

- Food Bank Nutrition Policy
- Foods to Encourage Model
- Diabetic Wellness Food Box Pilot
- Nutrition Education Program
- Gardening
- Farm Stand



This symbol signifies a healthy choice item in the food bank market



FOOD IS MEDICINE

**Fresh, local
produce
direct to
your kitchen**

HONORHEALTH®

Desert Mission Farm Stand

desertmission.com/freshveggies

Desert Mission Farm Stand

Enjoy fresh produce
from Arizona farmers

- ✓ Bring a bag and pick up fresh vegetables and fruit.
- ✓ Choose what you'd like from seasonal and organic options.
- ✓ Pay with a credit/debit card or cash. SNAP benefits accepted at John C. Lincoln and Scottsdale Osborn medical centers.

Enjoy the crunch!

Farm Stand schedule:

Visit your nearest HonorHealth medical center from 11 a.m. to 1 p.m., on select Wednesdays to shop the HonorHealth Farm Stand:

- 1 HonorHealth Deer Valley cafeteria
1st Wednesday of the month
- 2 HonorHealth John C. Lincoln cafeteria
1st Wednesday of the month
- 1 HonorHealth Scottsdale Thompson Peak cafeteria
2nd Wednesday of the month
- 1 HonorHealth Scottsdale Shea cafeteria
3rd Wednesday of the month
- 1 HonorHealth Scottsdale Osborn cafeteria
4th Wednesday of the month

Learn more at desertmission.com/freshveggies

12312_0918

HONORHEALTH®

Living Well Program: Call to Action



Financial, Career & Home Success Partnerships:

- St. Joseph the Worker
- HonorHealth Human Resources
- Local Initiative Support Corporation (LISC)
- Coming Soon: Housing Partner...

Living Well FOC

- Income Supports, Workforce Development and Financial Coaching:
 - Services include resume writing, mock interviews, free credit report, financial coaching, matched savings program.
 - The program is evidenced-based and has been proven to increase income and job retention.

Living Well: YTD 2018 Impact

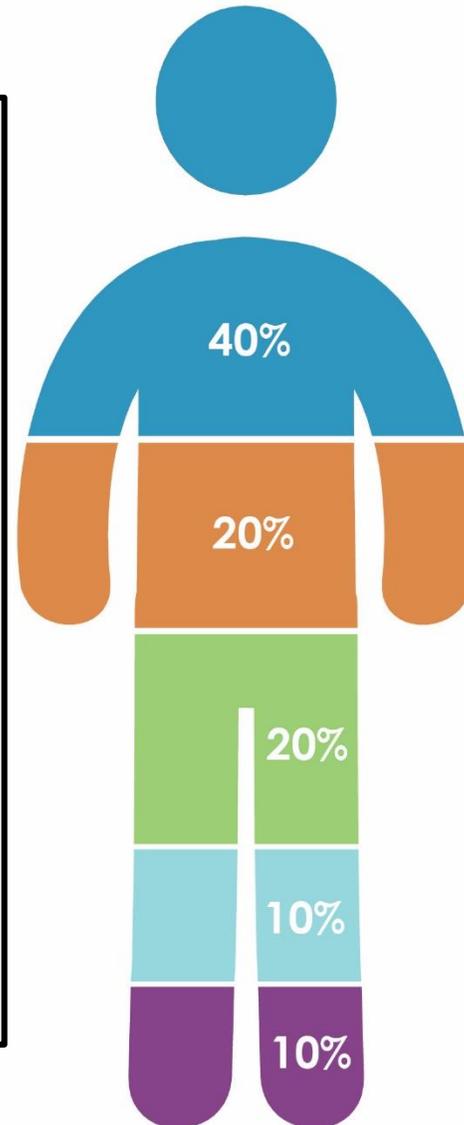
- Participants Enrolled: 140
- Participants Employed: 137
- Participants with Action Plan: 139

- 70% of Participants are using 2/3 FOC Services

- Success Story...

DETERMINANTS OF INDIVIDUAL HEALTH

70 percent
of health
and well being:
Social
Determinants,
Health Behaviors,
Physical
Environment



- Employment
- Education
- Family
- Social group
- Housing
- Income



- Access to care
- Quality of care
- Insurance



- Nutrition
- Physical activity
- Tobacco & alcohol use
- Chronic disease maintenance



- Home environment
- Neighborhood walkability
- Safe outdoor space
- Pollutants & toxins



- Predisposition to chronic issues, cancer etc.
- Overall physiology

Desert Mission

Celebrating 90 years of service

Making health and social services accessible to the most vulnerable members of our community



For more information visit desertmission.com.

HONORHEALTH®

HONORHEALTH®