



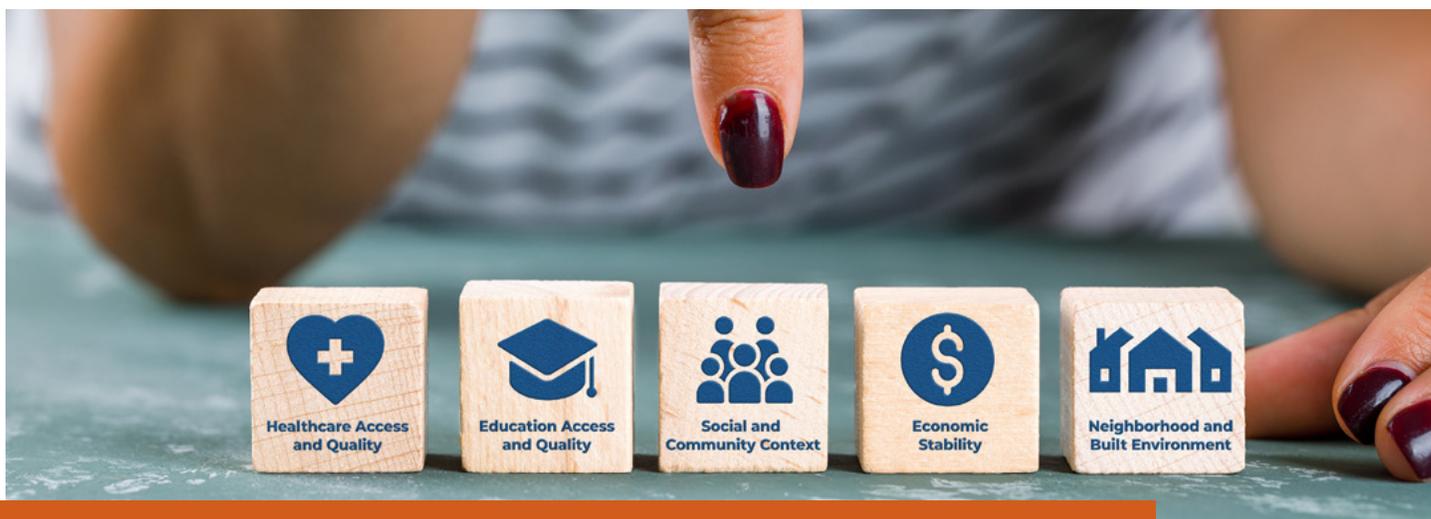
Guide to Attracting Funding Resources to Address Social Determinants of Health Needs

Expansion and improvement of community infrastructure to address social determinants of health (SDOH) for people facing complex challenges requires public and private leadership, commitment to common goals and funding sufficient to create and sustain the planned impact.

Across the United States there is a demonstrated rise in funding and investments from the health sector and other public and private corporations into projects and programs addressing Social Determinants of Health (SDOH). In response to this rise, health centers can proactively work to expand their understanding of innovative funding models and build their own capacity to attract funding necessary to reach defined outcomes.

This Guide to Attracting Funding Resources to Address Social Determinants of Health Needs will explore, from the community health center perspective, approaches to attract investments in SDOH that meet common, critical patient needs such as housing. This national audience guide will increase health center understanding of these funding strategies and how health centers and other community providers can leverage their expertise to advance approaches to meet true community needs and address long-standing inequities in access to SDOH community assets.

Health Centers, since their inception, have recognized the need to deliver wide ranging services, as well as establish broader community partnerships such as with food pantries and housing providers to address the realities of the social, economic and community conditions impacting their patients' health and well-being. In the most recent decade, other health sector providers, including hospitals, managed care, and insurance providers, have expanded both their understanding of, and their actions in response to, clear indications of SDOH needs. Health centers can maximize their leadership role in the community to attract and catalyze funding by positioning health system partners' perspectives and roles in the current SDOH landscape.



Attract Funding by Focusing on Key Trends in the SDOH Landscape

Highlighted in this section are key trends and topics in the SDOH landscape that engage partners to create a shared vision based on understanding the needs of patients and existing community capacity to address them. Building on this shared vision, the partners begin to design and develop the collaborative programs and strategies that are attracting investments from health sector partners. Examples of programs and funding strategies that address these key SDOH needs are highlighted below.

SDOH Screening, Referrals, and Impact

Determine the SDOH needs of patients through consistent and standardized tools for data collection and analysis. Identify the community programs and assets that can meet these needs and assess the effectiveness of any connections made to partner systems.

Conversations about the effectiveness of SDOH referrals and health outcomes should examine:

- + the effectiveness of screening tools,
- + who/how are staff using screening tools,
- + systems and procedures that connect SDOH screening data to health records to assure coordinated care,
- + shared data to document health-related outcomes.

SDOH DATA SCREENING AND CROSS-SYSTEM DATA COMPARISON

[UDS Quick Guide, CSH 5/2021¹](#)

[Data Integration Best Practices for Health Centers & Homeless Services, CSH 12/2020²](#)

When examining the effectiveness of SDOH referrals to support improved health outcomes, community service providers, health centers, government and other health sector partners are collaborating to develop and invest in systems for ‘closed loop’ and data resource referral networks. These systems enable partners to stay current of the status of community resources, find solutions to address gaps and barriers to access, and track outcomes for patients. Referrals to diminished food pantries or long waiting lists for affordable housing raise questions as to the true effectiveness of the referral, and any potential to impact health conditions.



Examples of local and statewide referral systems have been created by **Unite Us**³, **Help Finder**⁴ and **JIVA**⁵. Health plans have been the originators of some of these technology tools and introduce the opportunity for systems to also integrate into care management software to track health outcomes. The **NC Cares 360**⁶ powered by Unite Us is one of the most comprehensive statewide referral systems, funded through a partnership between the North Carolina State Department of Health and Human Services and the non-profit Foundation for Health Leadership & Innovation.

Strategic Partnerships

As health centers learn and track more about the non-clinical health needs of their patients, they seek to expand internal health center capacity and create strategic community partnerships. Effective community partnerships must build upon a comprehensive assessment of community assets and service provider capacity to meet patient SDOH needs. Networking with community providers to compare and map each system’s eligibility, priorities, and procedures is an effective means to identify gaps and highlight opportunities to create and invest in new programs and processes that increase capacity in those areas that can have true impact on patients’ health. Flexible housing and services pools (further detailed below) are an excellent example of how health and housing partners can not only consolidate investments to fund housing and support services, but also demonstrate how the organizations can collaborate to adapt procedures that minimize the number of doors and applications individuals and families experiencing homelessness will encounter before they can access housing and services.

Develop a SDOH Agenda with a Focus on Health Equity

Addressing the long-standing inequities in access to quality healthcare and housing to achieve improved outcomes, requires reconsideration of how decisions are made, how resources are allocated, and the steps systems must take to realign priorities to address where the systems are currently failing. A comparative analysis of SDOH needs in a community with an equity lens will look at SDOH screening and electronic health records data across racial, ethnic, and other demographics of who is served, with a comparison of the SDOH data to the representation of the demographic groups in the broader community. Building on the process mapping analysis of the community systems, communities can identify barriers to access for those that data shows are still under-served. An effective data driven SDOH agenda that prioritizes health equity should include outreach strategies, programs, staffing, partnerships, and outcome goals that provide direction for investments into necessary system changes.

LOCAL AND NATIONAL DATA SOURCES ARE AVAILABLE TO SUPPORT HEALTH CENTERS TO LEARN THEIR LOCAL DEMOGRAPHICS AND CAN HELP HEALTH CENTERS DETERMINE DISPARITIES IN THEIR COMMUNITIES:

- ☑ [Census Bureau](#)⁷
- ☑ [Robert Wood Johnson Foundation \(RWJF\) County Health Rankings](#)⁸
- ☑ Local health department
- ☑ [Corporation for Supportive Housing Racial Disparities and Disproportionality Index](#)⁹



Data Driven Health Equity at Work: Data indicating disparities in access to health care and other community resources can be used to guide health center priorities, partnerships, and potential investments. For example, study results ***showing poor infant and maternal health and mortality for African-American mothers***¹⁰ as compared to other community members is an example of how health data disparities can direct health center focus on the specific needs of that population. Strategies can work to address those needs directly such as intensive care coordination to address not only health needs but SDOH and/or developing an advocacy agenda that moves a state to expand Medicaid coverage for evidence based maternal practices such as 12 months post-partum primary and mental health services, and doula services to assist mothers in those early challenging months post-partum.

Collaborate with System Users

Engagement with patients and community to integrate the voice of People with Lived Expertise (PWLE) is vital at the start and throughout the process of building a health equity agenda. In the context of resources and investment, meaningful engagement with the community can be achieved by identifying an existing or developing a new multi-sector planning group to examine current systems and develop key strategies to address the gaps identified. This group should include persons who identify as Black, Indigenous or People of Color (BIPOC) and be led by individuals with lived experience of the challenges that have been identified. Each step must be grounded in what is learned from community engagement including feedback from patients and partners to understand how any new programs or changed procedures impact the health and SDOH needs of persons who use health center and community services. Integrating the voice of PWLE is not just a ‘one and done’ process but must be an integral part of the system change that drives decisions and investments.

Valuable input can and should be incorporated from front-line staff and community health workers (CHW) who may reflect the community demographically and increase the understanding of patient needs and improve referral pathways. For additional resources, explore ***Community Health Worker/Peer Workforce: Recruiting and Hiring for Social Determinants of Health Screening***¹¹ to further recognize the voice of CHWs in building community connections to address SDOH needs.



Align SDOH Agenda With Partner Interests

After collaboratively developing a health equity SDOH agenda, health centers are well positioned to attract funding partners who have a shared stake in achieving one or more strategic goals. When seeking partners, it helps to understand the priorities and motivations that bring the partners to the table.

In the context of SDOH funding and investments, these motivations are generally broken down into three primary categories:

1. Social Return/Mission Alignment
2. Cost Avoidance/Financial Return
3. Mandates/Policies

It is important to keep in mind, that any potential funding partner likely has multiple motivations that may fall into one or all of these categories.

1 Social Return/Mission Alignment

Potential partners may have a shared interest in improving a prevailing condition that impacts the lives of health center patients. A nonprofit homeless shelter whose clients receive services at the health center has a shared interest in working with a health center to better meet the medical and housing needs of their shared clients. For health centers focused on addressing patient nutritional needs to improve health outcomes, a food rescue organization could collaborate to raise philanthropic and community resources to improve access to healthy foods.

Private corporations have goals dictated by corporate social responsibility and may be willing to invest resources towards the implementation of health or SDOH focused initiatives. Sponsorship of a community health fair as a joint initiative with a health center represents an alignment of a social return agenda. In addition, the positive publicity generated by the launch of such initiatives may be additional motivation to corporations and other partners.



The Lilly Endowment, Inc., a private philanthropic foundation created by the Eli Lilly Corporation (pharmaceutical) in 1937 is investing in community initiatives to support Enhancing Opportunity in Indianapolis and other communities. Among the **2021 grant awards**¹², the Lilly Endowment, Inc. supported **Horizon House**¹³, a homeless housing and service provider in Indianapolis, to hire and train peer support specialists who have lived experiences of homelessness to connect their peers to health and community service providers in the community.

2 Cost Avoidance/Financial Return

In the context of healthcare partnerships, cost avoidance motivation is often applicable to managed care organizations, health systems and hospitals seeking alternative strategies that can reduce delivery of higher cost services. For a hospital or health system, they often see patients experiencing housing instability who are using the emergency room for non-emergent issues or who cannot be discharged from inpatient care due to a lack of available housing or support. Both hospitals and managed care organizations likely have patients and members using these high-cost services where costs could be reduced, and outcomes improved through better access to housing aligned with supports. These partners have a shared desire to redirect resources to support more preventive care, non-emergent primary health, and community-based supports which may align with a health center's agenda in terms of meeting medical and SDOH needs.

While private corporations have obligations to sustain their own financial well-being, they will often invest corporate funds with an expectation of a financial return that could still align with health center goals. Such investments that generate both financial and social return are sometimes called 'double bottom line.' Investments in affordable housing through tax credits, as further detailed below, highlight corporate funding that provides financial return and achieves a beneficial social outcome.

3 Mandates/Policies

At times, partners are incentivized to invest based on a need to meet particular funding or regulatory requirements. For instance, nonprofit hospitals are required by law to spend a portion of their financial surplus on what is termed **'community benefit.'**¹⁴ Development of a community benefit plan requires the hospital to engage with partners to complete a community assessment, presenting an opportunity for health centers to help direct where these resources are provided based on documented need. Common Spirit (formerly Dignity Health) works closely with communities to **identify health needs**¹⁵. Governments may also be incentivized based on legislative and court mandates. Federal law under the Americans with Disabilities Act and related court decisions such as the **Olmstead Supreme Court**¹⁶ Case require that people with disabilities be allowed to live in a setting that is integrated into the community. To comply with this mandate, some states have put resources behind creating additional housing and services so that people are not unnecessarily institutionalized. This spending may align with health center goals to provide community-based care to the greatest extent possible. Health Centers can play a significant role in **Community Based Supportive Housing Serving Persons with Disabilities at Risk of Institutional Care**¹⁷.

Considerations for Health Centers When Aligning a SDOH Agenda

The process of understanding alignment between health center goals and those of potential partners is critical to the success of future investment partnerships. The steps and questions for reflection below can guide these efforts. This list is not exhaustive, but is meant to offer health centers (HC) a way to jumpstart conversations with investment partners:

#	Component	Activities, Considerations and Decision Points
1.	Reviewing the Agenda	+ How do the elements on the HC agenda resonate for this potential partner, and vice versa?
2.	Population Alignment	+ What population does this organization serve? Is there alignment with the population served by the HC, and if so, are the desired outcomes for this population aligned? + What challenges does this partner have as it relates to an overlapping population? Can the HC help address the challenges through existing services or through implementing a new collaborative initiative?
3.	Resource Availability	+ What funding could the potential partner put toward implementing an aspect of the shared agenda? + What services or supports does or could this potential partner offer toward the shared agenda item or shared population of focus? <i>* Note: Resources may include direct financial investment or making existing services more available to health center clients.</i>
4.	Identifying Additional Partners	+ Does this partner have other potential partners that should be included? What is the best incentive to have them join the conversation? + How are the HC and potential partners inviting people with lived experience of the issue being solved for to the discussion? Who else should be at the shared table who is not?
5.	Taking Action	+ What shared action makes sense based on your identification of areas of alignment? Is it a new initiative? Expanded funding? Program redesign?



Understand Models and Approaches That Bring Funding to SDOH

A number of funding approaches and initiatives may be of interest to health centers in their efforts to accomplish their community's SDOH agenda. This section introduces and provides examples of four common funding approaches for investments in SDOH:

1. Tax Incentive Programs
2. Pay for Success
3. Collective Impact Funds
4. Health System Community Benefit Philanthropy

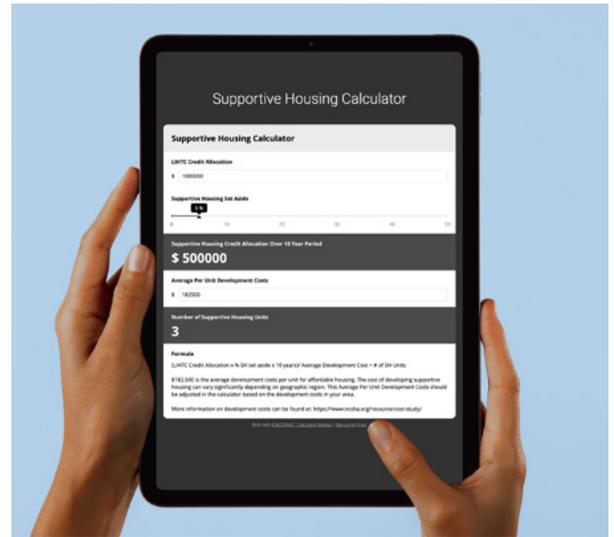
Details on these approaches include attention to the partners' motivations and interests as well as identification of shared goals and outcomes.

1 Tax Incentive Programs

The federal tax code has historically utilized a system of tax incentives (or disincentives) to drive public policy. Common examples include taxing products such as tobacco to discourage use or tax rebates on purchases of energy saving equipment to improve the environment. Tax incentives in the form of tax deductions or tax credits are frequently used to drive investments to build infrastructure, including housing and real estate and are often utilized as an alternative to direct grants or loans. The funders receive a financial benefit on their investment (reduced tax liability) when they invest in transactions that provide a tax credit or deduction.

The Low-Income Housing Tax Credit (LIHTC) program was added to the federal tax code in 1986 and provides a dollar-for-dollar reduction in federal tax liability for eligible investments in rental housing that meet specific criteria to serve low- and moderate-income households. Updated data from the **federal Department of Housing and Urban Development, Office of Policy Development and Research**¹⁸ indicates more than 3.44 million housing units have been created through 2020 through this program.

Corporations are the most common investors to use the LIHTC program to reduce federal tax liabilities, not just for one year, but for 10 years based on compliance with ongoing performance requirements. Priorities for the allocation of tax credits are outlined in the Qualified Allocation Plan (QAP) for each state. Health centers can provide input on the alignment of health and housing SDOH needs by participating in their state's annual QAP policy development. Stakeholders can use the public hearing and comment periods to advocate to the state housing finance agency to better target tax credits to properties that house people with greatest need. **Explore your state QAP using the CSH Analysis Tool**¹⁹. United Health Group is one of many health-related corporations that are leveraging their financial resources (**nearly \$800 million as of April 2022**)²⁰ to **expand affordable housing**²¹ and address SDOH gaps in communities.



*Anyone advocating for a Supportive Housing Set-Aside in their state's QAP can use the **CSH Supportive Housing Calculator**¹⁹ to project the number of supportive housing units that can be built through a dedicated supportive housing set-aside.*

2 Pay for Success (PFS)

Pay for Success refers to the concept of paying for positive social impact rather than paying just for services performed. Corporation for Supportive Housing's (CSH) report, **'Health Center Role in Housing Innovations: Pay for Success Models'**²² provides details on terminology, the outcome metrics, how funding will be invested to fund the service intervention, and roles of key partners.

Under this funding model, the impact is measured rigorously, and "success payments" are made based on the achievement of agreed-upon metrics. PFS typically includes performance-based contracting between an entity, often government, paying for the achievement of outcomes, and the organizations responsible for implementing a given intervention, often nonprofit organizations. Health centers have been involved in such models as providers of housing and services such as the **Denver Social Impact Bond**²³ and United Healthcare's role as an investor in the **Los Angeles Just in Reach Pay for Success initiative**²⁴. Such initiatives can align a broad range of stakeholders, including health centers as a key community partner, toward improving outcomes for groups of individuals and transforming systems toward more sustainable funding for SDOH such as supportive housing.

3 Collective Impact Investment Funds

Collective Impact Funds targeting SDOH engage a group of partners to pool their financial resources to maximize the funding available for a program or project that requires greater resources than just one partner can provide. The collective impact fund can generate an increased or greater social return or benefit to address shared goals and outcomes identified by the community and partners. The ***Oregon Housing is Health Initiative***²⁵ brought together six health system partners to fund over \$21 million for the development of the Blackburn Center, a co-located health and housing development that fills the significant gap in housing and services for vulnerable populations including respite beds, substance use services and recovery housing, and affordable housing with primary and behavioral health services.

Other examples of Collective Impact Investment Funds will have a longer time duration than a single investment with the goal of addressing ongoing needs identified in the community. The Flexible Housing Fund model highlights the potential impact of consolidating investments into an ongoing fund that can pay for access to housing and a range of SDOH needs for the community's most vulnerable populations. In Chicago for example, the funding partners include hospitals and health systems, county agencies, corporate and foundation philanthropic organizations. The shared goals identified by the partners include stabilized housing, access to regular health care, and reduced demands for emergency health and justice systems. ***The Chicago Flexible Housing Fund***²⁶ is administered by the Center for Housing and Health, an affiliate of the AIDS Foundation of Chicago. The resources invested total over \$13 million and continues to provide a significant social return for the broader community through quality housing and service supports for the most vulnerable and the highest utilizers of the City's crisis systems.

4 Hospital Community Benefits

Not-for-profit hospital and health systems, to maintain their federal tax status are required to invest and contribute a portion of their financial surplus on "community benefits." For decades 'charity care' for individuals with no means to pay for health services was often the benefit provided to meet this obligation. The ***Patient Protection and Affordable Care Act (ACA)***²⁷ expanded the obligation for not-for-profit hospitals to every three years conduct a community health needs assessment (CHNA) and adopt a Community Benefits Implementation Plan which is monitored by state agencies. The assessment is intended to inform and connect the hospital's community benefits plan with the demonstrated health needs in their communities. Community input is a key element in the CHNA. The ***Hilltop Institute report provides links to each state Community Benefit Law***²⁸. These ACA requirements, as well as the changing role of managed care Medicaid organizations and Medicare plans have influenced hospitals to revisit the scope of their connections to housing and SDOH.

Examples of recent community health benefit investments include community health advocacy and education, neighborhood revitalization, donated land or property, care coordination supports, leadership development and training, and economic and workforce development. The Boston Medical Center provides an example of diverse investment of community benefits resources. The health system is not building its own housing units but is instead ***investing community benefits***²⁹ resources into a range of community programs that address housing insecurity and quality. One of the noted investments includes a \$200,000 fund to make minor improvements in subsidized housing to address environmental health hazards such as lead paint or mold remediation. The most recent ***2019 Boston Medical Center Community Health Needs Assessment***³⁰ and ***Community Benefits Implementation Plan***³¹ provide guidance for community organizations for opportunities to engage with these health resources.



Moving to Action

The steps that health centers can take to attract additional funding for the SDOH needs of patients are summarized below.

- ☑ **Use data** from screening tools, health records, local and national sources, and conversations with community partners and patients to understand the SDOH needs of health center patients. Understand the extent to which such needs can be met by existing community resources.
- ☑ **Develop an SDOH agenda**, with a focus on health equity, which lays out health center priorities as it relates to meeting the SDOH needs of patients. Ensure that Persons with Lived Experience and those who identify as Black, Indigenous, People of Color (BIPOC) are part of this development process.
- ☑ **Use this agenda** to generate conversations with potential partners in the community who may have resources or funding to devote to a given SDOH need. In this process, work to understand the motivations that a potential partner may be bringing to the conversation.
- ☑ **Determine what opportunities exist** to better address a given SDOH need through collaboration. Look to models across the country for how stakeholders have attracted funding to meet SDOH needs.
- ☑ Once new resources are available to meet SDOH needs, **incorporate processes** to measure impact and evaluate the success improving health outcomes for patients.



Conclusion

Health centers are a key partner in communities implementing a patient-centered approach to meeting health outcomes and reducing disparities.

Health Centers are positioned at the front lines of understanding SDOH needs that go beyond those services traditionally provided such as housing.

This foundational understanding creates the opportunity to build community partnerships and attract financial investments building on a collective approach to improving outcomes for patients and communities.



Endnotes

- 1 https://www.csh.org/wp-content/uploads/2021/07/CSH_HRSA-Quick-Guide_WEB.pdf
- 2 <https://www.csh.org/resources/data-integration-best-practices-for-health-centers-homeless-services/>
- 3 <https://uniteus.com/>
- 4 <https://helpfinder.auntbertha.com/>
- 5 <https://www.zeomega.com/solution-trend/jiva-social-determinants-of-health/>
- 6 <https://nccare360.org/>
- 7 <https://www.census.gov/data.html>
- 8 <https://www.countyhealthrankings.org/>
- 9 <https://www.csh.org/supportive-housing-101/data/>
- 10 <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23>
- 11 <https://www.csh.org/resources/community-health-worker-peer-workforce-recruiting-and-hiring-for-social-determinants-of-health-screening-best-practices-guide-and-findings-from-covid-19-pandemic/>
- 12 <https://lillyendowment.org/wp-content/uploads/2021/03/eoi-grant-list.pdf>
- 13 <https://www.horizonhouse.cc/peer-support-services-case-management/>
- 14 <https://nchh.org/tools-and-data/financing-and-funding/healthcare-financing/hospital-community-benefits/>
- 15 http://cni.dignityhealth.org/?adobe_mc=MCMID=46975538098088942954992324295830968198&_ga=2.133460173.237708345.1613635986-293271128.1597054128
- 16 <https://www.olmsteadrights.org/about-olmstead/>
- 17 <https://www.csh.org/resources/community-based-supportive-housing-serving-persons-with-disabilities-at-risk-of-institutional-care/>
- 18 <https://www.huduser.gov/portal/datasets/lihtc/property.html>
- 19 <http://www.csh.org/qap/>
- 20 <https://www.unitedhealthgroup.com/newsroom/2022/additional-housing-investment-bolsters-uhg-efforts.html>
- 21 <https://www.unitedhealthgroup.com/newsroom/2019/2019-03-26-uhc-affordable-housing-path-metro-villas.html>

Endnotes (continued)

- 22 <https://www.csh.org/resources/new-health-center-role-in-housing-innovations-pay-for-success-models/>
- 23 <https://www.urban.org/features/housing-first-breaks-homelessness-jail-cycle>
- 24 <https://www.hiltonfoundation.org/learning/just-in-reach-and-pay-for-success-fact-sheet>
- 25 https://ccooregon.org/wp-content/uploads/2018/04/Housing-as-a-Pathway-to-Improved-Health_1.30.18_final-pres.pdf
- 26 <https://housingforhealth.org/our-work/fhp/>
- 27 https://nchh.org/resource-library/HCF_CBACA_overview.pdf
- 28 <https://www.hilltopinstitute.org/our-work/hospital-community-benefit/hospital-community-benefit-state-law-profiles/>
- 29 <https://www.bmc.org/news/press-releases/2017/12/07/boston-medical-center-invest-65-million-affordable-housing-improve>
- 30 <https://www.bmc.org/sites/default/files/CHNA-less-Graphics-2.pdf>
- 31 https://www.bmc.org/sites/default/files/About_Us/Commitment_to_Our_Community/field_Attachments/FY19-22-Implementations-Strategy.pdf





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For more information, visit **CSH.org**.