Impact Report

Fall 2024

Thrive18

A Community-Based Approach to Social Determinants of Health

Presented By:

The Buhl Foundation Highmark Health Project Destiny, Inc.

TABLE OF CONTENTS

EXECUTIVE PERSPECTIVES

Rev. Dr. Brenda Gregg

Executive Director, Project Destiny, Inc.

Over one year ago, when the health emergency was declared over, there was a collective sense of relief that the pandemic had come to an end. However, despite the world moving towards a new normal from personal experience and witnessing the COVID-19 cycle, its enduring impact persists. Many continue to mourn the loss of loved ones, grapple with ongoing health issues stemming from the virus, and face the repercussions of missed educational and employment opportunities. The aftermath of the pandemic continues to affect individuals striving to rebuild their lives and find stability in a changed world.

I am thrilled to share the remarkable impact of our community health outreach initiative, Thrive18, over the past several years. From October 2018 to May 2024, our dedicated team has canvassed over 11,000 households, reaching out to every corner of our community with a mission to enhance health and well-being.

One of the pivotal aspects of our outreach efforts has been the completion of social determinants of health surveys by over 3,200 households. These surveys have provided invaluable insights into the unique challenges individuals and families face in our targeted Northside communities, enabling us to tailor our support services effectively.

Equally inspiring is the fact that we've successfully connected over 2,900 households to vital social and healthcare support. Whether it's ensuring access to essential healthcare services, assisting with housing, or facilitating access to nutritious food, these connections are making a tangible difference in the lives of our neighbors.

These achievements underscore our unwavering commitment to addressing the root causes of health disparities and promoting equity across our community. By focusing on social determinants of health and fostering meaningful connections, we are laying the foundation for a healthier, more resilient community for generations to come.

I want to thank our grant funders, Highmark Health and Buhl Foundation, whose generous support has been instrumental in making our outreach efforts possible. Additionally, I am deeply grateful for the collaboration of over 300 local service partners, whose dedication and expertise have been essential in connecting our families to the resources they need.

Most importantly, I want to recognize that this is a resident-driven approach. I extend my sincerest gratitude to the community residents in all 18 Northside communities for their active participation and invaluable feedback, which has been instrumental in making this intervention effective and noteworthy.

None of this would have been possible without the dedication, trust, and support of each of you.

Thank you for your continued support.

EXECUTIVE PERSPECTIVES

Dan Onorato

EVP, Corporate Affairs, Highmark Health

At Highmark, we understand that health is more than just healthcare. It's deeply intertwined with the fabric of our lives – the conditions in which we are born, grow, work, live, and age.

We believe in collaborating with local partners to create a community where everyone has an equal opportunity to thrive. This means increasing access to the healthcare system and investing in social determinants of health, such as education, food security, housing, and social inclusion.

Strong partnerships and investment in community resilience are crucial for lasting change.

Our multi-year investment in Thrive18 exemplifies this approach. It demonstrates how investing in local organizations, which have earned credibility and trust within the community, can improve key health indicators in ways that government and the healthcare system alone cannot.

This report highlights the positive changes Thrive18 and Project Destiny have brought to the lives of individuals and families in Pittsburgh's Northside community. As a boy who grew up on the Northside, this project holds a special place in my heart. I am optimistic that by sharing the lessons learned from this initiative, we can inspire more multi-sector collaborations to improve community health.

As we continue to learn and grow, Highmark remains dedicated to finding new and innovative ways to expand our work in addressing social determinants of health and to play our part in pursuing more equitable and thriving neighborhoods.

We believe that by working together, we can create a future where everyone can achieve their best health.

EXECUTIVE PERSPECTIVES

Diana Bucco

President, Buhl Foundation

In 2013, the Buhl Foundation asked the residents of the Northside, "what does it take to live a dignified life?" What we heard led to a 20-year commitment and the formation of a place-based community building and grantmaking strategy to improve the quality-of-life of Northside residents called One Northside.

Through Buhl's One Northside work, we quickly came to understand our most vulnerable neighbors lacked the basic needs that many of us take for granted – food, shelter, transportation, and access to healthcare. We witnessed that "traditional" interventions were not working.

This awareness motivated a partnership with Project Destiny, Inc. and Highmark Health to design a new way forward. In 2017, the BUILD Health Challenge grant funded through the Kresge, Robert Wood Johnson, and Kellogg foundations awarded our collaborative effort the ability to pilot a new approach that the residents of the Northside named Thrive18.

Now, in its seventh year of operation, Thrive18's unique approach continues to connect the most vulnerable residents with the direct services they need through hands-on community outreach workers, themselves trusted community residents. This report highlights that by addressing a resident's most basic needs through compassionate and non-judgmental case management and care, the Thrive18 model works and can improve health outcomes.

Sophisticated data collection, and statistical analysis of resident outcomes spearheaded by Highmark Health, along with organizational collaboration led by Project Destiny, Inc. between the nonprofit, healthcare, and public sectors reveal the interconnectivity of a wide swath of issues – from primary care physician and emergency room visits, to school attendance, utility bill support, and food access.

The Buhl Foundation is grateful for the leadership of Reverend Gregg and her team who spend countless hours, day and night, delivering high-quality care to the residents of the Northside. We are also grateful to Highmark Health leadership for investing in a different way of work and having honest and thoughtful conversations about how current service delivery models and approaches by our public systems can be more effective when caring for our most vulnerable residents.

I believe that the Thrive18 model is the catalyst that we as a region can and must learn from to effectively tackle the quality-of-life root cause issues that have long persisted in Allegheny County and beyond.

We are dedicated to allowing the work to further evolve, and to understanding more deeply how these seemingly disparate social determinants of health can, and do, impact a family's overall quality of life and the overall health of our communities. By continuing to work together, we can make meaningful changes that allow all the city and region's children and families to live a dignified life.

Thrive18 Mission

To improve the health of the City of Pittsburgh's Northside residents by addressing the social determinants of community well-being.

Thrive18 Vision

If we meet our more vulnerable population's basic needs, then their physical, mental, and financial health will stabilize and improve.

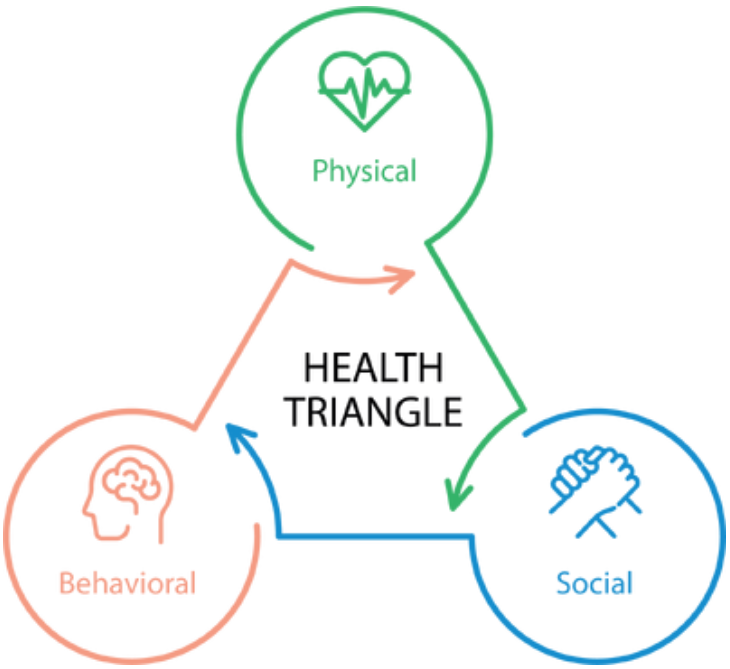
OVERVIEW AND TIMELINE

Overview

Social determinants of health (SDOH), such as access to nutritious food, transportation, safe housing, and jobs that provide a living wage, can impact up to 80% of health outcomes. (1,2,3) That is why an increasing number of community organizations, government health agencies, and health system payers and providers have created programs to help identify and address basic social needs. Effective SDOH strategies must assess the unique risks faced by each population and expand care to address those needs, including connecting patients with appropriate community resources.

Doing so can improve health outcomes while also reducing unnecessary emergency visits, lowering hospital readmission rates, and decreasing total cost of care. (4)

In 2018, through the BUILD Health Challenge grant and matching funds from the Buhl Foundation and Highmark Health, Thrive18 launched as an initiative to mobilize, hire, and train Northside residents as community health workers (CHW). (5) The neighbor helping neighbor approach has fostered a renewed sense of confidence and trust ensuring residents can receive the help they need to improve their quality of life and receive medical care.



These Thrive18 CHWs identify health-related social needs and barriers to care, some of which may not be known to a person's health care providers. The American Public Health Association (APHA) defines community health workers as "frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served." This trusting relationship enables the worker to serve as a link between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. (6)

"To effectively address behavior change and build trusted relationships with populations affected by healthcare and social determinants of health, the Thrive18 model essentially considers Maslow's Hierarchy of Needs. This psychological theory posits that individuals have a set of needs organized in a hierarchical order, from basic physiological needs to higher-level psychological needs. Understanding this hierarch has guided the approach of Project Destiny's outreach team, creating a supportive relationship and fostering trust.

At the base of Maslow's pyramid are physiological needs, such as access to food, water, shelter, and healthcare. The Thrive18 outreach team has initially focused on addressing these fundamental needs through the responses and feedback from participants. By ensuring reliable access to these essentials, the Thrive18 outreach team has helped to alleviate immediate stressors and establish a stable foundation, allowing individuals to progress toward addressing higher-level needs." – Dr. Daphne Curges, Director of Thrive18, Project Destiny, Inc.

Food insecurity, housing, and issues related to education, transportation, and utilities account for nearly two-thirds of barriers to health and well-being in households surveyed by Thrive18. These dedicated CHWs then step in to connect residents to healthy foods, liaise with landlords to remedy housing issues, assist with General Education Development (GED) and government benefits paperwork, and much more. They provide warm hand-offs to other community-based organizations (CBOs) who help meet specific social needs, while also referring residents back into the health system to address health care needs and establish a usual source of preventative healthcare.

"Addressing social determinants of health isn't just about treating illness; it's about transforming lives and communities. At Allegheny General Hospital and Allegheny Health Network, we believe that healthcare should encompass the whole person, addressing not only medical needs but also the social and economic factors that impact health outcomes. The Thrive18 program has been instrumental in this mission, offering tailored support to meet SDOH needs, ensuring our patients receive comprehensive care that extends beyond the hospital walls." - Imran Qadeer MD, President of Allegheny General Hospital

Timeline

In 2013, the Buhl Foundation, in partnership with local community leaders in Pittsburgh's Northside, formed a unique coalition to improve the quality of life for all its residents, called One Northside. The resident-driven coalition established working groups in five pillars – education, employment, safety, housing, and health. Thrive18 began in 2018 after receiving a BUILD Health Challenge grant with funding matched by Highmark Health and the Buhl Foundation.

After the grant funding period ended in 2019, Highmark Health and the Buhl Foundation continued financial support for the Thrive18 program based on early indicators that the program was making a positive impact in the lives of Northside residents, including decreased emergency department (ED) utilization and increased well visits.

Before the COVID-19 pandemic, the Thrive18 team prioritized outreach through neighborhood canvassing to identify individuals with social needs. During the pandemic the Thrive18 team pivoted from neighborhood canvassing to telephonic outreach and accepted referrals from community partners, serving as a lifeline for many Northside residents. From March 2020 through 2021, the Thrive18 team received 7,335 referrals, completed a comprehensive SDOH survey for 2,207 (30%) households, and enrolled 2,006 (91%) of those households into the Thrive18 program.

In 2023, Project Destiny, Inc., Highmark Health, Highmark Wholecare, Allegheny Health Network, and the Buhl Foundation worked collaboratively through a human-centered design approach to optimize the program based on learnings from the previous 5 years. From here, the collaborative designed Thrive 2.0, building upon the foundation of data driven, sustainable, whole person health program concepts. Implementation and evaluation of the Thrive18 2.0 design is the current focus.

"With all these voices working together, making those connections to community resources it's highly aligned to addressing the whole person as a part of Wholecare."
- Ellen Duffield, President & CEO
Highmark Wholecare

2018

Thrive18 program begins after receiving a BUILD health challenge grant with funding matched by Highmark Health & the Buhl Foundation

2019

Once grant funding ends Highmark Health & the Buhl Foundation continue financial support

2020

Thrive18 program focuses efforts on crisis management & fostering relationships with their community in light of the Covid-19 pandemic

2023

Thive18 leadership in collaboration with AHN, Buhl Foundation, and Highmark Health designs Thrive18 2.0

2024

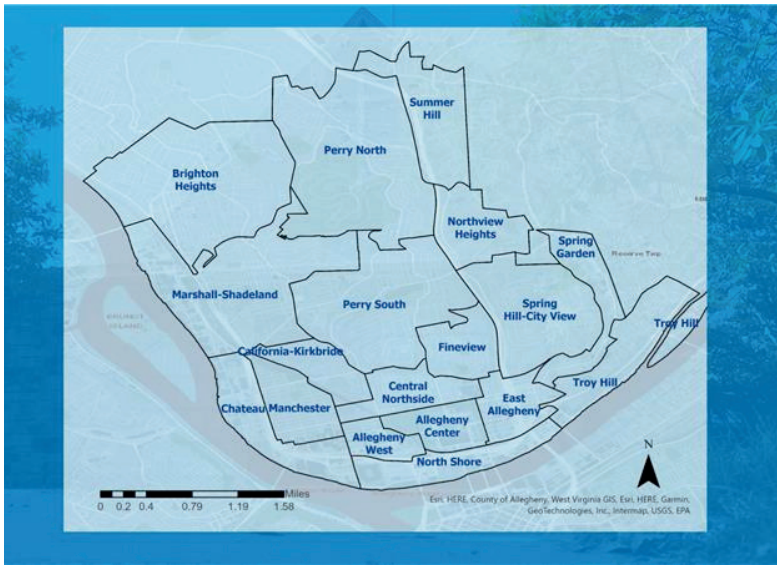
Efforts focus on implementation of Thrive18 2.0 and evaluation planning

Meet Project Destiny, Inc.

Project Destiny, Inc., located in Pittsburgh, Pennsylvania, has been a beacon of support since its establishment in 2004. Dedicated to serving the Northside communities of Pittsburgh, Project Destiny, Inc. offers vital resources, support groups, and enriching cultural, educational, and community health programs for youth and families. Through collaboration with community partners, Project Destiny, Inc. delivers essential information and services that enhance the quality of life in underserved areas. At its core, Project Destiny Inc.'s mission is encapsulated in its commitment to REIGN: Reach, Educate, Inspire, Grow, and Nurture youth and their families of Pittsburgh.

PITTSBURGH PA'S NORTHSIDE

"There are multiple barriers to health in the Northside. We have a large number of Northsiders, who, according to the census, are living in poverty, or are classified as working poor. That is why the services of the Thrive18 program and the trust they build is so vital to the wellbeing of this community." – Diana Bucco, President, The Buhl Foundation



Pittsburgh's Northside is not a single neighborhood, but rather a collection of 18 unique neighborhoods spread across the shores and hills north of the Allegheny and Ohio rivers, directly across from the Downtown area. (7) The Northside is diverse and vibrant and brings a rich history to the region. Once a thriving hub of industry and innovation, the Northside communities faced economic decline in the 20th century due to manufacturing shifts and urban renewal efforts that failed to revitalize the area. Despite these challenges, the Northside retains a strong sense of community, and its residents are actively working to preserve its rich history and build a brighter future.

Allegheny County has a higher Black population than the Pennsylvania average, with 13% compared to 11% statewide. The Northside of Pittsburgh's Black population is 12% higher than the county and 14% higher than in the rest of the state. (8, 9)

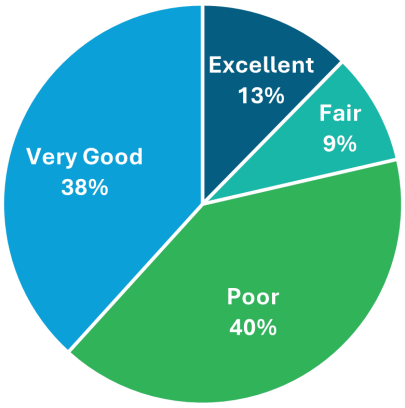
Northside residents, which make up 14% of Pittsburgh's total population, are often unable to access or are unaware of critical health and social services in their local community. According to the Allegheny County Community Needs Index, the Northside communities experience some of the highest levels of need. (10)

Some residents experience frequent and costly hospitalizations and ED visits and have low follow-up rates with human and social services agencies. On top of juggling the demands of day-to-day life, residents may not know who or where to turn for assistance or may wait until the situation turns into a crisis.

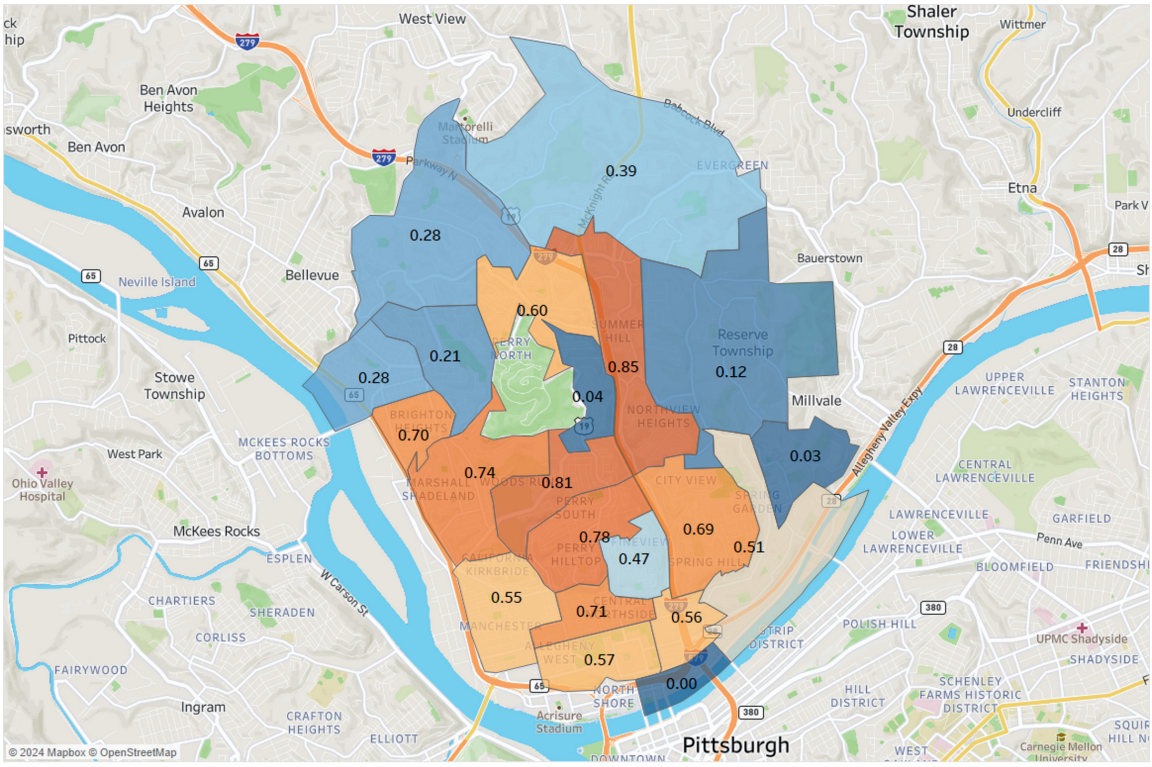
The Centers for Disease Control and Prevention (CDC) Social Vulnerability Index (SVI) (11) is a tool used to measure the relative vulnerability of every U.S. County and census tract. The SVI ranks tracts on 15 social factors, grouped into four themes: socioeconomic status, household characteristics, racial and ethnic minority status, and housing type and transportation.

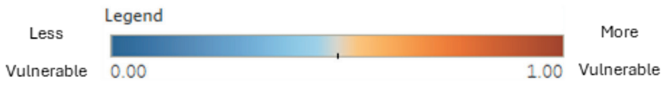
Our work in these communities has shed further light on their residents' self-reported general health. Of those surveyed by Thrive18, approximately 40% rate their own physical and mental health as poor, compared to an Allegheny County average of 15%. (12) These results reflect an opportunity for improvement in the health and well-being of Northside residents and illuminate the need for an organization like Thrive18.

Thrive18 Participant Self-Rated General Health



Social Vulnerability Index
City of Pittsburgh Northside Neighborhoods





HOW DOES THRIVE18 WORK?

At its core, Thrive18 is a resident driven model that relies on trained CHWs to work closely with residents to meet the needs of the Northside community. Thrive 18 CHWs reach out to Northside residents identified via referrals by trusted partners like the Federally Qualified Health Center (FQHC), Northside Christian Health Center, Medicaid plan, Highmark Wholecare, and Allegheny Health Network (AHN). The CHW then contacts the individual to identify their top needs. Once this step is complete, the residents are then connected to a network of CBOs, state, county, and other local resources.

One tenet of Thrive18's strategy is that identifying and addressing the needs of a community should be done by that community. Community members often have the clearest insights, along with the necessary trust and relationships, to develop and deliver successful solutions with lasting benefits. (13) This approach is critical in the Northside communities of Pittsburgh, whose residents have shared with Thrive18 CHWs that they often feel like their voices and experiences have not been heard or considered by health professionals and social service systems.

Thrive18 distinguishes itself from other organizations on the Northside of Pittsburgh through several key offerings and approaches.

- **Holistic Community Health Approach:** Thrive18 does not limit itself to addressing medical needs but seeks to address residents' spiritual well-being and other SDOH including housing stability, food security, and access to education.

- **Strong Collaborative Partnerships:** The Thrive18 outreach team has established strong partnerships with key stakeholders in the community, including healthcare providers like AHN Allegheny General Hospital and local FQHC, Northside Christian Health Center, as well as social service agencies, educational institutions, and local businesses. These partnerships enable Thrive18 to leverage resources, expertise, and networks to maximize impact and reach more individuals in need.

- **Innovative Programs and Initiatives:** To address emerging needs and gaps in services, Thrive18 includes initiatives on mental health awareness, community engagement, and local resource access for underserved populations.

- **Focus on Sustainable Impacts:** The Thrive18 outreach team is committed to creating a sustainable impact in the community by empowering individuals and families to become self-sufficient and resilient.

- **Responsive and Adaptive to Community Needs:** Thrive18 continually adapts its programs and services based on feedback from the community and emerging trends. This responsiveness ensures that the Thrive18 outreach team remains relevant and effective in meeting evolving needs and challenges faced by Northside residents.

"We as a family have had to overcome a lot of things. And I think places like Thrive18 help address some of those things. I met Rhandi [assigned CHW] because her son attends the school I work at. When I enrolled in Thrive18 she just happened to be the worker assigned to me. So, it felt a little more personal to me. Between Thrive18 and my children, I eat healthier, I feel more energized. My children are relieved with Thrive18 because they feel safer with Rhandi." - Rebecca, Northside Resident, Thrive18 Participant

"Before I started working with Thrive18, I was actually a family in need of help. From there I've been working with Thrive18 for two and a half years now. Because I know the need." - Rhandi Belland, Community Health Worker, Thrive18

Thrive18 Process and Workflow

Trusted Partners

Northside Christian Health Center, Highmark Wholecare, Medicaid Plans, and Allegheny Health Network identify an eligible resident and send a referral to Thrive 18.

Community Health Workers

Community Health Workers connect residents to state, county, and other community-based organizations.

Community Based Organizations

Connect residents to state, country and other local resources to fulfill their stated needs.

Why a Personalized Approach and Social Context Matter

A clinician from Allegheny General Hospital sent a referral to Thrive18 requesting assistance for a patient experiencing food insecurity. During the initial outreach, the CHW found that the patient resided in a home with multiple people, all experiencing food insecurity. The CHW provided the individual and family with emergency food assistance and then began to help the family pursue long-term assistance through various resources in the community.

This example demonstrates the importance of Thrive18's personalized approach and direct connection with CHWs who can problem solve with the understanding that individuals function within the larger system of family, community, and society. For healthcare staff, understanding a patient's food insecurity and broader social context is crucial for effective diabetes management because these factors directly impact their ability to adhere to treatment plans and achieve optimal health outcomes.

Thrive18 Community Collaboration

Thrive18 collaborates closely with leading organizations committed to holistic community care in a reciprocal process of both receiving and sending referrals. Key organizations include:

- **Northside Christian Health Center (FGHC):** Providing essential healthcare and behavioral health services to underserved populations in the community.
- **AHN Allegheny General Hospital:** Offering comprehensive medical care and support to individuals in need while reducing emergency room utilization.
- **Highmark and Highmark Wholecare:** Leading health insurer supporting Thrive18 efforts to expand access to essential health services, while reducing emergency room utilization.
- **Light of Life (local CBO):** Addressing homelessness and addiction with compassionate care and critical support services.
- **Allegheny County Department of Human Services:** Working tirelessly to enhance social services and support systems for vulnerable individuals and families.
- **Greater Pittsburgh Community Food Bank:** Addressing food insecurity by providing nutritious food to those in need throughout the region.
- **Duquesne Light and Peoples Gas (local utility companies):** Supporting community outreach efforts and enhancing quality of life through sustainable energy solutions.

This collaboration is instrumental in Thrive18's ability to deliver impactful programs and initiatives that address critical SDOH, including housing stability, food security, and access to healthcare.

AHN HOSPITAL CONNECTION

AHN's Allegheny General Hospital emergency department (ED) is one of only two Level 1 Trauma Centers in the entire region and serves high volumes of patients, including many with medically complex cases.

ED patients often have immediate social needs, and frequently those needs are directly related to why they came to the ED. However, connecting patients from the ED in real time with CHWs proved challenging. As part of Thrive 2.0, the collaborative is piloting Thrive18 CHWs at Allegheny General Hospital as a new method for reaching residents who may benefit from Thrive18 support.

Once a week, Thrive18 CHWs are present at Allegheny General Hospital to connect in person with patients who have been referred to the program and start to help them solve their needs before they leave the hospital.

Early feedback indicates the CHW's presence has led to increased awareness of the value of this resource among Allegheny General Hospital staff and increased engagement with residents referred to the program.

One tenet of Thrive18's strategy is that identifying and addressing the needs of a community should be done by that community.

Proof Point - Care at the Family Level

Recently, a Thrive18 CHW met with a patient at Allegheny General Hospital at the request of staff. When the CHW met the patient, they also met visiting family, including a female relative with a newborn baby and social needs. The CHW was able to quickly provide services to the entire family.

Our initial thought when implementing the Allegheny General Hospital Thrive18 Connection was that most opportunity to connect with patients would be only in the emergency department. We quickly realized that it was challenging to connect in real time partly due to the nature of the work and the availability of the Community Health Workers. From there, we decided to expand our workflow and develop a process to connect patients in any level of care in the hospital to the Thrive18 Community Health Workers. This allows for more connections to be made to Thrive18 before patients leave our care." - Jamie Nee, Director of Case Management, Allegheny Health Network

"Our team has had the opportunity to visit patients in the Allegheny General Hospital emergency department, Clinical Decision Unit, and the inpatient areas every week since February 2024. This has created a more personalized approach to allow our team to build and establish trusting relationships with those we see." - Gwendolyn Murphy, Outreach Manager, Thrive18

"By visiting face to face, we can immediately begin our intake process, discuss needs and concerns to assess their social determinants of health, and connect them to an assigned CHW to provide follow-up services more quickly once they are discharged. Patients have continually shared with us how they appreciate being able to put faces and smiles to the name of our Thrive18 team." - Celeste Benzo, Outreach Coordinator, Thrive18

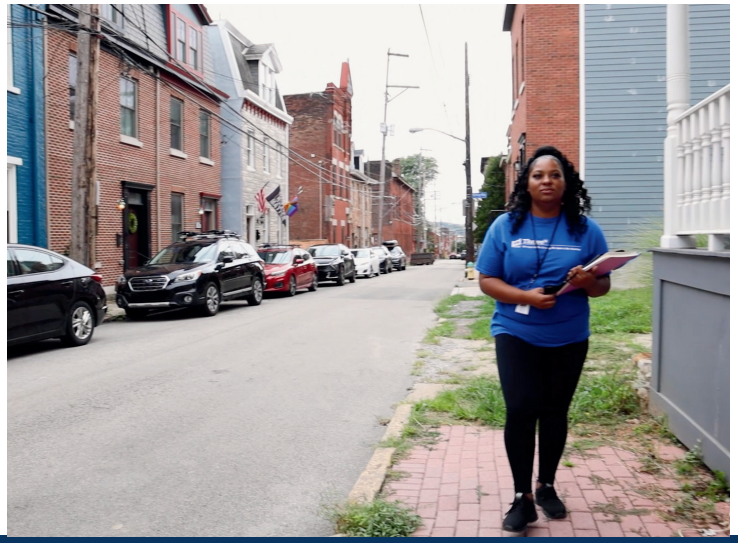
IMPACT TO DATE

"It makes me happy, to work for an organization that is really helping people and getting results for people's needs."
- Renita Freeman, CHW, Thrive18

Thrive18's community-focused approach has proven successful. Impressively, the program has sustained a 91% engagement rate among those with identified needs. This sustained engagement rate is critical, given that individuals engaged in their health care report better health outcomes. Programs like Thrive18 that start with a local approach focused on social needs can build a bridge to the health system, improving access to care for vulnerable populations. To better facilitate this connection the Thrive18 database was implemented, providing secure, real-time data access to CHWs, coordinators, and directors. This leads to increased insights into the impact this program has on their residents' lives.

As of August 2024, more than 3,000 Northside households have gained better access to health care and social services during the program's lifetime. Since most households have multiple needs, more than 43,000 needs have been addressed, leading to more stable living conditions and improved well-being.

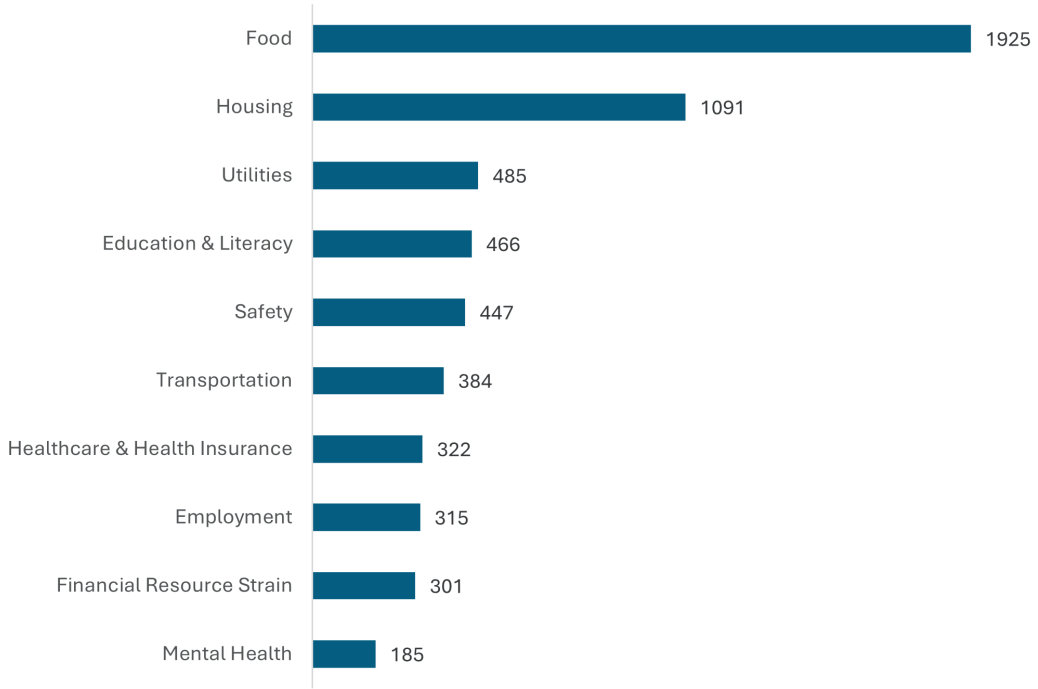
Health education and literacy have been a consistent need identified by residents in the initial Thrive18 intake process. Low health literacy is linked to poor health outcomes and increased healthcare costs. (14, 15) People with proficient health literacy can effectively navigate the healthcare system, understand medical instructions, evaluate health information, and engage in preventative care. This leads to better health outcomes, more effective management of chronic conditions, and overall improved well-being.



Thrive18 CHWs play a critical role in bridging gaps in health literacy and working toward improving health outcomes for the residents they serve. They support health literacy in several ways, including education and outreach, personalized support to help people understand the healthcare system and how to get the most out of their medical appointments, and resource navigation. Thrive18 excels in building trust and rapport with residents, and that helps improve communication between healthcare providers and patients.

Results have shown that residents who participate in the Thrive18 program experience significant improvements in food insecurity, housing, utility assistance, employment, and transportation. More than half of households engaged had at least one of their needs resolved. In addition, data provided by Thrive18 suggests that participants working with the Thrive18 CHWs are more likely to attend preventative wellness visits. These visits contribute to maintaining overall health, managing chronic and existing conditions, and preventing avoidable emergency care. (16)

Top Resident Needs Addressed by Thrive18 October 2018 – June 2024



Housing is one area where Thrive18's assistance has undeniable impact. According to studies by the National Low Income Housing Coalition, housing is unaffordable for a record-breaking number of families. Nationally, 70% of low-income families pay more than half their income on rent and only 1 in 4 low-income families who request housing assistance receive it. (17)

To date Thrive18 has addressed nearly 1,100 instances of housing needs, as reported by participants. More work needs to be done to measure medical cost avoidance, but housing insecurity is linked to an increased risk for chronic diseases, mental health issues, communicable diseases, and death. One study from the National Alliance to End Homelessness estimates each chronically homelessness person costs taxpayers more than $35,000 on average. (18)

Thrive18 Response to Housing Needs
October 2022 - April 2024

Thrive18 Response to Housing (June 2022- April 2024)	
Avoided eviction	61%
Enrolled in rent / financial assistance	59%
Homeless – helped find housing	39%
Provided information on home improvement resources	36%
Found housing	34%
Helped with home repairs	29%
Addressed unsafe housing condition	22%

LESSONS LEARNED

The Thrive18 program serves as a powerful example of how multi-sector collaboration between community organizations, philanthropy, government, healthcare payors, and healthcare systems can address SDOH. This initiative has also yielded valuable lessons about the importance of CHWs, the impact of clinical referrals, and the need for innovative funding models to sustain such impactful programs.

Impact of cross-sector collaboration and innovative funding models

Thrive18 exemplifies innovative collaboration between a community-based organization, philanthropy, government, community, healthcare payor, and health system stakeholders. By pooling their expertise and resources on the complex challenge of solving social needs at a community level the collective impact is magnified.

Population health programs are often hard to sustain because of the "wrong pocket" problem where an investment made by one organization or sector benefits another organization or sector. While analysis indicates this intervention did produce some medical cost savings, as designed, it was not nearly enough to offset the full cost of the program.

As a result, community initiatives such as Thrive18 likely require braided funding or innovative finance arrangements such as impact investing models to sustain the robust services needed to support the community. The investment in CBOs not only increases the likelihood of success because of their local knowledge and hard-earned trust, but it also empowers communities and builds resilience.

Value of referrals from clinical settings

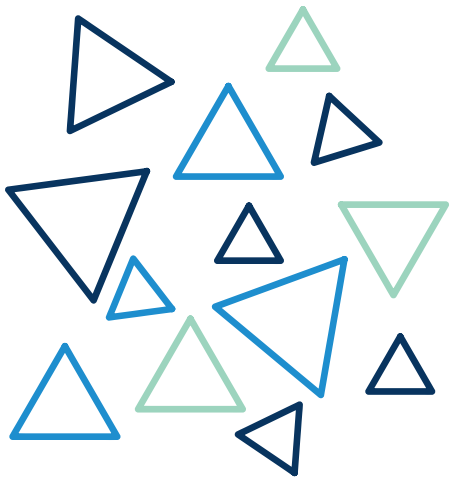
Referrals from clinical partners demonstrate higher engagement of families connected to Thrive18, highlighting the trust residents place in providers and the importance of warm hand-offs between the medical and social sectors. Data collected from the program has consistently demonstrated that referrals made by the healthcare sector have been successful. Warm hand-offs from AHN clinical staff to the Thrive18 team resulted in 98% engagement with residents. This sustained success has led to a collaborative pilot where Thrive18 CHWs are staffed in person at Allegheny General Hospital once a week to meet with patients who may benefit from services.

"One of the biggest problems Thrive18 is trying to solve and work on is getting people access to care, preventing serious involvement in health services or mental health services. Trying to meet people early and get them what they need in order to thrive. This unique opportunity where you have a community and hospital system aligned is amazing" - Erin Dalton, Director, Allegheny County Department of Human Services.

Value of CHWs in building trust

CHWs are key to Thrive18's high engagement rate, building trusted relationships and meeting the needs of socially vulnerable families. From the beginning of the Thrive18 program, it was evident that CHWs and their connections to local CBOs were a vital piece in connecting residents to the services they needed. CHWs build trust with residents, sometimes by sharing their own experiences and teaching them how to navigate an often-complicated social service ecosystem. Early door knocking campaigns brought Thrive18 staff to the doorsteps of people who needed services but often did not know where to look for assistance. The sustained engagement rate of over 90% indicates CHW based models are highly effective at engaging populations with barriers to care and trust with the healthcare system.

"We have a great appreciation for a like-minded team of skilled individuals working collaboratively on shared goals with Thrive18 participants. It is more than just a paycheck to accomplish complex tasks for our families to thrive. It goes beyond an 8-hour day to fulfill the needs of the families we serve."
– Dr. Daphne Curges, Director of Thrive18, Project Destiny, Inc.



CALLS TO ACTION

Addressing SDOH requires a multi-faceted approach that involves collaboration across communities, philanthropy, the healthcare sector, and policymakers. This call-to-action outlines key steps for each stakeholder to effectively address the social factors that impact health outcomes, ultimately creating a more equitable and healthier society.

"Programs like Thrive18 demonstrate that shared investment in health-related social needs can produce shared returns and challenge us to reach beyond the confines of clinical care to improve health at the community level."
- Nebeyou Abebe, Senior Vice President, Social Determinants of Health, Highmark Health

Community

- Acknowledge and address needs of your local community; advocate with community leadership to improve resources available to residents.
- Create advisory boards that can influence and collaborate with healthcare organizations to address SDOH in healthcare settings.

Philanthropy and Funders

- Consider collaborating with community organizations to focus on population specific needs and involve people with lived experience.
- Utilize open discussion with community members to determine the most impactful way to allocate funding.
- Be open and ready to fund community initiatives that address SDOH with an understanding that traditional return on investment metrics may not be immediately apparent, but the long-term benefits are significant.

Philanthropy and Funders

- Consider matching gifts or innovative financing models with other institutions that have both community social responsibility and business incentives for investing in the community, such as the healthcare payors, providers, and financial institutions.

Policy Makers

- Develop revenue streams and incentives for healthcare providers to screen for and address SDOH.
- Support the development of healthcare infrastructure that is inclusive of social care, such as data standardization and integration with state health information exchanges and funding for addressing social needs via channels like CMS 1115 waivers.
- Encourage the development of funding streams to navigate and close social health needs for community members.

Healthcare Sector

- Increase provider knowledge around health-related social needs, SDOH, and health equity, particularly highlighting how these contribute to health outcomes. For example, understanding that transportation access can impact office visits or that financial resource strain and cost of medications can impact adherence to treatment protocols.
- Implement processes and technology that integrate SDOH screening and referral at scale in your health system.
- Facilitate warm hand offs to trusted partners, like Thrive18, when SDOH needs have been identified by going beyond the technology and engaging directly with CBOs for the patient.
- Increase availability of resources by collaborating with community members in all neighborhoods served.

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